TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE PROFESSIONAL AFFAIRS COMMITTEE
OF THE BOARD OF DIRECTORS
April 13, 2017 – 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	1-3	2 min.	Chair
3.	Public Comments NOTE: During the Committee's consideration of any Agenda item, members of the public also have the right to address the Committee at that time regarding that item.		5 min.	Standard
4.	Ratification of minutes of the March 2017 Meeting	3.a – 3.g	2 min.	Committee
5.	New Business			
a.	Consideration and Possible Approval of Policies and Procedures	4-6		All
	Patient Care Services			
	1. Admission Criteria Policy	7-11		
	2. Admixture, Intravenous Procedure	12-15		
	3. Blanket Warmers Policy	16-17		
	4. Code Status/ Do Not Resuscitate DNR 312	18-23		
	5. Determination of Brain Death	24-28		
	6. Food and Nutrition Relationships with Other Departments Policy	29-31		
	7. Glucose Monitoring During Exercise Therapy for Diabetic Patients	32-33		
	8. Meals, Patients- Times, Menus, Substitutions and Nourishments Policy	34-35		
	9. Medication Recall Policy	36		
	10. Outpatient Summary List Procedure	37-38		
	11. PureWick Female Urinary Incontinence Management	39-42		
	12. Research Activity Investigational Drugs Policy	43-51		
	Administrative Policies and Procedures			
	1. EMTALA- Emergency Medical Screening 506	52-54		
	Unit Specific **Education**			
	1. ACLS Fee Waiver Policy	55-56		
	2. AHA Reciprocity Statement Policy	57		
	3. AHA Role of TCMC AHA Training Center Policy	58-60		
	4. AHA TC Course Content Requirements Policy	61-63		
	5. AHA TC Dispute Resolution- Disciplinary Action Policy	64-65		
	Medical Staff			
	1. Conflict of Interest 8710-555	66-68		
	2. Conflict Resolution Policy 8710-562	69-70		
	3. Credentialing Criteria, Chronic Non-Healing Wound Care 8710-523	71-72		
	4. Credentialing Criteria, Hyperbaric Medicine Oxygen Therapy, 8710-523A	73-74		
	5. Credentialing Policy, Expedited Credentialing and Privileging Process 8710-550	75-76		
	6. Credentialing Policy, Processing Medical Staff Applications 8710-	77-79		

6.	Review and Discussion of CLINICAL Contracts- NO Contracts To Review (*Discussion/ Possible Action*)			
7.	Motion to go into Closed Session		2 min.	Committee
8.	CLOSED SESSION a. Reports of the Hospital Medical Audit and/or Quality Assurance Committee (Health & Safety Code Section 32155) b. Conference with Legal Counsel – Significant exposure to litigation (Government Code Section 54956.9(b))		30 min.	Chair
9.	Reports from the Committee Chairperson of any Action Taken in Closed Session (Government Code, Section 54957.1)		10 min.	Chair
10.	Comments from Members of the Committee		5 min.	Committee
11.	The next meeting of the Professional Affairs Committee of the Board is on May 11, 2017.		1 min	Chair
12.	Adjournment		1 min	Chair

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
March 9, 2017

Members Present: Director Laura Mitchell (Chair), Director Jim Dagostino, Dr. Ma, Dr. Johnson, Dr. Contardo and Dr. Worman.

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

Others present: Jody Root, General Counsel, Marcia Cavanaugh, Sr. Director for Risk Management, Jami Piearson, Director of Regulatory Compliance, Kathy Topp, Kevin McQueen, Sherry Miller, Aimee Hardt, Nancy Myers, Sharon Davies, Jenessa French, Oska Lawrence, Natalie Mills, Zechariah Smith, Lisa Mattia, Priya Joshi, Patricia Guerra and Karren Hertz.

Members Absent: Director Leigh Anne Grass.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell called the meeting to order at 12:01 PM in Assembly Room 1.		Director Mitchell
2. Approval of Agenda	The committee reviewed the agenda; there were no additions. The Administrative Policy #4 on mandatory reporting requirements was pulled out of the agenda for further review.	Motion to approve the agenda was made by Dr. Contardo and seconded by Dr. Johnson.	Director Mitchell
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Mitchell read the paragraph regarding comments from members of the public.		Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Ratification of minutes of February 2017.	Director Mitchell called for a motion to approve the minutes from February 9, 2017 meeting. There was a clarification made on the statement that "only a neonatologist is allowed to intubate a baby". There was a short discussion and it was identified that this policy specifically deals with the presence of neonatologist in the OR for deliveries and not talking about the whole hospital.	The minutes were ratified following the amendments made. Director Dagostino moved and Dr. Ma seconded the motion to approve the minutes from February 2017.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:** 1. ALARIS System Data Set Approval and CQI Activities Procedure 2. Cardiac Wellness Center (On Campus) Emergency Treatment Standardized Procedure 3. Care of the Newborn Standardized Procedure	There was no discussion on this policy. This policy further clarified that BLS response now includes AED. There was a duplication in the section where the mother initiates breastfeeding when mother and infant are separated for longer than 3 hours. This will be corrected in the policy.	**ACTION:** The Patient Care Services policies and procedures were approved. Dr. Ma moved and Director Contardo seconded the motion to approve the policies moving forward for Board approval with the appropriate corrections noted by the Committee members.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Deceased Newborn Stillborn, Care of Procedure	There was no discussion on this policy.		
5. Enteral Feeding Preparation, Storage, Distribution, and Administration Policy	There was no discussion on this policy.		
6. Food Brought in From Outside the Hospital Policy	There was no discussion on this policy.		
7. Food Expiration Dates Policy	There was no discussion on this policy.		
8. Needle Aspiration Neonates Standardized Procedure	It was noted that all NICU babies are required to use the cardio respiratory monitoring which is the standard of care for this procedure.		
9. Pertussis Nasopharyngeal (NP) Swab, Adult Procedure	There was no discussion on this policy.		
10. Physicians Orders fro Life Sustaining Treatment (POLST) 393	There was no discussion on this policy.		
11. Rapid Response Team and Condition Help Policy	There was a clarification if staff in the unit knows how to initiate a Rapid Response call for condition H.		
12. Stroke Code,	The finger stick blood glucose is still being		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Emergency Department Procedure	done in the ED for stroke code patients. This is being done on other areas as well.		
13. Telephone Service for Patient Rooms Policy	There is no discussion on this policy.		
14. Therapeutic Hypothermia After Cardiac Arrest Procedure	The therapeutic hypothermia is usually done for arrests that happened inside and outside the hospital . It was agreed that policy should be kept as it is.		
15. Visiting Guidelines	There was no discussion on this policy.		
Administrative Policies and Procedures:			
1. Code Gray- Hostage Response Plan 283	Director Dagostino asked how will the BOD be informed in case there is a Code Gray situation. The group had a consensus to add: • The CEO will notify the Board of Directors • The CEO will notify the Chief of Staff	**ACTION:** The Administrative policies and procedures were approved. Director Dagostino moved and Dr. Ma seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Control for Locks and keys 243	There was no discussion on this policy.		
3. Helicopters on District Policy	There was a brief discussion on the weight of the helicopter ; it was noted that for the helicopters they factor in everything for compliance purposes—weight of the crew and equipment.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Mandatory Reporting Requirements	This policy was pulled out as it needs further review.		
Unit Specific Education 1. AHA and AWHONN Course Card Acceptance Policy 2. AHA Care and Decontamination of AHA Equipment Policy 3. AHA Continuing Education Statement Policy 4. AHA Mission Statement and Goals Policy 5. AHA Quality Assurance Program Policy 6. AHA TC Course Card Management Policy 7. Copyright Policy	Dr. Ma had an inquiry on why are we reviewing these policies for AHA. It was noted that sinceTri-City is an acredited AHA training center, the hospital needs to have these policies revisited, reviewed and approved.	**ACTION:** The Education policies were approved. Director Dagostino moved and Dr. Worman seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Infection Control 1. Meninoccocal Exposure IC 6.2 2. Risk Assessment and Surveillance Plan IC.2 3. Toy Cleaning IC 9.1	All sections that still have Tri-City Medical Center should be changed to Tri-City Healthcare Ditrict. The part that mentions significant deviations should be discussed in medical staff committees should be changed to only be on an as-needed basis.	**ACTION:** The Infection Control policies and procedures were approved. Director Dagostino moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
NICU			

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Blood Product Aliquot Syringes, Emergent preparation Of 2. Cardio-Respiratory Monitoring in the NICU 3. Neonatal Anstinence Syndrome, Management of Scoring **Women's and Newborn Services** 1. Infant Safety and Security	There was no discussion on these NICU policies. There is no discussion on this policy.	**ACTION:** The NICU policies and procedures were approved. Director Dagostino moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval. **ACTION:** The Women's and Newborn Services policy approved. Director Dagostino moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra Patricia Guerra
6. Clinical Contracts	No contracts were reviewed for this month.	**ACTION:** No action taken.	Director Mitchell
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Director Dagostino moved, Dr. Ma seconded and it was unanimously approved to go into closed session at 1:00 PM.	Director Mitchell
8. Return to Open Session	The Committee return to Open Session at 2:10 PM.		Director Mitchell
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Mitchell
10. Comments from Members of	No comments.		Director Mitchell

3.4

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

PROFESSIONAL AFFAIRS COMMITTEE
April 14, 2017

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Admission Criteria Policy	Practice Change	
2. Admixture, Intravenous Procedure	3 Year Review, Practice Change	
3. Blanket Warmers Policy	3 Year Review, Practice Change	
4. Code Status / Do Not Resuscitate DNR 312	3 Year Review, Practice Change	
5. Determination of Brain Death	NEW	
6. Food and Nutrition Relationships with Other Departments Policy	3 Year Review, Practice Change	
7. Glucose Monitoring During Exercise Therapy for Diabetic Patients	NEW	
8. Meals, Patients - Times, Menus, Substitutions, & Nourishments Policy	3 Year Review	
9. Medication Recall Policy	3 Year Review	
10. Outpatient Summary List Procedure	DELETE	
11. PureWick Female Urinary Incontinence Management	NEW	
12. Research Activity Investigational Drugs Policy	3 Year Review, Practice Change	
Administrative Policies & Procedures		
1. EMTALA- Emergency Medical Screening 506	3 Year Review	
Unit Specific		
Education		
1. ACLS Fee Waiver Policy	3 Year Review	
2. AHA Reciprocity Statement Policy	3 Year Review	
3. AHA Role of TCMC AHA Training Center Policy	3 Year Review	
4. AHA TC Course Content Requirements Policy	3 Year Review	
5. AHA TC Dispute Resolution - Disciplinary Action Policy	3 Year Review	
Medical Staff		
1. Conflict of Interest 8710-555	3 Year Review	
2. Conflict Resolution Policy 8710-562	3 Year Review, Practice Change	
3. Credentialing Criteria, Chronic Non-Healing Wound Care 8710-523	3 Year Review, Practice Change	
4. Credentialing Criteria, Hyperbaric Medicine Oxygen Therapy, 8710-523A	3 Year Review	
5. Credentialing Policy, Expedited Credentialing and Privileging Process 8710-550	3 Year Review	
6. Credentialing Policy, Processing Medical	3 Year Review	

PROFESSIONAL AFFAIRS COMMITTEE
April 14, 2017

CONTACT: Sharon Schultz, CNE

	Policies and Procedures	Reason	Recommendations
	Staff Applications 8710-543		
7.	Credentialing Standards Catheter-Based Peripheral Vascular Interventional Proc 8710-504	3 Year Review	
8.	Documentation Requirements for Emergency Department Residents 8710-532	3 Year Review, Practice Change	
9.	Election Process Members at Large MEC 8710-531	3 Year Review	
10.	Emergency Room Call: Duties of the On-Call Physician 8710-520	3 Year Review	
11.	Liability Insurance Requirements 8710-558	3 Year Review	
12.	Management of Conflict Between Medical Staff and MEC 8710-567	3 Year Review	
13.	Medical Record Documentation Requirements 8710-518	3 Year Review	
14.	Medical Staff Governance Documents Development and Review and Approval Mechanism 8710-500	3 Year Review	
15.	Name Tags for Health Practitioners 8710-521	3 Year Review	
16.	Peer Review Process: OPPE and FPPE 8710-509	3 Year Review	
17.	Physician Orders/Family Members 8710-529	3 Year Review	
18.	Physician/ Podiatrist Surgical Assistant 8710-536	3 Year Review	
19.	Physician Well Being Policy 8710-511	3 Year Review	
20.	Professional Behavior Policy 8710-570	3 Year Review	
21.	Requests for New Privileges/ Technologies New to TCMC 8710-526	3 Year Review	
22.	Standards For Endovascular Repair of Aortic Aneurysms 8710-503	3 Year Review	
23.	Supervision of Residents/Fellows/Medical Students 8710-513	3 Year Review	
24.	Surgical Assistance 8710-545	3 Year Review, Practice Change	
25.	Suspension for Delinquent Medical Records and Fine Process 8710-519	3 Year Review	
26.	Temporary Privileges 8710-515	3 Year Review	
27.	Unintended Intraoperative Awareness During Anesthesia 8710-546	3 Year Review	
	NICU		
1.	Peripherally Inserted Central Catheters and Midline Catheters Insertion	3 Year Review, Practice Change	
	Surgical Services		

PROFESSIONAL AFFAIRS COMMITTEE
April 14, 2017

CONTACT: Sharon Schultz, CNE

	Policies and Procedures	Reason	Recommendations
1.	Anesthesia Type, Location and Monitoring Policy	3 Year Review, Practice Change	
2.	Anticoagulation Management During Cardiopulmonary Bypass Procedure	DELETE	
3.	Disinfection of Stockert Heater-Cooler System 3T Tanks Procedure	DELETE	
4.	Donor Corneas, Transplant Preparation Procedure	DELETE	
5.	Eye Laser Patient Management Procedure	DELETE	
6.	Heart Lung Machine Procedure	DELETE	
7.	Heart Valves Thawing (Cryopreserved) Procedure	DELETE	
8.	Laser Safety Management Procedure	DELETE	
9.	Mira Cryo Unit Set-Up Procedure	DELETE	
10.	Patient Transportation in the Perioperative Environment Procedure	DELETE	
	Women & Newborn Services		
1.	Amnioinfusion	DELETE	
2.	Cord Gas Collection	3 Year Review, Practice Change	
3.	Elective Delivery Under 39 Weeks	3 Year Review	
4.	HIV Intrapartum Management	3 Year Review, Practice Change	
5.	HIV Newborn Management	DELETE	
6.	Misoprostol [Cytotec]	3 Year Review, Practice Change	
7.	Shoulder Dystocia	DELETE	
8.	Standards of Care: Antepartum	3 Year Review, Practice Change	
9.	Umbilical Cord Blood Banking Private Collection	3 Year Review	
Formulary Requests			
1.	Acetaminophen	Practice Change	
2.	Artificial Saliva	Addition to Formulary	
3.	Meperidine Oral Tablets	Remove from Formulary	
4.	Tobramycin Nebulized Solution	Remove from Formulary	
Pre-Printed Orders			
1.	Discharge Referral Services Orders 8711-4539	DELETE	

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 03/02	**SUBJECT: Admission Criteria**
REVISION DATE: 10/02; 6/03, 5/05, 12/05, 5/09, 2/12, 08/12	**POLICY NUMBER: VI.A**

Department Approval:	06/16
Clinical Policies & Procedures Committee Approval:	~~09/14~~08/~~16~~02/17
Nurse Executive Council Approval:	~~10/14~~02/17
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/14~~03/17
Professional Affairs Committee Approval:	01/15
Board of Directors Approval:	01/15

A. **PURPOSE:**

1. To provide guidelines for the medical staff, nursing personnel, ancillary disciplines, and admitting personnel to ensure:
   a. A consistent process for admission of patients
   b. An appropriate level of care is based on patient's needs/situation

B. **POLICY:**

1. Admission Requirements:
   a. Hospital admission requires a physician's **or Allied Health Professional (AHP)** order.
   b. Patients may be admitted to inpatient or observation status per current InterQual guidelines.
      i. Patients must be 14 years of age or older to be admitted.
         1) Patient must be 18 years and above to be admitted to the Progressive Care Unit (PCU) or Behavioral Health Services (BHS) including the Crisis Stabilization Unit (CSU) and Inpatient Behavioral Health Unit (IBHU).
         ~~i.~~**2) Refer to Women and Newborn Services Neonatal Intensive Care Unit (NICU) Policy: Admission and Discharge Criteria for the NICU regarding infants up to adjusted 44 week post conceptual age**
   ~~b.~~**c.** The attending physician**/AHP** shall be designated by the admitting physician**/AHP** at the time of patient admission.
   ~~c.~~**d.** The Administrative Supervisor (AS) /Assistant Nurse Manager (AN~~M~~**MN**) or designee assigns a bed based upon patient diagnosis, acuity, age, bed availability and physician/~~provider~~ **AHP** request.
   ~~d.~~**e.** Additional considerations:
      i. The decision to admit a patient continues to be the responsibility of the treating **physician/AHP**~~provider~~.
         1) If cases arise where the circumstances would pose a hazard to the patient's health and/or safety and the appropriate setting is in question, then the case shall be referred for secondary review per chain of command.
      ii. Each unit may have limitations of ability to care for certain types of patients in terms of physical layout, environment, equipment, staff expertise, availability, or patient acuity.

iii. Temporary staffing adjustments shall be made for those patients whose acuity level exceeds established guidelines.

1) If patient admission requirements exceed hospital bed and/or staffing capacity, AS collaborates with ANM, Charge Nurses and/or Managers, then forwards the request to hold admissions to the Clinical Operations On Call if deemed necessary.

~~c.~~**f.** Admission of patients to the nursing units may occur by any of the following methods:

i. Direct Admissions:

1) Patients may come directly from a physician's**/AHP's** office, their home, a long-term care facility or outpatient department as ordered by a physician**/AHP.**

2) The physician**/AHP** calls the AS for a bed assignment per Patient Care Services **(PCS)** Policy Transferring and Receiving Patients from Outside Tri-City Medical Center (TCMC).

3) The AS shall conduct a telephone triage on the patient to assess status. Admission ~~borders~~ **orders** are required for each patient ~~prior to admission~~. **The Registered Nurse will call the admitting physician for orders once the patient arrives to the nursing unit.** Orders may **also** be faxed to Registration Department at 760-940-4016**, entered electronically** or sent with the patient.

4) The AS assigns the patient to the appropriate unit and informs the ANM/relief charge.

5) Ambulatory patients report to the Registration Department between the hours of 0500-1800 and to the Emergency Department between the hours of 1800-0500.

6) The Registrar notifies the unit that the patient has arrived. Patients admitted via Registration may be escorted to the nursing unit by the office staff or volunteer personnel.

7) Patients unable to complete the registration process in one of the registration areas due to severity of illness or discomfort shall be escorted directly to the nursing unit. These patients shall be registered at the bedside by a registrar or by a family member/conservator/designee in the registration office.

8) Patients experiencing acute symptoms shall be triaged in the Emergency Department (ED) prior to being escorted by clinical staff to the respective nursing units.

9) If an inpatient bed is unavailable, the patient may be:

a) Admitted to the ED for evaluation and treatment.

b) Requested to remain in physician's**/AHP's** office until bed available.

c) Requested to remain home until bed available.

ii. Admissions to Acute Rehabilitation:

1) When a physician/AHP orders an inpatient be evaluated for admission to Acute Rehab, the Rehab Coordinator will determine if the patient meets the admission criteria.

~~**All patients being admitted to Acute Rehabilitation (Rehab) are direct admissions.**~~

~~**When a physician/AHP orders an inpatient be transferred to Rehab, the Rehab Coordinator will determine if the patient meets the criteria to be admitted to Acute Rehab.**~~

2) Once approval is obtained, the patient must be discharged from the inpatient unit and ~~re~~admitted as a direct admit to Rehab with a new financial account number (FIN#) when a bed is available.

a) The inpatient unit secretary will request a Rehab bed in Aionex

b) The RN will complete the Depart process including all required documentation.

c) A Cerner communication notice will be sent to Registration upon transfer.

~~a)~~**i) Registration will create the new FIN#.**

~~ii.~~**iii.** Emergency Admission:

1) ED admission to an inpatient unit:

a) After a physician**/AHP** determines that an Emergency Department patient will be admitted, the ED unit secretary will enter the bed request into Aionex, AS**/ANM or designee** will assign the bed in Aionex, and inputs the bed number into FirstNet.

2) ED patients being admitted to the ~~IBHSU~~ are converted to an Inpatient status with the same FIN # when a bed is available.

3) ED patients being admitted to the CSU are to be discharged from the ED and readmitted to CSU with a new FIN# when a bed is available.

a) **If the patient is admitted to IBHU or must return to the ED, the patient is to be discharged from the CSU and a new account with new FIN# must be created.**

~~iii.~~**iv.** Transfer Admission:

1) The AS shall arrange patient transfers from another in-house patient care unit or outside facility.

~~iv.~~**v.** Surgical Admission:

1) Surgery patients are pre-scheduled through Surgery Scheduling.
2) Surgery Scheduling schedules the appointment for pre-admission procedures and teaching.
3) Surgery Scheduling generates a computerized list of pre-scheduled surgical admissions and forwards the list to the AS.
4) The AS assigns the bed and notifies the nursing unit.

~~v.~~**vi.** Outpatient Admissions:

1) Registration processes all outpatient admissions.

~~vi.~~**vii.** Boarders:

1) WNS - Boarders are newborn infants admitted after delivery and not discharged with their mother. Boarders **may be**~~are~~ admitted to the newborn nursery **or NICU based on infant status** ~~only~~.

~~1)~~**2) ED – Boarders are patients with admission orders greater than four (4) ~~two (2)~~ hours after a bed has been requested for inpatient admission or observation.**

~~vii.~~**viii.** The following departments coordinate admissions to their unit(s), see department specific admission criteria:

1) ~~Behavioral Health,~~ **BHS – Inpatient or ~~Crisis Stabilization Unit~~ (CSU) – Outpatient Observation.**
2) Neonatal Intensive Care Unit (NICU),
3) **Acute** Rehabilitation Unit (**ARU or** Rehab)
4) Women and Newborn Services
~~3)~~**5) Progressive Care Unit (PCU)**

2. Unit Specific Criteria:

a. Intensive Care Unit (ICU) (1 East, 1 West):

i. This level is appropriate to use when the patient has an acute cardiac, medical, surgical, or trauma event, along with any of the following:~~.~~

1) Invasive hemodynamic monitoring
2) Urgent temporary pacemaker insertion
3) Urgent cardioversion
4) Intra-aortic Balloon pump (IABP)
5) Continuous cardiac monitoring

6) Acute intubation and mechanical ventilation management
7) Sepsis
8) Therapeutic Hypothermia
9) Dialysis
10) Coronary Bypass Surgery
11) Advanced Hemodynamic monitoring

ii. The following patients shall not be managed on this unit due to the lack of available resources:
1) Undergoing organ transplants
2) Requiring specialized burn treatments
3) Under the age of 14 or less than 35kg

b. Telemetry (2 East, 2 West, ~~3 East, 4~~ East, 4 West, 3 Pavilion):
i. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available **cardiac** monitored beds.
1) Continuous cardiac monitoring
2) Continued mechanical ventilation with stable ABG's and extended ventilator weaning
3) Stable temporary pacemaker insertion or transcutaneous pacing
4) **See Telemetry Policy: Admission and Discharge Criteria**

c. Progressive Care Unit (3 North, 3 South)
i. This is a 41 bed secured unit that provides various services to patients age 18 and above demonstrating aberrant behavior requiring 24 hour supervision concurrently with their medical condition. Justice involved individuals may be placed on this unit. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available bed.
1) Continuous Cardiac Monitoring
2) Chemotherapy Administration ~~Chemotherapy Administration Policy)~~
3) Acute rehabilitation
4) Ante-partum care
5) Post-partum care
6) Medical-Surgical

~~c.~~**d.** Acute Care Services (1 North, 2 Pavilion, ~~3 Pavilion~~, 4 Pavilion and Acute Rehabilitation):
i. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available beds.
1) Post critical care or Telemetry monitoring
2) Procedures requiring inpatient hospitalization
3) IV medications requiring hospitalization for initial therapy
4) Designated inpatient post surgical~~/delivery~~ care.

ii. 1 North/Ortho (Ortho and Medical/Surgical Patients)
1) This unit specializes in nursing care for patient's ages 14 years of age and older suffering from diseases, injuries or conditions of the human musculoskeletal system.
2) Orthopedic diagnoses are emphasized with an emphasis on orthopedic surgeries including total joint replacement, spinal surgeries and hip replacements.

iii. 2 Pavilion (Oncology and Medical/Surgical Patients)
1) This unit provides nursing care for adolescent patients (ages 14 years to 21 years) or adult patients (age 22 years and older).
a) Patients receiving chemotherapy must be age 18 or older.
2) Oncological diagnoses are emphasized~~;~~ along with women's surgeries and ~~the daVinci Robotic Surgery patients, in addition to~~ general medical surgical diagnosis.

~~iv. 3 Pavilion (Adolescents Adult Medical/Surgical Patients overflow)~~
~~a) Adolescent (ages 14 to 21 years) medical/surgical patients~~
~~b) Adult patients (ages 22 and older) medical/surgical patients~~

v. 4 Pavilion (Dialysis, Rate Monitoring for Medical/Surgical patients, ~~and~~ Designated Stroke Unit**, and Epilepsy Monitoring Unit [EMU]**)
1) This unit specializes in nursing care for patients ages 14 years of age and older:
a) Medical/Surgical patients requiring rate monitoring
b) Hemodynamically stable patients status post CVA
c) Visual monitoring of stable epilepsy patients **(EMU)**

vi. Acute Rehabilitation Unit (ARU)
~~ii.~~1) The ARU provides restorative and maintenance programs for the adult patient (ages 14 years and older) suffering from cerebral vascular disease and other diseases or conditions requiring neurological or functional rehabilitation services.

~~d.~~**e.** Emergency Services:
i. This unit provides nursing care for patients of all ages that:
1) Require medical care and are in stable, mild, moderate, or acute status.
2) Are afflicted with conditions involving major trauma, major burns, or requiring hyperbaric therapy, and pediatric intensive care services that can be stabilized to the degree medically feasible and subsequently transferred to facilities providing these specialty services in compliance with EMTALA regulations.

f. Women and Newborn Services:
i. This unit specializes in nursing care for:
1) Perinatal patients who have conditions associated with antepartum, intrapartum and/or postpartum management needs to include surgical requirements related to perinatal care.
2) **Neonates born in the hospital that may need resuscitation, stabilization and ongoing evaluation**

C. **RELATED DOCUMENTS:**
1. Behavioral Health Unit Inpatient Policy: Inpatient Unit Admission Criteria
2. Patient Care Services Policy: Transferring of Patients and Recovering Patients from Outside ~~Tri City Medical Center~~**TCMC**
3. PCS Policy: Transfer of Patients, Intra Facility
4. Surgery Policy: Scheduling Surgical Procedures
~~4.~~**5. Telemetry Policy: Admission and Discharge Criteria**
~~Women and Newborn Services Policy: Admission Policy~~
~~5.~~**6. Women Newborn and Services**~~Neonatal Intensive Care Unit~~ ~~(~~NICU~~)~~ Policy: Admission and Discharge Criteria for NICU

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**ADMIXTURE, INTRAVENOUS**
Purpose:	To outline the responsibilities and technique for Registered Nurses (RNs) in compounding sterile intravenous admixture preparations in patient care areas to prevent harm that could result from microbial contamination (non-sterility), excessive bacterial endotoxins, and large content errors in strength of correct ingredients, and incorrect ingredients in compounded sterile preparations (CSP).
Supportive Data:	Aseptic technique refers to performing a procedure in a manner that minimizes the chance of contamination caused by the introduction of microorganisms. Because contaminants may be introduced from the environment, equipment, supplies, or personnel, it is essential to control these different sources of contamination at the time **an** aseptic **procedure**~~technique~~ is **performed**~~carried out~~. Touch contamination by the person performing a procedure is the most frequent cause of contamination, occurring when proper control over manipulation is not maintained. Good technique in the preparation of **intravenous** (IV) admixtures is critical to producing a sterile product. All objects that come in contact with the drug additive or IV solution must be sterile, or contamination will result.
Equipment:	~~A.~~**1.** Admixture (medication) ~~B.~~**2.** IV solution ~~(refer to TCMC Standard Concentrations for specialty areas to identify correct solution and volume: Attachment 1)~~ ~~C.~~**3.** Sterile syringe: appropriate size based on the volume of solution to be measured and the graduation marks on the syringe. (The smallest size syringe should be selected, but should not be filled to capacity **or the** plunger may become dislodged). Selecting the smallest size syringe allows the volume of solution to be measured most accurately. ~~D.~~**4.** Sterile needles for transfer; not less than 19 gauge recommended (*filtered needles or filter straws are needed to draw any medication from ampules)* ~~E.~~**5.** 70% alcohol swabs/wipes

A. **POLICY:**

1. Pre-mixed standard concentration infusions shall be utilized whenever possible.
~~1. When an on-site licensed pharmacist is available; sterile medications, intravenous admixtures, and other drugs shall be compounded or admixed in the pharmacy.~~
2. Intravenous admixture of pharmaceutical products which require the measured addition of a medication to a 50 mL or greater bag or bottle of IV fluid ~~u~~must be compounded in the pharmacy except:
   a. Emergencies when nursing staff may need to prepare a dose of a sterile product for immediate use.
      i. Medications for immediate use shall have administration started within one hour of preparation. If administration is not started within one hour the dose must be discarded.
   b. Product stability is of short duration.
3. Compounding personnel must visually confirm that ingredients measured in syringes match the written order.
   a. All admixtures shall be visually examined for the presence of particulate matter and not administered or dispensed when such matter is observed.
4. **All IV solutions mixed by nursing must be discarded within 24 hours of spiking.**
5. All CSP labels shall include:
   a. Patient name
   b. Correct names and amounts or concentrations of ingredients
   c. Total volume

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
3/06, 9/08, 6/11, 4/12, **09/16**	4/12, **10/16**	4/12, **01/17**	**11/16, 02/17**	5/12, **03/17**	06/12	06/12

d. Date and time of preparation
e. **Beyond use date (BUD) and time is 1 hour from time of preparation.** ~~Expiration date and time, 24 hours from time of preparation unless indicated by pharmacy~~
   i. **Medication must be administered or have infusion initiated prior to BUD time.**
f. Initials of the compounding nurse

B. **DEFINITIONS:**

1. Admixture:— One or more drugs are commonly added to the intravenous solution to prepare the final sterile product. The drug is referred to as the additive and the final product is referred to as the admixture. This does not include the drawing up of medication into a syringe and/or adding medication to a buretrol or intravenous line.

C. **PROCEDURE:**

1. Assess designated preparation area for cleanliness and gather all appropriate supplies prior to beginning admixture procedure. If admixture area is visibly soiled, clean with hospital-approved **disinfectant**~~antibacterial cleaner~~.
2. Perform hand hygiene.
3. Use of Needle and Syringe for Transfer:
   a. Open the syringe and needle using proper aseptic technique, do not allow syringe package to come in contact with the syringe, since the outside surface is contaminated.
   b. Remove the protective cover over the syringe tip by twisting.
      i. When a needle is to be added to a syringe, the needle package must be opened before removing the protective cap.
   c. Remove the protective cover over the syringe tip by twisting.
   d. Insert the tip of the syringe into the hub of the needle. The needle may be held on by friction or by a locking mechanism. The finger should be held well back from the point of attachment of the needle to the syringe.
   e. Leave needle guard in place until just before use. To remove the guard, pull it straight off or twist very gently.
4. Use of Ampules:— When preparing sterile products contained within an ampule container, special precautions should be taken to avoid glass fragments from entering the final sterile product. Even tiny glass fragments entering the circulatory system can cause great damage to vital organs or carry contaminants that cause infection.
   a. Tap or shake all the liquid into the bottom half of the ampule.
   b. Wipe the ampule neck with an alcohol swab and break it at a horizontal angle away from you. Discard the wipe and the ampule neck immediately to prevent accumulation of glass particles in the CSP area.
   c. Choose an appropriate size syringe and attach a *filter straw or filter needle*.
   d. Hold the ampule at a nearly horizontal angle to ensure proper airflow around the neck area. Tip the ampule downward as necessary to keep the tip of the straw below fluid level.
   e. Withdraw the contents of the ampule with the syringe. When pulling back the plunger of the syringe, the fingers should not come in contact with any part of the plunger except the flat knob at the end. The barrel of the syringe should be held in the other hand. Contamination of the medication can occur in some procedures if the plunger is touched with the fingers.
   f. ~~Withdraw the contents of the ampule with the syringe.~~ Remove the filter needle or filter straw and replace it with a needle.
   g. Tap the air bubbles from the syringe barrel, bring the liquid to the correct volume, squirt any excess liquid into the ampule, and deliver the liquid.
5. Use of Vials:
   a. Remove the protective cap from the vial and scrub the diaphragm with alcohol swab, **and allow to air dry before piercing the vial.**~~.~~
   b. Draw the volume of air equivalent to the volume of solution that will be withdrawn from the vial into the syringe. **When pulling back the plunger of the syringe, the fingers should**

not come in contact with any part of the plunger except the flat knob at the end. The barrel of the syringe should be held in the other hand.~~The syringe plunger should not be contaminated by contact with the hands.~~

c. Hold the vial~~ at an angle;~~ **and** insert the needle **at 45 degree angle with bevel up** into the vial, taking care to prevent coring of the closure.

d. Hold the vial in a vertical position (inverted) and force air into the vial, withdraw slightly more than the required amount of fluid.

e. With the vial in the vertical (inverted) position and the needle in the diaphragm, tap the barrel of the syringe to remove air bubbles and bring the syringe to the proper volume. Read the volume of solution by aligning the rubber end of the plunger with the graduation marks on the barrel of the syringe. Squirt excess liquid back into the vial.

6. To Reconstitute and Transfer a Drug from a Vial:— Some drugs inside a vial may be in powder or liquid form. If the drug is in powder form, an extra step – reconstitution - must be performed before it can be added to the IV solution. Diluents such as sterile water for injection, bacteriostatic water for injection, or bacteriostatic 0.9% sodium chloride injection are usually used to reconstitute powdered drugs. The volume of a suitable diluent is specified in the package insert and frequently on the vial itself.

a. Remove the protective tab and swab the top surface of the rubber closure of each vial with alcohol swab**, and allow to air dry before piercing the vial.**

b. Determine the correct volume of suitable diluent to reconstitute the powdered drug.

c. Inject a volume of air equal to the volume of solution to be removed from the diluent vial using a needle and syringe, and then remove the diluent from the vial. (Hold the diluent vial in an inverted position).

d. Inject the diluent into the medication vial.

e. Remove the needle and shake the vial until the drug is dissolved unless shaking is not recommended.

f. Reinsert the needle and remove the proper volume of drug solution. Do not inject air before withdrawing the drug solution unless air was withdrawn before the needle was removed.

g. Remove all air bubbles from the syringe so the volume can be read accurately.

7. Drug Transfer into a Plastic Bag:– A syringe and needle are generally used to transfer a drug additive from a vial or ampule to a plastic bag. It is recommended the needle gauge be not less than 19 to ensure resealing of the protective rubber cover. The needle must be at least ½ inch long to penetrate the inner diaphragm.

a. Remove the plastic IV from the outer wrap.

b. Assemble the needle and syringe.

c. Swab the medication vial or ampule with alcohol swab and withdraw the necessary amount of drug solution. If the drug is in powder form, reconstitute it with the recommended diluent. (See previous section of procedure).

d. Swab the medication port of the plastic IV bag with an alcohol swab**, and allow to air dry before piercing the port**.

e. Insert the needle into the medication port and through the inner diaphragm. The medication port should be fully extended to minimize the chance of going through the side of the port.

f. Remove the needle and dispose of in appropriate sharps container.

g. Shake and inspect the admixture.

8. In Emergency Situations:

a. The RN **may**~~shall~~ prepare the first infusion bag using aseptic technique for the following but not limited to: phenylephrine, nitroprusside, norepinephrine, epinephrine, epinephrine/calcium, diltiazem, aminocaproic acid, and labetolol.

~~a.~~**b. Label the compounded product appropriately**

~~a. On pharmacist PharmNet order entry, an initial label is printed and the nurse completes the "IV Drip Request Form" for number of bags needed at the designated delivery times. (see attachment A)~~

~~b. The medication is administered based on a new written order by the physician or a PRN order. For "PRN" orders, the nurse shall call their unit pharmacist when the IV is started after it is made on the unit. This eliminates duplicate IV preparation.~~

D. **REFERENCES:**

1. USP General Chapter. Pharmaceutical Compounding-Sterile Preparations. 797th ed: USP/NF,2004. Print .
2. Buchanan, C.E., and P.J. Schneider. Compounding Sterile Preparations 2nd Ed.: American Society of Health-System Pharmacists, 2005. Print.
3. Contianment Technologies Group, Pharmacopeal Form, August 2003. <http.//www.mic4.com/regulations/USP-797.pdf>.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 02/09	**SUBJECT: Blanket Warmers**
REVISION DATE: ~~08~~5/12	**POLICY NUMBER: IV.OO**

Department Approval:	**03/17**
Clinical Policies & Procedures Committee Approval:	**~~06/12~~03/17**
Nursing Executive Council Approval:	**~~06/12~~03/17**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee	**~~07/12~~ n/a**
Professional Affairs Committee Approval:	**08/12**
Board of Directors Approval:	**08/12**

A. **PURPOSE:**

1. To ensure blanket warmers are maintained according to manufacturer's recommendations.

B. **POLICY:**

1. Blankets are stored in the blanket storage compartment of the warmer unit.
2. The warmer is not to be overfilled. Leave approximately two inches between stack of blankets and the roof and walls of the blanket warmer.
3. Blanket warmers **thermostats** shall be set to a maximum temperature of 130°F. ~~Blanket warmer temperature shall be monitored and recorded daily by department personnel for adherence to the temperature recommendation of 110°-130°F.~~

~~a. If the temperature falls outside the correct range:~~

~~i. The department personnel shall correct any situation causing an obvious deviation from accepted temperature range (i.e., close the warmer door if it is found ajar).~~

~~ii. If the temperature is not corrected within one hour after correcting the problem, Engineering shall be notified at extension 7148 and a work order entered.~~

~~iii.4.~~ ~~Corrective actions shall be documented on the Blanket Warmers Temperature Monitoring Log.~~

~~4.~~5. Blanket warmers shall be used for clean blankets only.

~~B. FORMS:~~

~~1.~~6. ~~Blanket Warmer Temperature Monitoring Log located on the Intranet~~

BLANKET WARMER TEMPERATURE MONITORING LOG

Year: ____ Month: _____ Location: _____

Definition: The blanket warmer temperature shall be monitored daily and maintained at a temperature of 100°-130°F.
Blanket Warmer: Maximum 130° F

Guideline: Mark an "X" in the corresponding box for the observed temperature daily.
Shaded area indicates that the temperature is outside the range.
If temperature is outside the range:

1. Take action to correct any obvious reason for out of range temperature (i.e. close the door if found ajar)
2. If not correct notify Engineering @ext. 7148.
3. Relocate contents to an alternate location with appropriate temperature control.
4. Record actions taken and resolution

Temperature (°F)

138																														
136																														
134																														
132																														
130																														
128																														
126																														
124																														
122																														
120																														
118																														
116																														
114																														
112																														
110																														
108																														
106																														
104																														
102																														
100																														
Day of Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Problem/Action Resolution Documentation—Record with reference to above date.

Date	Problem	Action Taken	Resolution Achieved

ISSUE DATE: 10/88

SUBJECT: Code Status / Do Not Resuscitate (DNR) / Withholding or Withdrawing Life Sustaining Treatment

REVISION DATE: 9/91; 8/94; 12/96; 11/06; 11/09; 4/14 **POLICY NUMBER:** 8610-312

~~Administrative Policies & Procedures Committee Approval:~~	~~11/09~~
Clinical Policies and Procedures Committee Approval	09/15
~~Operations Team Committee Approval~~	~~12/09~~
Nursing Executive Committee Approval:	09/15
Critical Care Committee Approval:	~~06/16~~02/17
Medical Executive Committee Approval:	03/17
Professional Affairs Committee Approval:	01/10
Board of Directors Approval:	01/10

A. PURPOSE:

1. To outline the policy ~~and procedure~~ for withholding and/or withdrawing life sustaining treatment during hospitalization **including code status orders**.
2. **To provide direction to all personnel and medical staff members who may be involved in the care of a patient for whom life-sustaining treatment is withheld or withdrawn during hospitalization.**
3. ~~1.~~**This policy conforms with the decision of the California Court of Appeal, Second Appellate District, in Barber Vs. Superior Court, 147 Cal. APP 3d 1006 (1983), which established guidelines for decisions to withhold or withdraw life-sustaining treatment. These guidelines address all situations in which life-sustaining treatment may be discontinued, including but not limited to cases of irreversible coma and brain death.**

B. DEFINITION(S):

1. **Advanced health care directive or advance directive — Designation of an agent (surrogate) appointed by the patient to make medical decisions for him/her should the patient no longer have the capacity to express his/her wishes.**
2. ~~A.~~**Brain Death:~~ See Patient Care Services Policy, Determination of Brain Death.**
3. **Capacity~~:~~: The patient's decision making ability to understand the consequences of his/her decisions. Capacity is commonly secured by determining the patient's ability to understand basic information about his/her condition and prognosis, the nature of a proposed intervention, the alternatives, the risks and benefits, and the consequences of his/her decisions.**
4. ~~1.~~**Code Status:**
   a. Full Code~~—~~**:** A full code is synonymous with "full resuscitation" which consists of basic and advanced life support. The patient is a "full code" unless withholding of life sustaining treatment is ordered. Resuscitative measures are defined as: electric defibrillation, chest compressions, mechanical ventilations, endotracheal intubations.
   b. No Code~~—~~**:** A "no code" is synonymous with "no resuscitation" or "do not resuscitate (DNR)". This means that no basic or advanced life support will be administered.
      i. Resuscitative measures <u>do not</u> refer to ordinary or reasonable methods used to maintain the life, health or comfort of a patient such as the administration of pain or other appropriate medications, IV fluids and nutritional support.
      ii. DNR orders are not intended to govern pre-arrest care.
      iii. A patient may decline **basic life support**~~CPR~~ for arrest conditions but may readily agree to mechanical ventilation for a likely reversible respiratory condition (ie., pneumonia, aspiration).
      ~~a.~~**iv.** A patient with ventricular tachycardia, bradycardia or heart block is not

considered arrested. Emergency medications, external pacemaker and/or rapid fluid infusions may be administered as appropriate.

c. **Allow Natural Death (AND):— AND orders are intended for terminally ill patients only. An AND order would ensure that only comfort measures are taken. This would include withholding or discontinuing resuscitation, artificial feedings, fluids, and other measures that would prolong a natural death.**

~~2.~~**5. Incapacitated:— A condition of the patient where the capacity to make informed decisions regarding care is temporarily or permanently lost.**

~~3.~~**6. Individual Health Care Instruction: Designation for a Surrogate – An adult having capacity may give an individual health care instruction orally or in writing. The instruction may be limited to take effect only if a specified condition arises. A patient may also designate an adult as a surrogate to make health care decisions for him/her. The patient must do so by personally informing the supervising health care provider. An oral designation of a surrogate must be promptly recorded on the medical record, and is effective only during the course of treatment in the health care institution when the designation is made.**

~~4.~~**7. Futile Care:— Any health care that the primary physician and his or her consultant(s), consistent with prevailing standards of practice, in good faith believe(s) cannot, within a reasonable possibility, be expected to satisfactorily cure, ameliorate, improve, or restore a quality of life to the patient.**

~~5.~~**8. Permanent Unconscious Condition:— An incurable and irreversible condition that, within reasonable medical judgment, renders the patient in an irreversible coma or persistent vegetative state.**

~~6.~~**9.** POLST Form:— Physician Order for Life Sustaining Treatment form means a request regarding resuscitative measures that direct a health care provider regarding resuscitative and life-sustaining measures. **If a Patient is admitted with completed POLST, POLST order will be honored by staff in accordance with California Assembly Bill 3000, Chapter 266. It is the policy of Tri-City Healthcare District (TCHD) to treat the patient in accordance with a POLST form (Probate Code Sec. 4781.2 (d)). Refer to Patient Care Services Policy POLST.**

~~2.~~**10.** Prehospital DNR:— In cases where there is a completed approved "Emergency Medical Services Prehospital Do Not Resuscitate (DNR) Form" (a written request to limit the scope of emergency medical care), an approved DNR medallion or bracelet, or a valid DNR order from the patients medical record from a nursing facility and the patient experiences a respiratory or cardiac arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotonic medications are to be initiated unless the patient or surrogate decision maker instructs us to do otherwise. The Emergency and Attending Physicians will be notified of the existence of the advanced directive and a copy will be placed in the patient's medical record. Documentation in the patient's medical record regarding patient's DNR status will be completed.

~~7. Terminal Illness – an incurable or irreversible condition that, without the administration of life-sustaining treatment will result in death within a relatively short time (Health and Safety Code, Section 718(i).~~

11. Terminal Illness:— means a medical condition resulting in a prognoses of life of one year or less, if the disease follows its natural course (California Health and Safety Code 1746 - p).

~~8.~~**12.** Withdrawing Life Sustaining Treatment: —The discontinuation of specified medical therapies that may be prolonging the patient's death.

~~9.~~**13.** Withholding Life Sustaining Treatment:— The withholding of all or some basic life support (**BLS** ~~CPR~~) and advanced life support interventions in the event that a respiratory and/or cardiac arrest is recognized.

C. POLICY:

~~3.~~**1.** All physician orders regarding **code status,** withholding or withdrawing life sustaining treatments must be ~~in writing on the Physician Order Sheet~~**recorded (written) legibly or entered electronically into the patient's ~~medical~~health record**.

~~4.~~**a.** All withdrawing life sustaining treatment orders must specify which treatments and

devices are to be discontinued (i.e., ventilator support, endotracheal tube, pacemakers, vasoactive drips, parenteral and enteral fluids, parenteral and enteral nutrition) and how they are to be withdrawn.

b. ~~An~~ **Registered Nurse** (RN) may accept verbal/telephone orders; however, another RN must witness the order by having the physician repeat the order to the second RN and then co-signing the receiving RN's transcription of the order.

~~1. All "no code" orders must be renewed every 72 hours UNLESS the attending physician has ordered "no code for duration of hospital stay" or has written specific orders pursuant to an advance directive. A "no code" that requires renewal, but is not renewed will be considered expired and the patient will become a "full code".~~

2. **The treating physician and consulting physicians (if any) shall be responsible for determining the patient's diagnosis, prognosis and providing the patient or the patient's surrogate with the requisite information to enable him/her to evaluate the treatment's benefits and burdens.**

~~a.~~**3.** The decision to withhold or withdraw life-sustaining treatment must be substantiated by physician documentation in the progress notes, which describes the circumstances surrounding the decision to limit or withdraw care.

~~1.~~**4.** Physicians shall discuss a patient's Do Not Resuscitate (DNR) status with the patient and/or decision maker prior to a surgery or procedure that requires anesthesia. The discussion shall include possible temporary suspension of the DNR status during the surgery/~~ or~~procedure **and recovery periods**. The DNR status shall be reevaluated immediately after the procedure. This discussion shall be documented in the ~~medical~~ **health** record and an appropriate order written.

5. The RN/Respiratory Care Practitioner (RCP) shall follow the physician order for discontinuation of the specified treatment or device.

~~2.~~**a. Every necessary procedure shall be performed to relieve the patient's suffering and to maintain the patient's hygiene and comfort in the setting of DNR and/or withholding/withdrawing treatment orders.**

~~a.~~**b.** Any health care provider who objects to withholding or withdrawing life-sustaining treatment based on the individual's moral, and/or religious beliefs or affiliations should immediately report their ~~conscience~~ objections to their supervisor or manager. Refer to **Administrative Human Resources Policy 480~~.~~, ~~Staff Requests Not to Participate in Care**~~Patient Care Services Policy VIII.J, Staff Requests~~.

~~b.~~**6. The patient shall be the decision – maker whenever possible. If the patient is incapable of making the decision, the health care providers and surrogates shall act in accordance with the patient's desires previously expressed. If a patient is incapable of making the decision because of his/her medical or mental condition, a surrogate decision-maker should be identified.**

a. Parent or Guardian, Attorney-In-Fact, Conservator.

~~5.~~**i. If patient is a minor, his/her parents or guardian must be consulted. If the patient has executed a Durable Power of Attorney for Health Care which remains valid, the designated attorney-in-fact must be consulted. If the patient is an adult for whom a conservator has been appointed with authorization to make health care decisions for the patient, the conservator must be consulted. A copy of the Durable Power of Attorney for Health Care or the certified letters of guardianship or conservatorship must be obtained and placed in the patient's medical record.**

b. Consultations in the event of disagreement.

~~3.~~**i. If the withholding or withdrawal of treatment is appropriate, but a family member or significant other disagrees, the hospital administrator on call shall be contacted and it shall be determined whether court authorization for the issuance of such an order should be sought.**

c. Review if there is no surrogate decision-maker.

~~a.~~**i. If the patient is incompetent, incapacitated and no surrogate decision-maker can be identified, a DNR order may be issued when the treating~~patient's~~ physician determines it is medically appropriate. It is**

advisable that the physician seeks a consultation before issuing the order and notifies hospital administration.

~~b.~~7. When a patient's primary physician believes that further or additional health care would constitute futile care, as defined above, the following steps should be taken:

~~c.~~a. The primary physician shall carefully explain to the patient and/or his or her representative the nature of the ailment, the available treatment options, and the patient's prognosis. The physician shall explain that in no event shall the withholding or withdrawal of health care involve a withdrawal or withholding of comfort, dignity, and psychological care and support.

~~d.~~b. The primary physician shall provide the names of appropriate medical consultants to provide independent opinions concerning the patient's diagnosis, prognosis and available treatment alternatives, if any.

~~e.~~c. The support of TCMC nurses, chaplain, patient care representative, and social services shall be offered to the patient's representative(s). A joint conference or other collaborative communication between these parties and the primary physician and/or the patient or his or her representative(s) may arranged as needed.

~~i.~~d. Adequate time should be given for the patient or his or her representative(s) to consider the information and situation.

~~6.~~e. If the above steps are taken and the patient or his or her representative disagrees with the primary physician as to whether further or additional health care would be futile:

~~7.~~i. The primary physician shall cooperate with the patient or his or her representative in transferring the care of the patient to another qualified physician and/or health facility who will consent to implementation of the patient's or his or her representative's health care wishes. The responsibility for finding such an alternate physician and/or health facility shall lay with the patient or his or her representative, though the primary physician and hospital shall make reasonable efforts to assist such efforts.

~~i.~~ii. If a disagreement persists between the physician and the patient or his or her representative as to the futility of further or additional health care, and the patient cannot be transferred to another physician and/or facility, the physician and/or TCMC shall petition the court to approve or deny the proposed health care, as the case may be, pursuant to Health and Safety Code Section 32000. In so doing, the physician shall consult with the Bioethics Committee, who shall in turn consult with legal counsel to ensure compliance with applicable laws and regulations. Life-sustaining treatment shall not be withdrawn when a dispute exists under this Section until the dispute is resolved by an order of the court.

~~3.~~8. Incarcerated patients: When the patient is a prisoner at a state correctional facility and the prisoner is incapable of making decisions on their behalf, the attending physician at the hospital should make an attempt to contact the primary care physician at the state correctional facility before determination can be made on withholding or withdrawing life support.

~~4.~~9. The hospital's administrator and/or risk manager shall be consulted before an order to withhold or withdraw treatment is issued whenever:

a. The patient's condition has resulted from an injury which appears to have been inflicted by a criminal act.

b. The patient's injury or condition was created or aggravated by a medical accident

c. The patient is pregnant.

d. The patient is a parent with custody or responsibility for the care and support of young children.

e. A dispute exists regarding the desires or best intentions of an incompetent patient.

~~f.~~ No appropriate legal representative exists.

~~5. t is the policy of TCHD to treat a patient in accordance with a POLST form [Probate Code Sec. 4781.2 (d)]. Refer to Patient Care Services policy POLST.~~

~~D. PROCESS:~~

~~1. The physician shall be responsible for issuing all orders to withhold treatment that is usually automatically initiated or withdraw life-sustaining treatment in accordance with policy statement C.3. The physician shall complete the documentation in the Progress Notes in accordance with policy statement C.4.~~

~~2. Withholding Life Sustaining Treatment - the RN shall transcribe the "No Code" order into the electronic health record (EHR).~~

~~3. Withdrawing Life Sustaining Treatment - the RN shall follow the physician order for discontinuation of the specified treatment or device.~~

~~4. Every necessary procedure shall be performed to relieve the patient's suffering and to maintain the patient's hygiene and comfort in the setting of DNR and/or withholding/withdrawing treatment orders.~~

~~5.~~D. **RELATED DOCUMENT(S):**

1. **Administrative Human Resources Policy 480: Staff Requests Not to Participate in Care**
2. **Patient Care Services ~~Administrative~~ Policy 354: Advance Health Care Directive**
3. **Patient Care Services Policy: End of Life/Comfort Care Policy**
4. **Patient Care Services ~~Administrative~~ Policy 393: Physicians Orders for Life Sustaining Treatment (POLST)**

E. **FORM(S) ~~REFERENCED WHICH CAN BE LOCATED ON THE INTRANET~~:**

1. Pre-Hospital Do Not Resuscitate (DNR) FORM **Sample**
2. ~~Physician Order for Life Sustaining Treatment Form (POLST)~~

F. **REFERENCES:**

1. Consent Manual, California Hospital Association, ~~2009~~**2015**
2. ~~Administrative Policy #354, Advance Health Care Directive~~
3. ~~Patient Care Services Policy POLST~~
4. ~~California Probate Code, Sections 4600-4806, Health Care Decisions.~~

EMERGENCY MEDICAL SERVICES
PRE-HOSPITAL DO NOT RESUSCITATE (DNR) FORM SAMPLE

An Advanced Request to Limit the Scope of Emergency Medical Care

1._____requests limited emergency care as herein described.
(Print Name)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.
I understand this decision will not prevent me from obtaining other emergency medical care by pre-hospital emergency medical care personnel and/or medical care directed by a physician prior to my death.
I understand I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.
I give permission for this information to be given to the pre-hospital emergency care providers, doctors, nurses, or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

Patient/Surrogate _____ Date _____

Surrogate's Relationship to Patient

Witness Signature _____ Print Name _____ Date _____

I affirm this directive is the expressed wish of the patient/surrogate, is medically appropriate, and a copy of this form is in the patient's permanent medical record.
In the event of a cardiac or respiratory arrest, no chest compressions, assisted ventilation, intubation, defibrillation, or cardiotonic medications are to be initiated.

Physician's Signature _____ Date _____

Print Name _____

Address _____ Phone Number _____

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY.

PRE-HOSPITAL DNR REQUEST FORM
Approved by the San Diego Medical Society
P.O. Box 23581
3702 Ruffin Rd
San Diego, CA 92193-3581
(619) 569-1334

White Copy: To be kept by patient
Canary Copy: To be kept in Patient's permanent medical record
Pink Copy: If authorized DNR medallion desired, submit this form with Medic Alert enrollment form to:
Medic Alert Foundation, Turlock, CA 95381

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: NEW **SUBJECT: Determination of Brain Death**

REVISION DATE:

Department Approval	**09/15**
Clinical Policies & Procedures Committee Approval:	**09/15**
Nurse Executive Committee Approval:	**09/15**
Critical Care Committee Approval Date(s):	**06/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval:	**10/16**
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**
1. To establish guidelines for brain death determination in adult patients (~~18~~ 15 years and older) as a means of standardization of:
   a. Criteria for the diagnosis of brain death
   b. Medical decision making
   c. Health record documentation.

B. **DEFINITIONS:**
1. Brain death: An irreversible cessation of all functions of the entire brain, including the brain stem (Health and Safety Code§ 7180). A physician may determine an individual has suffered brain death (as defined by statute). Law requires that a second physician independently confirm the patient's brain death. (Health & Safety Code§ 7181). Patient time of death is recorded at the time the second physician confirms brain death. These physicians:
   a. May not participate in procedures for removing or transplanting part(s)
   b. Must document in the health record procedures used to determine the death and factual basis for determination of death.
   c. Must practice within the specialty of Neurology, Neurosurgery, or Critical Care Medicine.

C. **POLICY:**
1. Determination of Death: Based on current medical standards (California Code, Health and Safety Code § 7180 of The Uniform Determination of Death Act), an individual who has sustained either of the following is dead:
   a. Irreversible cessation of circulatory and respiratory functions or
   b. Irreversible cessation of all functions of the entire brain, including those of the brain stem.
2. A determination of brain death must be made in accordance with accepted medical standards, at this time considered to be those standards outlined in the American Academy of Neurology Guidelines.
3. The declaration of brain death should not be given as a choice for families.
   a. Testing should be performed when clinical signs and symptoms suggest brain death has occurred.
   b. Appropriate efforts should be made to discuss the patient's medical condition and the process of determining death with family or surrogate decision-makers prior to evaluating whether or not the patient is dead.
      i. Family/surrogate must be provided with the policy if requested.
   c. Determination of death should be accomplished as early as practical in the patient's clinical course, for the benefit of both family/surrogate decision makers and staff.

4. Declaration of brain death by neurological criteria is outlined in the 2010 American Academy of Neurology (AAN) Guidelines,reaffirmed on April 30, 2014, and is reflected in *Declaration of Brain Death, Physician Progress Note* which should be used for documentation. Brain death by neurologic criteria requires the following evaluations:
   a. Clinical reflexes
   b. Apnea testing
   c. If one of the evaluations cannot be completed, ancillary testing should be considered.
5. Two licensed physicians must independently confirm the diagnosis of brain death, (California Health and Safety code, § 7181).
   a. Each physician must practice within the specialty of Neurology, Neurosurgery, or Critical Care Medicine.
   b. One physician should be an active member of the patient's care team.
   c. One physician must actively participate in the clinical evaluation of any patient where declaration of brain death is determined. This participation must include an appropriate clinical exam performed by the physician to include being present during the apnea test if performed to observe for respiratory movement, and documenting the results of the exam in the patient's health record.
   d. The time of brain death must be recorded as the time the second physician confirms brain death diagnosis.
   e. A physician involved in the declaration of death must NOT participate in the procedure for organ/tissue procurement or transplantation.
6. The Care Team will follow California Health and Safety Code § 1254.4 requiring that a reasonably brief period of accommodation be provided for family or next-of-kin to gather at the bedside after the determination of death has been made through the discontinuation of cardio pulmonary support.
   a. The period of reasonable accommodation is generally not greater than 24 hours after brain death has been declared.
   b. Reasonable accommodation also may include the hospital's consideration of the needs of other patients and prospective patients in urgent need of care.
   c. The care team shall make reasonable efforts to accommodate the religious/cultural practices and concerns of the family.
7. Required Notification to provide for option of Donation of Organ and Tissue.
   a. If imminent death criteria are present and/or brain death is being considered, validate that the Organ Procurement Organization (OPO) has been notified. The OPO will be responsible for the evaluation of potential organ and tissue donation options.
   b. The OPO is responsible for verifying death in any patient where organ donation is being considered or is authorized. The OPO will review the brain death documentation to validate that it meets the requirements set forth in the 2010 AAN Guidelines; this may include a physical assessment of the organ donor patient as well as a review of the brain death declaration documentation.
   c. The OPO will evaluate the declaration of brain death as an element of medical suitability for organ donation. The OPO may ask the hospital for clarification or additional testing if the declaration does not include elements in brain death by neurologic criteria outlined in the AAN Guidelines. The OPO will not participate in the actual brain death declaration process.

D. **FORM(S)**:
   1. Declaration of Brain Death Physician Progress Note

E. **RELATED DOCUMENT(S)**:
   1. Patient Care Services Policy: Code Status/Do not Resuscitate (DNR)/ Withholding or Withdrawing Life Sustaining Treatment.
   2. Patient Care Services Policy: Organ Donation, Including Tissue and Eyes.

F. **REFERENCES**:

1. California Health and Safety Code § 7150.65(c), § 7180-83, § 1254.4
2. Wijdicks, E. F., Varelas, P. N., Gronseth, G. S., and Greer, D. M. Evidence-Based Guideline Update: Determining Brain Death in Adults: Report of the Quality Standards Subcommittee of the American Academy of Neurology (June 8, 2010). *Neurology* (74)23, 1911-1918.
3. Scintigraphic Confirmation of Brain DeathPartha Sinha, MD, and Gary R. Conrad, MD Semin Partha, S., and Conrad, G. R. (2012). Scintigraphic Confirmation of Brain Death. *Seminars in Nuclear Medicine* (42), 27-32.

DECLARATION OF BRAIN DEATH, PHYSICIAN PROGRESS NOTE

Prerequisite	**Yes**	**No**
Evidence of acute CNS catastrophe compatible with brain death		
Exclusions:		
1. Presence of CNS-depressant drug effect by history, drug screen*		
2. Recent administration or continued presence of neuromuscular blocking agent		
3. Electrolyte imbalances, acid-base imbalances or endocrine disturbances		
4. Conditions such as severe facial trauma, preexisting pupillary abnormalities, pulmonary disease resulting in CO_2 retention		
5. Core body temperature less than 32°C (90°F)		

**Calculate drug clearance using 5 times the drug half-life*

Clinical Exam ***Do not proceed with Apnea test if any 1-6 in Clinical Exam PRESENT***	**Yes**	**No**
1. Motor response to pain in extremities (nail-bed pressure; supraorbital pressure; temporomandibular joint compression)		
2. Pupillary response to light		
3. Doll's Eyes movement (oculocephalic reflex) present		
4. Eye movement to ice water calorics (oculovestibular reflex)		
5. Eyelid movement to corneal swab/touch (corneal reflex)		
6. Cough or gag to deep endotracheal suctioning		

Apnea Exam Pre Conditions, ~~Guidance for Testing~~ Inclusion Criteria	**Verified**
1. Normotensive (may require vasopressors, MAP greater than or equal to 60-65mmHg)	
2. Normothermic: (core temp greater than or equal to 36°C)	
3. Normal pCO_2 (35 - 45 mmHg) or at patients documented pCO_2 baseline	
4. pO_2 greater than or equal to 200 mm Hg or ability to pre oxygenate to 200mmHg	
If unable to complete Apnea Exam, proceed with Ancillary Testing	
Apnea Exam:	**Completed**
1. Increase FiO_2 to 100% and PEEP of 5mmHg	
2. Draw baseline ABG	
3. Disconnect patient ventilator	
4. Provide O_2 via cannula at level of carina at 6 L/min (or 1-piece with CPAP at 10 cm H_20)	
5. Observe closely for respiratory movements for approximately 8-10 minutes	
6. Repeat ABG in approximately 8-10 min	
7. Reconnect ventilator	

DECLARATION OF BRAIN DEATH, PHYSICIAN PROGRESS NOTE

Apnea Exam Results						
If pCO_2 is greater than or equal to 60mmHg OR pCO_2 increase is greater than or equal to 20 mmHg over baseline normal pCO_2 WITHOUT respiratory movement noted — patient is apneic and apnea testing is consistent with diagnosis of Brain Death. If respiratory movements are observed, the apnea test result does not support the clinical diagnosis of brain death.						
Test 1—Adult	**pH**	**pO_2**	**pCO_2**	**BP**	**SpO_2**	**Apnea Time**
Baseline Blood Gas						
Apneic Blood Gas						

Ancillary Testing		**Verified**
Cerebral Angiography	Flow absent in all major intracranial vessels consistent with death	
CBF Isotopic Scan	Cerebral perfusion is absent in cortex and brain stem, consistent with death.	
Other		

PHYSICIAN COMPLETING ABOVE DOCUMENTATION:

I have examined the patient, together with the health record and laboratory results and was present and observed the apnea test if performed. I declare that the patient is dead on the basis of this evaluation.

Signed: _____ **Date:** / / **Time:** _____

Print: _____

BRAIN DEATH DECLARATION

Attestation: Physician 2

I have examined the patient_____**together with the health record and laboratory results. This included conducting or reviewing the results of the apnea test and or/any ancillary tests. The patient is declared dead on the basis of this evaluation.**

Signed: _____ **Date:** / / **Time:** _____

Print: _____

This form is a composite drawn from a number of sources, reflecting best practice — and amended in the context of the 2010 AAN Adult and 2011 SPA/SCCM Pediatric guidelines.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 5/78	**SUBJECT:** Food and Nutrition Relationships with other Departments
REVISION DATE: 4/00, 6/03, 7/05, 7/07, 3/10, 1/13	**POLICY NUMBER:** I.P

Department Approval:	02/17
Clinical Policies and Procedures Committee Approval:	~~01/13~~03/17
Nursing Executive Committee Approval:	~~01/13~~03/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	04/13
Board of Directors Approval:	04/13

A. **POLICY:**

1. Food and Nutrition Services is organized, staffed and integrated with other units and departments of the hospital in a manner designed to assure the provision of optimal nutritional care and quality food service. The department maintains operating relationships with most of the medical care and administrative activities of the hospital. Close relationships are maintained with the medical staff on special dietetic needs of patients; with nursing services on provisions of regular and modified diets and between meal nourishments; and with administration on management matters.

B. **NURSING SERVICE:**

1. Food and Nutrition personnel are responsible for:
   a. Preparation and delivery of all trays to patient units, including the provision of nourishment supplies.
   b. Return of soiled trays and dishes to the kitchen on food carts. Check soiled utility room for soiled trays / dishes, put on food carts, and bring back to kitchen.
   c. Dietitians screen and assess nutritional status of patients to provide optimal nutritional care or instruction regarding special dietary needs.
   d. Upon receiving a physician's order, or as deemed appropriate, dietitian instructs patients in maintenance of modified diets at home, prior to discharge.
   e. Visit patients daily to pick up or assist with completion of selective menu for the next day. Both nursing and food service personnel may help the patients with menu selections.
   f. Preparation and delivery of mid-morning, mid-afternoon, and evening nourishments to nursing stations.
   g. Preparation and delivery of enteral feedings.
   h. Preparation, delivery, and service of attractive, nutritional, and satisfying meals under approved standards of sanitation.
   i. The clinical dietician will establish priorities of care, determine nutritional status, and develop nutritional care plans.
   j. Providing in-services on nutrition-related and food and nutrition services related topics as requested.
   k. Communicating with nursing regarding patient's nutritional needs and concerns.
2. Nursing personnel are responsible for:
   a. Obtaining a physician's order for each patient's diet.
   b. Transmitting diet orders to Food and Nutrition Services.
   c. Assisting patients with choices on selective menus.
   d. Preparing patients to receive trays.

e. Passing trays to patients upon arrival of food carts **under direction of Primary Registered Nurse**.
f. Ensuring two patient identifiers are used when delivering trays and nourishments.
g. Feeding patients who need assistance.
h. Serving special interval nourishments **(for example snacks)**.
i. Preparing infant formulas for the obstetrical nursery.
j. Obtaining height and weight and recording in patient's chart.
k. Complete Braden Scale Score and initiate nutrition consult for patients at high risk for skin breakdown.
l. Notifying the Food and Nutrition Services Dietitian if a patient is not eating well.
m. Transmitting guest tray orders.
n. Collecting finished food trays and placing on food cart if still on floor, or storing in dirty utility room.
~~n.~~**i. Remove protected health information from tray.**
o. Completion of patient history related to nutrition risk factors (generating nutrition consults if any risks are identified.)

C. **BUSINESS OFFICE:**
1. Food & Nutrition personnel are responsible for:
   a. Submitting a cafeteria cash report.
2. Business Office personnel are responsible for:
   a. Initiating receipts for cafeteria cash received.

D. **INFORMATION TECHNOLOGY:**
1. Food and Nutrition personnel are responsible for entering physicians' cafeteria charges into the computer at the end of each month.
2. Information Technology personnel are responsible for:
   a. Consulting with Food and Nutrition when initiating new dietary data processing procedures.
   b. Providing the system for receiving patient discharges, admissions, and room changes.
   c. Assisting Food and Nutrition in the use of the computer system.
   d. Providing support for Cerner.

E. **EMPLOYEE HEALTH:**
1. The Employee Health Nurse and/or the Emergency Room handle all Food and Nutrition Services employee accidents, pre-employment physicals, and annual physical reviews.

F. **ENVIRONMENTAL SERVICES:**
1. Food and Nutrition personnel are responsible for:
   a. Returning soiled ~~towels, and~~ mop heads to the laundry.
2. Environmental Services personnel are responsible for:
   a. Providing clean ~~towels and~~ mop heads for use in Food and Nutrition Services.
   b. Cleaning Food and Nutrition offices and carpeted and tiled areas of cafeteria.

G. **FACILITIES MANAGEMENT:**
1. Food and Nutrition personnel are responsible for:
   a. Initiating work requests for repair of equipment.
   b. Reporting hazardous working conditions.
2. Facilities personnel are responsible for:
   a. Preventive maintenance and repair on all Food and Nutrition equipment unless under contract with an outside agency.
   b. Keeping records of preventative maintenance in Facilities Management.
   c. Keeping files on maintenance of Food and Nutrition equipment.

H. **EDUCATION:**

1. Education ~~provides~~ **facilities** in-service education for Food and Nutrition personnel for hospital orientation and other areas as needed and/or requested.

I. **AUXILIARY:**

1. Food and Nutrition Services provides refreshments for Auxiliary meetings.
2. Food and Nutrition Services provides supplies for Auxiliary functions.

J. **PHARMACY:**

1. Pharmacy personnel are responsible for:
   ~~a. Providing updated list of patients receiving total parenteral nutrition (TPN) for Registered Dietician (RD) on daily basis.~~
   ~~b.~~**a.** Conferring with RDs regarding drug-nutrient interactions.
   ~~c.~~**b.** Conferring with RDs regarding best means to achieve nutritional needs via TPN for those patients receiving TPN.
2. Dietitians are responsible for:
   a. Conferring with Pharmacists regarding potential drug -- nutrient interactions.
   b. Conferring with Pharmacists on patients receiving TPN to optimize nutrition support via TPN.

K. **ALL TRI-CITY MEDICAL CENTER DEPARTMENTS:**

1. Food and Nutrition Services provides room set-ups and catering upon request for meetings/events for departments, Board of Directors, and the medical center in general.
   a. Coordination is completed by contacting the Event Coordinator, the Catering/Cafeteria Supervisor, and/or the Operations Manager of Food & Nutrition.
2. Individual departments may request catering with approval from the department director/manager.
3. Individual departments/cost centers are charged for internal catering.
   a. Departments may authorize payment via an external source (i.e. a vendor).

L. REFERENCE(S):

~~a.~~**1. Title 22**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: NEW

SUBJECT: **Glucose Monitoring During ~~and~~ Exercise Therapy for Diabetic Patients**

REVISION DATE(S):

Department Approval Date(s):	**05/16**
Clinical Policies and Procedures Approval Date(s):	**02/17**
Nurse Executive Committee Approval Date(s):	**02/17**
Medical Staff Department/Division Approval Date(s):	**n/a**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**03/17**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

A. **PURPOSE:**

1. To provide safe, therapeutic care for **out**patients with diabetes during their exercise training session **in Tri-City Healthcare District (TCHD) rehabilitation facilities.**

B. **POLICY:**

1. All phase 2 patients who are taking insulin or oral diabetes medications will have their blood glucose level checked before and after exercise during their first 3 exercise sessions by **the Registered Nurse RN~~nursing~~ / or Respiratory Care Practitioner** (RCP) staff trained in the use of the Nova Stat Strip glucose monitoring system.
2. If blood sugars are stable (between 100-300 mg/dL) after 3 visits pre and post exercise, patients will no longer need to continue having checks (unless symptomatic).
3. If blood sugars are unstable (under 100 or over 300 mg/dL) after 3 visits, patient must make an appointment with their **Primary Care Provider** (PCP) to have **their~~his/her~~** medication and diet reviewed. The patient will need to bring back a note from PCP stating he/she is cleared to return to exercise.
4. The **RN~~nurse~~**/RCP will again check blood sugars pre and post exercise over the next 3 visits. If stable (100-300mg/dL), patient does not need to continue being checked. If unstable (below 100 or above 300 mg/dL) patient will again need clearance from PCP to return to exercise. A referral to a diabetes educator will be given to patient, as well as other educational materials.

C. **PROCEDURE:**

1. **RN~~Nurse~~**/RCP on staff shall test diabetic patients' pre and post exercise blood sugars for their first 3 visits ~~Follow~~ **followed** immediately with action based on results.
2. If blood glucose is less than 100 mg/dL, the patient shall eat a pre-exercise snack of 15 grams of carbohydrate which they are instructed to bring to every session. Juice, glucose tabs, and glucose gel are kept in the department in case the patient did not bring his/her own snack. (Examples of fast acting carbohydrate are ½ cup orange juice, 1 cup skim milk, 3-4 glucose tabs or glucose gel equal to 15 grams, 8-10 lifesaver candies).
3. For patients with a pre exercise blood sugar less than 100 mg/dL who have eaten a 15 gram carbohydrate snack, wait 15 minutes after snack and recheck blood sugar. If below 100, repeat treatment. Notify physician for repeated low blood sugar levels.
4. If blood glucose is greater than 300 mg/dL, patient may not exercise that day. Notify physician if patient is unable to exercise due to elevated blood glucose level.

5. If the patient is driving him/herself, the post exercise blood sugar should be 100 mg/dL or greater. If the post exercise blood sugar is less than 100 mg/dL he/she should have a snack of 15 grams carbohydrate and re-check in 15 minutes and repeat until blood sugar is 100 or greater before being discharged home.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 5/78	**SUBJECT:** Meals, Patients – Times, Menus, Substitutions and Nourishments
REVISION DATE: 4/00, 6/03, 8/05; 5/08; 02/11	**POLICY NUMBER:** IV.AA

Department Approval:	**02/17**
Clinical Policies and Procedures Approval:	**~~05/15~~03/17**
Nursing Executive Council Approval:	**~~05/15~~03/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**06/15**
Board of Directors Approval:	**06/15**

A. **POLICY:**

1. The Food and Nutrition Services Department provides three (3) patient meals daily and offers between-meal nourishments three (3) times daily. No more than 14 hours shall elapse between the serving of the dinner meal and the breakfast meal of the following day.
   a. Patient tray line shall operate according to the following schedule:
      i. Breakfast: 7:00 AM – 8:15 AM
      ii. Lunch: 11:00 AM – 12:15 PM
      iii. Dinner: 4:45 PM – 6:15 PM
      iv. (All finish times are approximate)
   b. Patient trays shall be loaded on food carts and delivered to the nursing units in a predetermined sequence.
2. Meal service shall be provided for patients who are not served meals during normal meal service time.
   a. Delayed trays are ordered via the computer system.
      i. All delayed tray requests shall be filled with a minimum of delay.
      ii. Food & Nutrition personnel trained on special diets shall prepare the tray as listed on the diet slip. Supervisory personnel shall monitor performance.
      iii. All food items shall be covered.
      iv. Normal tray line delivery systems shall be used to ensure maximum temperature retention.
   b. Early breakfast trays are available upon request.
   c. Standard late breakfast trays are served from 8:30 AM until 10:00 AM. Late trays shall be delivered on the half-hour.
   d. From 10 AM to 10:30 AM, Continental-type breakfast may be served.
   e. Standard late lunch trays are served from 12:30 PM until 2:30 PM.
      i. From 2:30 PM until 4:00 PM, soup, sandwich, dessert, and beverage lunch shall be served.
   f. Standard late dinner trays are served from 6:00 PM until 7:00 PM.
      i. From 7:00 PM until 1:30 AM, grilled items and cold sandwiches, appropriate to the patient's diet, can be obtained in the cafeteria.
   g. Late trays served shall comply with the patient's diet order.
   h. Floor stocks are used for after-hours.
3. Most patients receive selective menus from which to make their meal choices. Exceptions are: New admissions, patients who are NPO, patients on liquid diets, severely restricted diets, and those electing not to select.

a. The next day's menu is distributed by a representative from Food & Nutrition. The menu is reviewed with the patient and appropriate selections are made. New admits receive a selective menu by their second meal.
b. Patients willing but unable to fill out the menu by themselves shall receive assistance from family members, Nursing or Food & Nutrition personnel.
c. Upon receipt of a new diet order, the patient shall be visited by a dietitian or food service partner within two (2) meals of receipt of the diet order.
    i. The patient shall receive the house menu prior to visitation.
    ii. Patients with new diet orders received by 8:00 AM shall be allowed to choose a lunch and dinner for that day in addition to the next day's menu.
    iii. Patients with new diet orders received between 8:00 AM and 12:30 PM shall be allowed to choose dinner for that day as well as the next day's menu.
    iv. Patients with new diet orders received between 12:30 PM and 8:00 AM the next day receive a house diet for dinner and breakfast and then are allowed to choose subsequent meals.

4. Menu substitutions are offered to patients who cannot make adequate choices from the printed menu.
    a. Substitutions are offered from the substitution list when the patient asks for other foods due to reasons as stated above.
    b. Suggestions are made based on the reason for patient's request from substitution list.
    c. A two-hour notice is required for staff to request a substitution item.
    d. Production area is alerted by diet clerk if "write-ins" are done on the day food substitutions are to be served.
    e. Patients are familiarized with available menu substitutions.
    f. The hospital cafeteria menu, appropriate to the patient's diet, is made available to patients who request additional selections.
    g. Every effort within reason shall be made to accommodate the patient's nutritional needs.
5. Nourishments or "between meal feedings" shall be recommended and provided to meet the patients' nutritional requirements.
    a. Criteria for recommending/providing supplements or nourishments:
        i. Multiple feeding plans, i.e. IDDM, dumping syndrome, and hypoglycemia.
        ii. Patients' inability to consume daily caloric requirements within a three (3)-meal per day plan.
        iii. Calorie or protein needs are greater than the prescribed diet.
    b. All nourishment orders shall be received and planned by the food service partner or dietitian. The food service partner or the dietitian shall initiate specific nourishment orders.
    c. The dietitian or food service partner shall review patient acceptance and tolerance and revise the nourishment/meal plan as appropriate.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE:	**02/03**	**SUBJECT:**	**Medication Recall**
REVISION DATE:	**06/03, 08/05; 01/06; 03/08; 02/09 07/11**	**POLICY NUMBER:**	**IV.I.9**

Department Approval:	**10/16**
Clinical Policies & Procedures Committee Approval:	**~~05/14~~11/16**
Nurse Executive Council Approval:	**~~05/14~~01/17**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Committee Approval:	**~~07/14~~02/17**
Medical Executive Committee Approval:	**~~09/14~~03/17**
Professional Affairs Committee Approval:	**10/14**
Board of Directors Approval:	**11/14**

A. **POLICY:**

1. The Pharmacy Department shall maintain a system whereby drugs subject to recall are immediately identified, removed from active inventory, and sequestered.
2. The Pharmacy Department is notified of manufacturer's or Food and Drug Administration (FDA's) recall or medication discontinuation proceedings through direct mail, wholesaler's notification, written or electronic FDA Safety Alert or Recall Notification.
   a. Chronological files of such notifications, alerts, and recall notices shall be maintained for at least one (1) year.

B. **PROCEDURE:**

1. When the Pharmacy Department receives information about a medication recall or discontinuation by the manufacturer or the FDA for safety reasons:
   a. All individuals ordering, dispensing, and/or administering recalled or discontinued medications are notified.
   b. Patients will be notified of the recall or discontinuation if required by law or regulation.
2. The pharmaceutical buyer or designee shall remove all lots of a recalled drug if found in inventory. Recalled medications are replaced with an unaffected lot number of the same medications or generic equivalent, when available.
   a. A record of actions taken shall be written on the recall notice; including none found in inventory and the date the action was taken.
   b. The notice is forwarded to the Director of Pharmacy or designee upon completion of the recall action.
3. All drug storage areas of the hospital shall be inspected, including satellite pharmacies, surgery and other floor stock areas if applicable.
4. Recalled medications are quarantined in a designated area separate from active stock. This area is clearly identified.
5. Recalled medications are returned in accordance with manufacturers/recall notice specifications.
6. Medications recalled for safety reasons are reported to the Pharmacy and Therapeutics Committee.

Tri-City Medical Center	Distribution: Patient Ca

DELETE – no longer required. Now documented in Cerner

PROCEDURE:	OUTPATIENT SUMMARY LIST PROCEDURE
Purpose:	To provide ongoing documentation for continuity of care for the outpatient population
Supportive Data:	This process is unique to Tri-City Medical Center and is not included in Mosby's Nursing Skills
Equipment:	Outpatient Summary List Form 6185-1002

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

~~1. Tri City Medical Center is committed to providing continuity of care to the outpatient population. The Outpatient Summary List (OPSL) will facilitate this continuity of care over a period of time by keeping current information regarding patient's diagnoses, procedures, medications, and allergies. This information will be available to all caregivers and is quickly and easily available to staff.~~

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

~~1. The OPSL will be used in the following areas:~~
~~a. Outpatient Chemotherapy~~
~~b. Special Procedures Recovery Area (SPRA)~~
~~c. Cath Lab~~
~~d. Interventional Radiology~~
~~e. Dialysis Unit (4 Pavilion)~~

~~2. The registered nurse will complete the Outpatient Summary List (Form #6185-1002) by the patient's third visit (may be completed earlier).~~

~~3. At the completion of the visit, the OPSL will be sent to Medical Records with the patient's medical record and a copy made and placed in unit file.~~

~~4. At each subsequent visit, the registered nurse will retrieve the copy of the OPSL from the unit file and update. Any changes will be lined out with a single line, and additions made as appropriate. The RN shall sign/date the form.~~

~~5. At the completion of the visit, a copy is made of the revised OPSL and placed in the unit file. The revised original shall be sent to Medical Records along with the discharged encounter for scanning.~~

~~6. Units will purge the OPSL file quarterly by shredding.~~

~~7. Other outpatient units not addressed in this procedure will develop and maintain their own forms per their unit specific procedures.~~

Department Review	Clinical Policies & Procedures	Nursing Executive Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
2/06; 11/06, 11/07, 7/09; 12/09; 11/12, 12/16	7/09, 1/10;12/12, **02/17**	8/09, 1/10;12/12, **02/17**	8/09, 2/10; 5/13; **03/17**	9/09, 3/10, 6/13	9/09, 3/10, 6/13

○ ○ ○ ○ ○

Patient Name _____ DOB: _____ HT: _____ WT: _____
Date Summary List Was Initiated: _____
Allergies/ Reaction _____

1. Medical Diagnosis and Conditions

Diagnosis and Conditions		Diagnosis and Conditions	
Date		Date	

2. Hospitalizations/Surgeries/Invasive Procedures

Hospitalizations/Surgeries/Invasive Procedures		Hospitalizations/Surgeries/Invasive Procedures	
Date		Date	

3. Home Medications (Including OTC & Herbal)

Medications				Medications			
Name	Dose	Start Date	Stop Date	Name	Dose	Start Date	Stop Date

4. Family History

Family History						
☐ Allergies	☐ Asthma	☐ Bleeding Disorders	☐ Diabetes	☐ High Blood Pressure	☐ Kidney Disease	
☐ Sickle Cell	☐ Seizures	☐ High Cholesterol	☐ Liver Disease	☐ Hearing Loss	☐ Cancer	
☐ Psychological Problems		☐ Heart Disease				

Explain: _____
☐ Any Other Problems:
_____
_____
_____

RN _____ Date _____ RN _____ Date _____ RN _____ Date _____

5. Date Summary List Was Reviewed (Must be Reviewed Every Outpatient Visit)

Outpatient Summary List Reviewed									
Date	RN Signature	Date	RN Signature	Date	RN Signature	Date	RN Signature	Date	RN Signature

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

6185-1002
(Rev. 11/09)

OUTPATIENT SUMMARY LIST

Affix Patient Label

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**PUREWICK FEMALE URINARY INCONTINENCE MANAGEMENT**
Purpose:	To define the appropriate procedure for initiation of urinary incontinence management through implementation of the PureWick system. To define the assessment, monitoring, and maintenance of urinary incontinence management **with**~~through~~ implementation of the PureWick system.
Supportive Data:	Reduces the need for inserting an indwelling urinary catheter for incontinent female patients and avoids the risk associated with catheter-associated urinary tract infections (CAUTI). Keeps patient's skin dry, avoids pressure ulcers, **contact dermatitis**~~rashes~~ from urine, and the need for diapers
Equipment:	PureWick System Wall suction regulator Suction **c**~~C~~anister -and -~~I~~**l**~~L~~iner Suction **t**~~T~~ubing Suction tubing -connectors Incontinence ~~P~~**p**ads**, patient undergarments, mesh panties (optional)** Hygiene supplies

A. **DEFINITION(S):**

1. Wick: Disposable, latex free flexible urine collection tube with a vacuum, with cloth material on one side and plastic or tape on the other side that is positioned between the labia and the bottom to collect urine. The wick is designed to connect to the suction regulator via suction tubing. The suction is set at 20mmHg to produce a mild vacuum inside of the wick. Wicks are capable of capturing 100% of urine.

B. **POLICY:**

1. PureWick urine management system may be implemented for female patients with urinary incontinence 24 hours per day and the following:
   a. ~~w~~**W**alking from bed to chair to a toilet is difficult or painful
   b. ~~i~~**I**nability to retain urine
   c. P~~p~~ost-surgical **or procedure** -immobility
   d. Accurate urine output measuring
   ~~c.~~**e. Strict intake and output orders**
   ~~d.~~**f.** ~~p~~**P**ressure ulcers or contact dermatitis associated skin injuries related to urine
   ~~e.~~**g. U**~~u~~rine sample, if a sample cannot be obtained from a clean catch
2. The PureWick system is contraindicated for the following:
   a. Male patients
   b. Patients with male genitalia
   c. Patients with urinary retention
   ~~a.~~**d.** Uncooperative patient
      i. Uncooperative patients will remove wicks
   ~~b.~~**e.** Patient gets out of bed without supervision
   ~~c.~~**f.** Bowel incontinence with frequent episodes
3. Precautions for the use of the PureWick system include but are not limited to:
   a. Skin irritation
   b. Pressure from device
   c. Patient discomfort
4. PureWick urine management system will be implemented by a Registered Nurse (RN)**; a physician order is not required.** The RN is responsible for:
   a. Identifying patients that will benefit from the use of a PureWick
   b. Maintenance of PureWick.

Department Review	Clinical Policies and Procedures Committee	Nurse Executive Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
11/16	01/17	02/17	n/a	03/17		

c. Documentation in the medical record

5. Each wick may be used for a maximum of 12 hours.
6. Change the wick prior to the end of each shift, as needed (PRN) and if the following occurs: .
   a. Indications for changing the wick
      i. Patient comfort or request
      ii. Skin irritation
      iii. Frequency of urinations
      iv. After each stool
      ~~iv.~~**v. Menstruating**
7. Assessment
   a. Assess the following at least twice per shift and PRN
      i. Urine output, if urine is escaping the wick, refer to the Troubleshooting section below
      ii. Patient's comfort
      iii. Proper placement of the wick at least three times per shift **and with position changes**
      iv. Presence of skin redness or irritation related to the wick location
      ~~iv.~~**v. Ensure patient does not insert the wick into the vagina, anal canal or other body cavities**
8. **Transport On and Off a Unit**
   a. Patients with PureWicks suction will be:
      i. Disconnected from suction prior to transport by RNs and Advanced Care Technicians (ACTs)
      ii. Reconnected to suction by RNs and ACTs when returning from test or procedures

C. **PROCEDURE:**

1. Perform hand hygiene per TCMC policies and procedures
2. Obtain a PureWick Urinary System ~~for the unit supply Pyxis or cart~~
3. Explain procedure to patient
4. Set up suction per manufacturer's instructions
5. Set vacuum pressure i.e., suction to 20mmHg (low setting) continuous suction. ~~-~~Suction may be increased if required to a maximum of **6040** mmHG. **Do not exceed 60 mmHG**
   a. Ensure suction is working by closing and opening the suction tubing end with your thumb or by placing the suction tubing open end in the palm of your hand.
6. Perform hand hygiene and don new gloves.
7. Position patient on their back or ~~side~~**side;** place an incontinence pad under her buttocks to capture urine that escapes the wick.
8. Provide pericare ~~as needed~~
9. Remove wick from the **package**~~plastic bag~~.
10. Peel the PureWick label from bag and wrap it around the suction tubing.
    a. It will serve as a method of identifying the hose when replacing wicks.
11. Insert the plastic **hose** ~~connector~~ on the end of the wick into the connector on the suction tubing
12. **Separate the gluteus muscle and the labia**
~~12.~~**13.** Hold the wick vertically with the connection to the suction tubing on top and the cloth surface facing the patient's perineum.
~~13.~~**14.** Gently place the wick -snugly against the perineum, between the labia and patient's buttocks.
    a. The cloth surface of the wick **(white side)** should be snugly positioned between the labia and close to the urethra.
    b. The wick should touch the perineum between the anus and the pubic bone
       ~~b.~~**i. Failure to properly place the wick will result in urine leakage**
    c. If the patient is lying still, the wick will typically stay in-position.
    d. Assist patient with repositioning at least every 2 hours and PRN.

e. Mesh stretch panties or the patient's undergarments may be applied to hold the wick in place.

15. Ensure the hose connector is above the pubic bone

~~14.~~**16.** Verify the suction is functioning

~~15.~~**17.** Ensure there are no kinks in the suction tubing

~~16.~~**18.** Maintenance of Suction Canister

a. The suction will stop working when the suction canister is full

b. Change the suction canister when it is ¾ full.

i. The canister may be changed without removing the wick. Disconnect the suction tubing from the plastic connector attached to the wick and change suction canister per manufacture's recommendations.

c. Observe the amount of urine in the canister a minimum of 3 times daily.

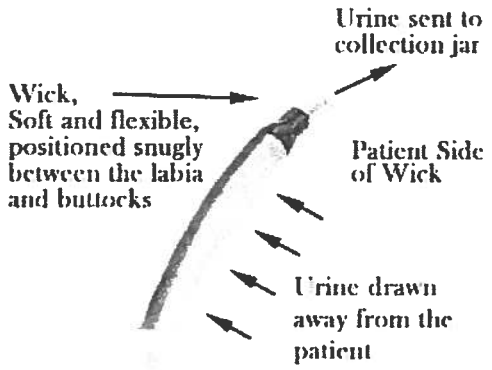
D. **OBTAINING A URINE SAMPLE WITH THE PUREWICK:**

1. Set up suction ~~as outlined in C. 1-5~~
2. See Online Clinical Skills: **Specimen** Collection: Midstream (Clean-Voided) Urine
3. Female patient
   a. Spread or have the patient spread the labia minora with the thumb and forefinger or forefinger and middle finger of the nondominant hand.
   b. Use the dominant hand to cleanse the urethral area with antiseptic ~~swabs moving~~**swabs moving** from front (above the urethral orifice) to back (toward the anus).
   c. Using a fresh swab each time, employ the front-to-back motion first with the left side, then the right side, and then down the center. Again using a fresh swab each time, repeat the process
   d. While continuing to hold the labia apart,
      i. Apply **a**~~the~~ PureWick **(do not connect the PureWick to suction)** have the patient initiate a urine stream, discard the PureWick~~, urine, and discard suction liner and tubing~~
      ~~ii. Place a clean suction liner in the suction canister and suction tubing to collect the specimen.~~
      ~~iii.~~**ii.** Apply a new PureWick**, connect to suction** -and allow patient to void to collect a midstream specimen
      ~~iv.~~**iii.** After collecting the midstream specimen, disconnect the suction tubing from the suction canisters, close the lids on the liner, ~~remove~~**and remove** the liner.
         1) If the PureWick is to remain in place, **a**~~A~~pply a new liner and connect the suction
         2) If the PureWick is no longer require remove and discard suction tubing.
      ~~v.~~**iv.** Pour midstream specimen in a specimen container and label according to TCMC **Specimen Labeling** ~~policy.~~
      ~~vi.~~**v.** Transport specimen to lab according to TCMC policy
      ~~vii.~~**vi.** Document in the medical record according to TCMC policy

E. **TROUBLESHOOTING:**

1. If a large amount of urine is escaping from the wick, contributing factors include but are not limited to:
   a. The wick is not correctly tucked between the labia and buttocks.
      i. The wick must be snugly positioned between the labia with the bottom end between the buttocks.
      ii. Ensure the top of the wick reaches just above the pubic bone.
      iii. Change the PureWick
      ~~ii.~~**iv. Apply mesh panties to assist with maintain the PureWick's position**
   b. No or low suction.

i. Check suction settings and ensure the regulator is set at 20 mmHg
ii. Check for kinks in the tubing or sediments
iii. Ensure the suction canister lid is firmly in place
iv. Verify the suction regulator is functioning
v. Ensure the suction tubing is connected to the wick connector



~~v.~~**vi.** _____

~~2. For other troubleshooting assistance, PureWick is available at 619-660-0734.~~

F. **RELATED DOCUMENT(S):**
1. **Clinical Skills** (Mosby's): **Specimen** Collection: Midstream (Clean-Voided) Urine
2. Urine Collection Clean Catch Urine Specimen: TCMC Clinical Laboratory Manual
3. Patient Care Services Policy: Specimen Labeling~~, Nurse Collectibles~~

G. **REFERENCE(S)** ~~**LIST**~~**:**
1. PureWick, Inc. (**2016, April**~~n.d.~~).**Instructions for use (in hospital settings)**.~~ How does it work. Retrieved from~~ ~~http://www.purewick.com/how-does-it-work-2/~~
2. PureWick, Inc. (n.d.). Successful incontinence management for women. Retrieved from http://www.purewick.com/

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 05/08	**SUBJECT:** Research Activities: Investigational Drugs
REVISION DATE: 09/09; 12/09	**POLICY NUMBER:** IV.I.12

Department Approval:	10/16
Clinical Policies & Procedures Committee Approval:	~~01/10~~11/16
Nurse Executive Council Approval:	01/17
Medical Staff Department/Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	02/17
~~**Patient Care Quality Committee Approval:**~~	~~01/10~~
Medical Executive Committee Approval:	03/17
Professional Affairs Committee Approval:	02/10
Board of Directors Approval:	02/10

A. **PURPOSE:**

1. **To provide guidelines for coordination of medical, nursing, administration, and pharmacy staff in providing for the safe use and dissemination of investigational drugs, biologics and devices within the hospital. More information can be found in the Clinical Research Policies Manual and the Pharmacy sub-manual Investigation Drugs Services Policies and Procedures, both ~~department~~departments – specific manuals.**

~~1.~~**2.** To provide guidelines for coordination of medical, nursing, administration, and pharmacy staff in **hospital-driven research such as Evidenced Based Practice (EBP) and new healthcare research.**~~providing for the following:~~

~~a. Safe use of investigational drugs within the hospital~~
~~b. Adequate overall financial compensation~~
~~c. Development of operational procedures to coordinate investigational studies~~

B. **DEFINITION(S):**

1. **Clinical Research Coordinator (CRC): The CRC is a TCMC credentialed clinical trial coordinator employed by the clinical research site conducting the clinical trial or study.**
2. **Clinical Research Site refers to the external organization that is conducting the Clinical Trial or Study.**
3. **Comprehensive-Unit Based Safety Program (CUSP): The Clinical Research Department (CRD) is actively involved in supporting a culture shift towards patient safety via the Pronovost invented CUSP program.**
4. **Evidence-Based Practice (EBP): Evidence-Based Medicine (EBM) aims to apply the best available published evidence gained from the scientific method to clinical decision making and medical intervention. It seeks to assess the strength of evidence of the risks and benefits of treatments (including lack of treatment) and diagnostic tests as well as drives the support for determining "best practices". This helps clinicians to learn whether a treatment will do more good than harm.**
5. **Exemption Determinations for Research Projects: Research projects *may be* determined exempt from federal oversight and Investigational Review Board (IRB) review under 45 CFR Part 46 if they not involve a Federal Drug Administration (FDA) regulated product such as a drug or device and if prisoners are not included in the research. Exemption Determinations are reviewed by the Tri-City Medical Center (TCMC) CRD and the opinions derived by the TCMC Exemption Determination Committee. The policy number describing exempted research is Clinical Research Exempted Research Policy 8010.021.**

6. **Informed Consent Form (ICF): A document which explains the following:**
   a. **Details of the study**
   b. **The potential risks and benefits**
   c. **Rights and responsibilities**
7. Investigational Drugs **and Biologics** – New drugs **or biologics which**~~, or investigational uses for Food & Drug Administration (FDA) approved drugs that~~ have been issued an Investigational New Drug (IND) number by the FDA. These **medical treatments**~~medications~~ are **for investigational use only**~~not for general use~~
8. **Investigational Devices: New devices which have been designated as a Humanitarian Use Device (HUD) and been issued a Humanitarian Device Exemption (HDE) or have an Investigational Device and been assigned an Investigational Device Exemption (IDE) by the FDA.**
   a. **HUD is as defined in 21 CFR 814.3(n), as a "medical device intended to benefit patients in the treatment or diagnosis of a disease or condition that affects or is manifested in fewer than 4,000 individuals in the United States per year.**
   b. **HDE is defined in 21 CFR 814.3(m), as a "premarket approval application" submitted to FDA pursuant to Subpart A, 21 CFR Part 814 "seeking a humanitarian device exemption from the effectiveness requirements of sections 514 and 515 of the [FD&C Act] as authorized by section 520(m)(2) of the [FD&C Act]."**
   c. **An IDE allows an investigational device (i.e. a device that is the subject of a clinical study) to be used in order to collect safety and effectiveness data required to support a premarket approval (PMA) application or a premarket notification [510(k)] submission to the FDA.**
~~1.~~**9. Investigational Review Board (IRB): An IRB is a committee established to review and approve research involving human subjects. The purpose of the IRB is to ensure that all human subject research be conducted in accordance with all federal, institutional, and ethical guidelines. Western IRB is TCMC's IRB of record.**
10. Principal Investigator **(PI) – Physician(s) with privileges at Tri-City Medical Center (TCMC) who are responsible for the conduct of the clinical study. In the case of drug studies,** the **PI** ~~Tri-City Medical Center (TCMC) approved physician(s)~~**would** sign~~ing~~ **the** FDA Form 1572 **and TCMC would be listed on the Form as a site**~~for obtaining investigational drugs from the study sponsor~~
11. **Publication: Publications shall consist of manuscripts for journal publication, posters and power point presentations aka talks, speaking engagements etc. A completed publication is to be provided to the CRD for approval.**
12. **Research Subject: All patients enrolled in a clinical trial are referred to by trial personnel as a study subject per FDA guidelines.**
13. **Research is a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program which is considered research for other purposes.**
14. **Scientific Review Committee: The Scientific Review Committee (SRC) serves to assess the scientific, business, contractual, and financial considerations for each clinical research project at TCMC.**
~~2.~~**15. Sponsor: An individual, company, institution or organization which takes responsibility for the initiation, management and/or financing of a clinical trial.**

C. **POLICY:**
1. **All IRB requests are to be made through the TCMC Director of Clinical Research.**
~~1.~~**2. Clinical trials**~~Investigational drugs~~ are administered only in accordance with protocols approved by the **SRC**~~Clinical Research Administrative Review Committee (CRARC) and developed by Performance Improvement,~~**. Representatives from all ancillary services, education** ~~Pharmacy~~, nursing **and physicians**~~, and Lab and Radiology when applicable.~~ **are members of**

the SRC and play a role in determining whether the study is feasible to be conducted at TCMC and whether there were no regulatory obstacles.

~~2.~~**a.** Investigational drugs, **radiation, biologics or devises** shall be used only under the supervision of the principal investigator **and/**or ~~co~~**sub**-investigator, who assumes the burden of **responsibility for the proper conduct of the clinical trial and** securing the necessary **ICF**~~informed~~ consent.

b. The principle or ~~co~~**sub**-investigator must be a member of the Medical Staff of TCMC for all investigational drug protocols approved by the **SRC**~~CRARC~~ of TCMC.

~~a.~~**c.** **Investigational medications are administered only under the supervision of the authorized investigator and according to protocol. They are to be distributed by the IDS Pharmacy.**

3. **The CUSP program may be used to study quality improvement methods or EBP research.**
4. **TCMC has an EBP Committee. This committee is available for teaching or coaching hospital employees who would like to conduct EBP research.**
5. **The CRD will issue a written opinion for a proposed project that may be exempted from Federal Oversight and IRB review under 45 CFR Part 46. The policy describing exempted research is Clinical Research Exempted Research Policy 8010.021.**
6. **TCMC CRD is available to review and assist with manuscript preparation and revision for those discoveries made at TCMC.**
7. **TCMC conducts various forms of research not based on the reproduction of earlier findings but based on a novel concept that could change medical practice or healthcare workflow. The CRD and EBP Committee are available as a resource.**

~~3. The investigational protocols and a complete TCMC submission packet must be submitted by the principal investigator to the CRARC for review of operational and financial impact.~~

~~a. Approval by CRARC must be granted before patients may enroll.~~

~~b. Investigational medications are administered only under the supervision of the authorized investigator and according to protocol.~~

8. **TCMC's IDS Pharmacy**~~The Principal Investigator (PI)~~ is responsible for providing information on storage, labeling, ~~and~~ distribution **and waste**~~ to pharmacy~~. **A clinical IDS pharmacist shall review the Investigational Drug Fact sheet with nursing personnel as requested. This is detailed in the Pharmacy IDS Policy and Procedure manual.**
9. **Each hard copy of the patient medical record shall contain a research tab. The signed ICF is to be placed in this section.**
   a. **IF THERE IS NO CONSENT and the patient does not have one available, the RN or Healthcare provider needs to call the clinical trial site to obtain a copy.**
   b. **No procedures or trial-related medications may be administered until this consent is on file in the Medical Record.**
10. **Prior to the initiation of the clinical research study, sufficient education is provided to the pharmacy and nursing staff charged with dispensing and administering the medication. Copies of the orders are to be provided to lab and radiology when appropriate.**

D. ROLES AND RESPONSIBILITIES:

1. **Sponsor:**
   a. **Provides information on storage, labeling, and distribution to pharmacy**
2. **Principal Investigator:**

~~4.~~**a.** ~~The PI is also responsible for p~~**Provide**~~s~~**s**~~ing~~ a nursing summary and drug fact sheet to the **Nursing Educator group**~~nursing staff~~ in one-page outlines. The ~~minimal~~ information provided shall include:

~~a.~~**i.** Dosage form
~~b.~~**ii.** Route of administration
~~c.~~**iii.** Strength
~~d.~~**iv.** Actions
~~e.~~**v.** Uses
~~f.~~**vi.** Side effects
~~g.~~**vii.** Adverse effects

~~h.~~viii. Interactions
ix. Symptoms of toxicity

~~i.~~b. **Obtains fully executed ICF and places a copy in the medical record.**

~~5. When nurses are required to administer investigational drugs, the study coordinator shall provide the Investigational Drug Fact Sheet (see attached) with the initial dose of study drug.~~

~~a. A clinical pharmacist shall review the Investigational Drug Fact sheet with nursing personnel as requested.~~

c. Upon study initiation, the PI shall provide a written order to the IDS pharmacy. If oral study medication has been provided to study subject they may take their own study drug. An order from the PI for the oral drug can be provided by the site or IDS pharmacy.

3. Pharmacist:

a. Prior to study enrollment, the Sponsor or the Contract Research Organization (CRO) shall conduct a site initiation visit (SIV) with the investigational drug service pharmacist

i. Review study procedures to include randomization, dispensing, blinding and unblinding documentation, and planning for routine monitoring visits.

ii. Every attempt shall be made to conduct a SIV in the TCMC Pharmacy.

b. Review the Investigational Drug fact sheet with nursing personnel as requested.

c. Process all investigational medications

i. The TCMC Pharmacy address must be listed as the receiving party for all investigational drug study medications.

ii. Study drug distributor/Sponsor must notify pharmacy as to expected date of receipt, and every attempt must be made by distributor to deliver during normal business hours.

iii. Once received in the pharmacy, investigational study medications shall be inspected for damage, quantity verified, documented on the study master accountability form, and stored at appropriate temperature by the IDS pharmacist or delegated pharmacist trained on the study.

1) If no appropriately trained staff is available to complete the above on the day of receipt, the medications will be sequestered in the investigational drug study room at appropriate storage conditions until above documentation can be completed.

2) No study medications shall be removed for patient use unless the above has been completed.

iv. Investigational study medications shall be stored in a separate locked room within the pharmacy, accessible only to pharmacists and other pharmacy personnel under the supervision of a pharmacist.

1) High/low temperature logs shall be maintained in this room for drugs stored under ambient and refrigerated conditions.

v. Drug receipt shall be logged into appropriate IVRS/IWRS within 24 hours of receipt and all shipping documents processed per study instructions.

vi. An inventory record shall be kept on each investigational drug. A record shall be kept for each dose of investigational drug dispensed.

vii. Inventory of investigational drugs shall be kept and include the following:

1) Quantities dispensed

2) Identities of patients

3) Quantities of medications returned, lost, or destroyed.

viii. Clinical trial materials and/or investigational drugs shall be returned or destroyed per protocol and sponsor direction.

ix. Information on current Drug and Study Protocols is maintained in the Pharmacy IDS locked storage room. Information on closed studies is maintained in the Pharmacy IDS locked storage room for a period of at least one year following the study close-out. After one year, the information may

be moved to on-site storage for at least another year before transfer to off-site storage. All IDS study documentations are to be kept permanently.

d. Dispenses Investigational drugs (TCMC licensed pharmacist only)
   i. All investigational drugs shall be properly labeled, with auxiliary labeling if necessary:
      1) Name of drug or identification of investigational protocol.
      2) Strength
      3) Expiration date of the drug. If no expiration date is available, a re-test date shall be used as the expiration date. In the event that an expiration or re-test date is not available, a memo from the sponsor shall be obtained stating that they assume responsibility for notifying the pharmacy prior to the drugs expiration date.
   ii. For intravenous investigational agents the following process shall be followed:
      1) A pharmacist (IDS or IV room pharmacist) shall prepare or directly supervise preparation of all IV investigational infusions.
      2) For any IV doses not dispensed during the IV room pharmacist shift, communication will be made to the evening pharmacist of any pending investigational infusions.
      3) IV infusions for investigational drugs should be infused via a separate site and clearly labeled as "Investigational Drug" whenever possible. If IV infusions for investigational drugs are infused into a line with other medications, the line must be flushed with normal saline, or flushed per study protocol if specified by the sponsor.
   iii. For outpatient study medications, the study site staff will pick up the investigational drug from pharmacy. Pharmacy personnel and study site staff member will sign the transportation log once picked up. The logs will be filed and kept in the IDS storage room.
      1) The only exception to this shall be when the study sponsor requires a study-specific dispensing log.
   iv. For studies without a study-specific transportation log, a TCMC dispensing/transportation log shall be completed whenever investigational medications are delivered by pharmacy personnel to nursing units. The pharmacy personnel and receiving nurse will sign the log.
   v. Procedures pertaining to the disposition of any remaining study drug or study drug preparation shall be determined prior to patient enrollment.
      1) Medications not used by the patient shall be returned to the pharmacy or may be retained by the patient per physician's order.
      2) When the protocol is closed, the medications shall be returned to the sponsor, physician, or destroyed through standard hospital procedure, as directed by the sponsor or PI.

e. All pharmacists involved in investigational drug dispensation must complete training by the IDS pharmacist and sign-off that they have received training.
   i. Training and delegation logs shall be maintained in the pharmacy study binder.
   ii. CV's and California pharmacist license shall be maintained in the pharmacy study binder if required by the sponsor.
   iii. Staff education is provided in the departments and to the staff involved

4. Study Coordinator:
   a. Provides an in-service to the nursing educator group when all items are finalized.
   b. Study requirement checklist must be completed by the PI or research coordinator prior to enrollment of patients.
   c. Staff education is provided in the departments and to the staff involved.
      i. Pharmacists involved in study drug dispensing or monitoring shall be educated on study procedures. This shall include:

1) **Documentation**
2) **Monitoring (if required by the study)**
3) **Randomization (when pharmacy is the responsible party)**
4) **Blinding**
5) **Proper storage, preparation, and dispensing of the study drug.**

5. **Education Group**:
   a. **Reviews orders, the nursing summary, and drug fact sheets**
   b. **Coordinates distribution of the information and in-service education to the nursing staff.**
6. **Nursing:**
   a. **Verifies informed consent.**
      i. **A copy of the consent is retained in the IDS pharmacy and medical record under the research tab**
   b. **Reviews the PPO, drug fact sheet and nursing summary**
   c. **Administers IV infusions for investigational drugs via a separate site and clearly labeled as "Investigational Drug"**
      i. **Investigational drugs can only be infused into a line with other medications with approval from the PI and IDS pharmacist.**

~~6. For patients entering TCMC who are participating in an outside clinical trial (not recognized or approved by the TCMC CRARC), the pharmacy shall adhere to the following:~~
~~a. The PI shall be notified and evaluate the appropriateness of the patient's continuance in the investigational study. If no contraindication exists, the investigational study medications may be continued during hospitalization.~~
~~i. If the PI is not the admitting physician, this information must be communicated to the admitting physician or hospitalist assuming care of the patient.~~
~~b. Physician shall provide a written order for "patient may take own study drug" or similar wording~~
~~c. The PI shall verify identity and confirm study drug~~
~~d. The PI shall complete the Investigational Drug Fact Sheet for nursing and pharmacy.~~
~~e. The CRARC and pharmacy shall accept a copy of original informed consent~~
~~i. A copy shall be placed on the patient's medical chart~~
~~f. Sufficient education is provided to the pharmacy and nursing staff charged with dispensing and administering the medication.~~
~~7. All investigational medications must be processed through Pharmacy.~~
~~a. The TCMC Pharmacy address must be listed as the receiving party for all investigational drug study medications.~~
~~b. Study drug distributor must notify pharmacy as to expected date of receipt, and every attempt must be made by distributor to deliver during normal business hours.~~
~~c. Once received in the pharmacy, investigational study medications shall be inspected for damage, counted, and entered on study master accountability form by a pharmacist trained in study procedures.~~
~~i. If no appropriately trained staff is available to complete the above on the day of receipt, the medications will be sequestered in the investigational study room for no longer than 24 hours.~~
~~ii. No study medications shall be removed for patient use unless the above has been completed.~~
~~d. Investigational study medications shall be stored in a separate, locked room within the pharmacy, accessible only to pharmacists and other pharmacy personnel under the supervision of a pharmacist.~~
~~i. High/Low temperature logs shall be maintained in this room for drugs stored under ambient and refrigerated conditions.~~
~~e. Drug receipt shall be logged into appropriate IVRS/IWRS within 24 hours of receipt and all shipping documents processed per study instructions.~~
~~8. The study coordinator or the registered nurse caring for the patient shall provide a written physician's order and a copy of the signed informed consent to obtain study drug.~~

9. ~~An inventory record shall be kept on each investigational drug. A record shall be kept of each dose of the investigational drug. Clinical trial materials and/or investigational drugs shall be returned or destroyed per protocol and sponsor direction.~~
10. ~~Information on current Drug and Study Protocols is maintained in the Pharmacy IV room. Information on closed studies is maintained in the investigational drug storage room for a period of at least one year following study close-out. After one year, the information may be moved to on-site storage for at least another year before transfer to off-site storage. The Investigational Drug Pharmacist shall maintain records of studies sent to storage.~~
11. ~~Investigational drugs shall be dispensed by a TCMC licensed pharmacist.~~
12. ~~IV infusions for investigational drugs should be infused via a separate site and clearly labeled as "Investigational Drug" whenever possible if IV infusions for investigational drugs are infused into a line with other medications, the line must be flushed with normal saline.~~

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

1. ~~The PI or clinical study coordinator presents the study in person to the CRARC.~~
2. ~~If the study is approved, the following occurs:~~
   a. ~~The PI and/or clinical coordinator work with pharmacy to develop study specific pre-printed orders (PPO), drug fact sheet, and nursing summary.~~
      i. ~~Copies of the PPO are distributed to the lab and radiology for input if applicable.~~
      ii. ~~PPO, drug fact sheet, and nursing summary are distributed to nursing for input.~~
   b. ~~When all items are finalized, the study coordinator provides an in-service to the nursing educator group.~~
      i. ~~The educator group shall decide who will provide in-service education to the nursing staff.~~
   c. ~~Study requirement checklist must be completed by the PI or research coordinator prior to enrollment of patients.~~
   d. ~~Prior to study enrollment, the Sponsor or the Contract Research Organization (CRO) shall conduct a site initiation visit (SIV) with the investigational pharmacist to review study procedures to include randomization, dispensing, blinding and unblinding documentation, and planning for routine monitoring visits. Every attempt shall be made to conduct SIV in the TCMC Pharmacy.~~
   e. ~~Medications not used by the patient shall be returned to the pharmacy or may be retained by the patient per physician's order.~~
   f. ~~Procedures with the disposition of any remaining study drug or study drug preparation shall be determined prior to patient enrollment.~~
   g. ~~Inventory of investigational drugs shall be kept and include the following:~~
      i. ~~Quantities dispensed~~
      ii. ~~Identities of patients~~
      iii. ~~Quantities of medications returned, lost, or destroyed.~~
   h. ~~When the protocol is closed, the medication shall be returned to the company, physician, or is destroyed through standard hospital procedure, as directed by the drug company or PI.~~
      i. ~~Training and delegation logs shall be maintained in the pharmacy study binder.~~
      ii. ~~CVs and California pharmacist license shall be maintained in the pharmacy study binder if required by sponsor.~~
   i. ~~Staff education is provided in the departments and to the staff involved. Pharmacists involved in study drug dispensing or monitoring shall be educated on study procedures. This shall include all documentation, monitoring (if required by the study), randomization (when the pharmacy is the responsible party), blinding, and the proper storage, preparation and dispensing of study drugs.~~
   j. ~~Consent is obtained and a copy retained in the medical record.~~
3. ~~For intravenous investigational agents the following process shall be followed:~~
   a. ~~A pharmacist (usually the IV room pharmacist) shall prepare all IV investigational infusions.~~
   b. ~~A second pharmacist shall check and co-sign the final solution after prepared~~

~~i. If no other pharmacist on site, then an IV technician shall check the final product.~~
~~c. For IV doses not dispensed during the IV room pharmacist shift, the IV labels shall be placed in the "Time flag" area with the rest of the IV labels with short stability.~~
~~d. The IV room pharmacist shall communicate to the PM IV technician and either the evening or night pharmacist of the pending investigational infusion(s).~~

~~4. All investigational drugs shall be properly labeled, with auxiliary labeling if necessary:~~
~~a. Name of drug or identification of investigational protocol~~
~~b. Strength~~
~~c. Expiration date of the drug. If no expiration date is available, a re-test date shall be used as the expiration date. In the event that an expiration or re-test date is not available, a memo from the sponsor shall be obtained stating that they assume responsibility for notifying the pharmacy prior to the drug's expiration date.~~

~~5. A dispensing/transportation log shall be completed whenever investigational medications are delivered by pharmacy personnel to nursing units and whenever investigational medications are picked up in the pharmacy by a nurse or study coordinator. The only exception to this shall be when the study sponsor requires a study-specific dispensing log.~~

E. **DOCUMENTATION:**

1. Documentation in the medical record shall include:
   a. Signed copy of informed consent filed under research tab
   b. Physician's order for the investigational drug including:
      i. Name
      ii. Dose
      iii. Route
      iv. Duration of administration (included on the PPO)
      v. Frequency of administration
      ~~v.~~**vi. Acceptable rescue medications for an adverse drug reaction**
   c. Order for disposition of any unused medication
   d. Completed Medication Administration Record (MAR)
   e. All side effects and adverse reactions to the investigational drug shall be noted in the nursing notes and reported to the physician.
   f. Results for all tests ordered **at TCMC** as part of the research protocol

F. PATIENTS ENTERING TCMC WHO ARE PARTICIPATING IN AN OUTSIDE CLINICAL TRIAL:

1. For patients entering TCMC who are in an outside clinical trial (not recognized or approved by the TCMC SRC), the pharmacy shall adhere to the following guidelines:
   a. The PI shall be notified and evaluate the appropriateness of the patient's continuance in the investigational study.
      i. If no contraindication exists, the investigational study medications may be continued during hospitalization.
      ii. If the PI does not have privileges at TCMC this information must be communicated to the admitting physician or hospitalist assuming care of the patient.
   b. The admitting physician or Allied Health Professional (AHP) shall provide a written order for "patient may take own study drug" or similar wording.
   c. The IDS pharmacist shall verify identity and confirm the study drug.
   d. The PI shall complete the Investigational Drug Fact Sheet for nursing and pharmacy.
   e. The TCMC SRC and pharmacy shall accept a copy of the original informed consent
      i. A copy shall be placed on the patient's medical chart
   f. Sufficient education is provided to the pharmacy and nursing staff charged with dispensing and administering the medication.

G. RELATED DOCUMENT(S):

1. Clinical Research Exempted Research Policy 8010.021

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

1. http://www.fda.gov/RegulatoryInformation/Guidances/ucm389154.htm
2. **https://www.nlm.nih.gov/services/ctconsent.html**
~~https://www.google.com/search?sourceid=navclient&aq=&oq=Clinical+Trial+Informed+Consent+Definition&ie=UTF-8&rlz=1T4VRHB_enUS623US624&q=Clinical+Trial+Informed+Consent+Definition&gs_l=hp.....0.0.0.7596.....0.OKAS8cKvMU4#q=IDE+definition+FDA~~

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 5/00 **SUBJECT:** EMTALA: Emergency Medical Screening

REVISION DATE: 6/03; 1/06; 8/09; 02/11; 2/17 **POLICY NUMBER:** 8610-506

Administrative Policies & Procedures Committee Approval:	~~12/10~~ 02/17
Medical Executive Committee Approval:	~~01/11~~03/17
Professional Affairs Committee Approval:	02/11
Board of Directors Approval:	02/11

A. **PURPOSE:**

1. To ensure compliance with the Federal requirements contained in the Emergency Medical Treatment and ~~Active~~ Labor Act (EMTALA). EMTALA waiver allows hospitals to direct or relocate individuals which would normally be prohibited under EMTALA of individuals with unstable emergency medical conditions if necessitated by the circumstances of the declared emergency. CMS will provide notice of the waiver.

B. **DEFINITION(S):**

1. Individual who presents with an emergency medical condition: An individual who presents with an emergency medical condition anywhere on Tri-City Healthcare District (TCHD) campus, even if the individual presents at a location other than the Emergency Department (ED). TCHD's campus includes ambulatory services departments located on or adjacent to the campus, as well as the medical center parking lots, sidewalks, and access roads.
2. Emergency Medical Condition:
   a. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in either placing the health of an individual (or with respect to a pregnant woman, the health of her unborn child) in serious jeopardy; serious impairment of bodily functions; or serious dysfunction of any bodily organ or part; or
   b. With respect to a pregnant woman who is having contractions, there is adequate time to affect a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or her unborn child.
3. Medical Screening Exam (MSE): The process required to reach, with reasonable clinical confidence, the point at which it can be determined whether an emergency medical condition does or does not exist. MSE requires an evaluation by a qualified medical provider, within the capability of the hospital's ED, to determine whether an emergency medical condition exists, or if the person is in labor. The MSE is a dynamic process and represents a spectrum ranging from a simple process involving only a brief history and physical, to a complex process that involves performing ancillary studies and procedures, depending on the patient's presenting symptoms.
4. Stabilization: Stabilization includes the provision of such medical treatment for the condition, necessary to assure within reasonable medical probability that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or that the woman has delivered the child and placenta. Stabilization may include either stabilization for discharge or stabilization for transfer.
5. Triage: Determines the order in which patients will be seen.

C. **POLICY:**

1. Collection of financial information in the ED must be performed in accordance with this policy.

2. Hospitals may not delay in providing a medical screening examination (MSE) or necessary stabilizing treatment by inquiring about an individual's ability to pay for care. Individuals who have an emergency medical condition must be offered, and if desired, receive a MSE regardless of answers the individual may give to questions asked during the registration process. In addition, a hospital may not delay screening or treatment to an individual while information is verified. However, hospitals may continue to follow reasonable registration processes for individuals presenting with an emergency medical condition. Reasonable registration processes may include requesting information about insurance as long as these procedures do not delay screening or treatment.
3. Each patient seeking treatment in the ED is entitled to an emergency MSE. When collecting financial information in the ED setting, the following guidelines must be followed:
   a. A MSE and necessary stabilization may not be refused by TCHD for any reason, even if a managed care plan refuses to authorize treatment or pay for services **the MSE must be completed despite ability to pay.**
   b. A MSE for an ED patient may not be delayed in order to:
      i. Inquire about an individual's ability to pay
      ii. Inform the patient that he/she must pay a co-pay or deductible if they choose to be treated
      iii. Perform insurance verification and authorization
      iv. Inform the patient that his/her care will be free or at a lower cost if another facility is used
   c. The MSE must be the same for all individuals presenting to the ED with the same condition, regardless of financial status or payment source. Triage does not qualify as an appropriate medical screening exam.
4. The registrar **or Triage RN** must refrain from making any comments that the patient might interpret to mean that services might not be provided based on ability to pay. For example, the registrar must not say, "We don't accept XYZ insurance here."
5. The registrar shall not request co-pays, deductibles, or past due balances from the patient until the MSE and necessary stabilization have occurred.
6. If a patient expresses the intent to leave the ED, the patient shall be encouraged to remain in the ED until the MSE and necessary stabilization are completed. If a patient leaves TCHD as a result of questions asked prior to receiving the MSE, it may be interpreted that the there was a suggestion that the patient leave the ED. **This must be well documented by the Triage RN.**
~~6.~~**7.** If a patient presents to the ED with a life-threatening emergent condition (i.e., patient arrives via ambulance in cardiac arrest) the MSE and necessary stabilization will begin immediately. The registrar may obtain the information identified in C.10 below from a source other than the patient (i.e., next of kin). Otherwise, financial information shall be obtained after the patient has received a MSE and necessary stabilizing treatment. Financial information may be discussed with the patient only after stabilization.
~~7.~~**8.** In case of an emergent situation or active labor identified after the MSE, stabilization and treatment will begin immediately. The registrar may obtain the information identified in C.10 below, as well as insurance verification and authorization, provided that the necessary stabilization and treatment are not delayed. When the physician determines that an emergency medical condition no longer exists, the patient may;
   a. Accept treatment and financial liability.
~~8.~~**9.** If the MSE determines that the patient does not have an emergency medical condition, or the patient is not in active labor, the patient shall be informed of his/her treatment options. The registrar may obtain the information identified in C.10 below, as well as insurance verification and authorization. After the MSE is completed, and once the physician has made the determination that an emergency medical condition does not exist, the patient may be informed of his/her potential financial liability. The patient may;
   a. Accept treatment and financial liability.
   b. Refuse additional treatment. If treatment is refused, the physician may refer the patient to another facility.

~~9.~~**10.** The registration process may be initiated as long as the process does not cause a delay in the provision of a MSE and necessary stabilization for an emergency medical condition. Basic identifying information may be gathered and entered into Affinity to allow for processing of tests in the order entry system. Basic information obtained may include:

a. Patient's full name
b. Patient's date of birth
c. Social Security number
d. Family physician
e. Insurance plan information, if applicable

~~10.~~**11.** If patient's information is already present in Affinity, the registrar will verify the existing information.

~~11.~~**12.** An Advance Beneficiary Notification Notice (ABN) shall not be obtained when rendering emergency medical treatment.

~~12.~~**13.** Signage indicating payment is due at time of service, or indicating that the patient's insurance may not pay for the service may not be placed in the ED lobby or treatment area.

~~13.~~**14.** Registration/ patient access management personnel must educate all registration staff responsible for registering, billing, and maintaining patient records.

~~14.~~**15.** The Registration supervisor shall observe registrars at regular intervals during the orientation period and at least annually thereafter to ensure compliance with this policy. Deviations from the policy will result in corrective action.

D. **REFERENCES:**

1. Social Security Act, Section 1867, 42 U.S.C. 1395dd, Examination and Treatment for Emergency Conditions and Women in Labor.
2. Social Security Act, Section 1867, 42 U.S.C. 1395cc, Emergency Medical Treatment and Active Labor Act.
3. Federal Register 489.24, Special Responsibilities of Medicare Hospitals in Emergency Cases.
4. Federal Register 489.53, Terms of Provider Agreements, Acceptance of Program Beneficiaries.
5. Current California Hospital Association (CHA) Consent Manual – Chapter: Patient Transfer, Discharge, or Temporary Absence
6. EMTALA Answer Book 2016, Author Mark M. Moy

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

SUBJECT: ACLS FEE WAIVER

ISSUE DATE: 07/13
REVISION DATE(S):

Department Approval Date(s):	**~~12/16~~02/17**
Medical Executive Committee Approval Date(s):	**n/a**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	**07/13**

A. **PURPOSE:**

1. To establish a policy wherein Acute Care Services **Registered Nurses** (RNs) may receive a fee waiver to take the Advanced Cardiac Life Support **(ACLS)** course ~~(hereinafter referred to as ACLS)~~ at Tri-City ~~Medical Center~~**Healthcare District** ~~(hereinafter referred to as TCMC~~**TCHD**), when it is not a requirement for their current position. The $50.00 refundable deposit for the ACLS course shall remain in effect.

B. **POLICY:**

1. ACLS is not a requirement for RNs working on 1 North and 2 Pavilion. However, RNs from those departments may receive a fee waiver to take the ACLS Provider Course offered at ~~TCMC~~**TCHD**, subject to approval by their Manager or Assistant Nurse Manager, under the following condition:
   a. After taking the ACLS Provider course and receiving the ACLS Provider card from ~~TCMC~~**TCHD**, RNs will be expected to float to Telemetry, 4Pavilion, and Forensics in rotation with the rest of the ACS staff with ACLS Provider certification.

C. **PROCEDURE:**

1. Obtain the ACLS Fee Waiver Form from the Education Department
2. Sign the ACLS Fee Waiver Form.
3. Obtain Manager's or Assistant Nurse Manager's signature on the Form.
4. Turn in the Form to Education when enrolling in the ACLS Course.

D. **FORM(S):**

1. ACLS Fee Waiver

~~E. APPROVAL PROCESS~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

ACLS Fee Waiver Form for ACS RNs (1N/2P)

Instructions: This completed and signed form is to be presented to the Education Department prior to enrolling in the ACLS course. If the form is not presented, a payment must be received in order to enroll in this course. The $50 refundable deposit still applies.

ACLS certification is required for RNs working on 4P. This is not a requirement for other ACS RNs. RNs from 1N and 2P who want to attend the ACLS course must pay for the course, unless a fee waiver form is completed and signed by Management.

The fees for this course will be waived upon successful completion of the ACLS course. Upon completion, there will be the expectation that you will orient and float to Telemetry, 4Pavilion, and Forensics in rotation with the rest of ACS staff with an ACLS provider certification.

ACLS 2 Day Full Provider Course:
Date Classes Scheduled: _____ / _____

I acknowledge and accept the above requirements for Fee Waiver:

_____

Employee Name (Please Print) / Employee ID / Employee signature

_____

Manager or Assistant Nurse Manager Name (Please Print) / Signature

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

SUBJECT: AHA: RECIPROCITY STATEMENT

ISSUE DATE: 06/07
REVISION DATE(S): 03/10, 04/13

Department Approval Date(s):	**02/17**
Medical Executive Committee Approval Date(s):	**n/a**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	**07/13**

A. **POLICY:**

1. **American Heart Association** (AHA) Training Center (TC) Reciprocity Statement
   a. AHA Provider reciprocity is recognized nationally. A current Provider card is valid anywhere in the **United~~.~~ States~~.~~ America**.
   b. Instructor Reciprocity is recognized nationally.
      i. Instructors must align with a ~~Training Center (~~TC~~)~~ in their region.
      ii. An instructor may teach for more than one Training Center but may only align with one primary TC per discipline.
   c. When an instructor moves to another area, he or she must ask the primary TC to transfer records to the new primary TC. The new primary TC must monitor the performance of the Instructor and may impose additional requirements before they can be placed on active status.
      i. TCs are not obligated to accept all instructors who apply for alignment.
   d. **Tri-City Healthcare District (~~TCMC~~ TCHD)** TC will not issue a new Instructor card until satisfactory monitoring of approved course is documented.
   e. Training Center Faculty (TCF) between Training centers in not recognized at the TCF level.
      i. A TCF member who transfers to another TC will need to work within the new TC to establish TCF status.
   f. Regional Faculty Reciprocity- Reciprocity between regions in not recognized at the Regional Faculty level. A Regional Faculty member who moves to another region should contact the Regional **Emergency Cardiovascular Care** (ECC) office in the new Region for specific information.

~~B. APPROVAL PROCESS~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

SUBJECT: **AHA: ROLE OF THE TCMC AMERICAN HEART ASSOCIATION (AHA) TRAINING CENTER (TC)**

ISSUE DATE: 07/05
REVISION DATE(S): 05/07, 03/10, 04/13

Department Approval Date(s):	**02/17**
Medical Executive Committee Approval Date(s):	**n/a**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	**07/13**

A. **POLICY:**

1. The role of the ~~TCMC~~ **Tri-City Healthcare District (TCHD)** American Heart Association (AHA) Training Center (TC) is to provide Basic Life Support (BLS), Advance Cardiac Life Support (ACLS), and Pediatric Advance Life Support (PALS) educational courses and strengthen the AHA Chain of Survival. The TC is responsible for the proper administration and quality of Emergency Cardiovascular Care (ECC) courses as well as the day-to-day management of its local Training Network. The Training Center is considered the principal informational resource, support, and quality control for all AHA ECC Instructors.
2. The TC local Network may be comprised of some or all of the following AHA Job roles:
   a. Regional Faculty is the quality assurance and educational section of the ECC program. These are ACLS, BLS, and PALS instructors appointed as Regional Faculty **(RF)** by the Regional ECC Committee because of the exemplary service. ~~Regional Faculty~~**RF** members are assigned to their TC to serve as outside resource experts on ECC-related issues and to conduct site visits (i.e. Course monitoring and administrative functions). A ~~Regional Faculty~~**RF** member cannot conduct a course monitoring or administrative site visit for their primary TC. RF cannot receive payment for RF activities
   b. Training Center Coordinator (TCC) is a representative of the TC and the primary contact for the AHA. The TC is responsible for selecting the TCC. It is understood that the AHA expects the TCC to have the appropriate skill to either perform or manage all TC responsibilities as describe in the (See Position Description for Training Center Coordinator Attachment A)
   c. Training Center Faculty (TCF), at least one per each discipline the TC teaches. The number of TCF members will be determined by the TC needs based on the number of courses provided. (See Position Description for Training Center Faculty Attachment B).
   d. ACLS/PALS Lead Instructors are responsible for working with the Course Director and staff of the sponsoring institution to ensure quality and to oversee the actual operation of the AHA courses offered by the TC. The Lead Instructor must be present throughout the course to answer questions and resolve logistical problems. (See Position Description for Lead Instructor Attachment C).
   e. Course Instructor is an individual who has received Provider and Instructor training in a specific discipline through the AHA, has been monitored, received an instructor card, and is qualified to teach a Provider Courses to other individuals in this discipline. Before the Instructor can operate as an instructor, they must align with a contracted AHA TC. Any Instructor who is not aligned with an AHA TC is not authorized to act as an AHA Instructor.
3. Operational Responsibilities of the ~~Training Center (~~TC~~)~~ are as follows:

a. Perform all duties in a manner consistent with the AHA mission and guidelines as outlined in the "Emergency Cardiac Care Program Administrative Manual (PAM).
b. Maintains a current signed Agreement with the Regional ECC Office that states the TC will teach all AHA courses in accordance with the AHA science, curriculum, policies, and procedures.
c. Secure and/or maintain general liability insurance in the amount of $1,000,000.00 throughout the term of its Agreement with the AHA ECC.
d. Maintain AHA agreements with Training sites and Instructors. (See Attachment D).
e. Use the most current AHA ECC training materials in all courses and ensure that course participants have the most current course textbooks for use *before, during, and after the course*.
f. Make available to all course Instructors current videos, Instructor toolkits, posters, manikins, and other equipment such as step stools and knee pads to accommodate any participant with physical limitations for use in each course.
g. Assists Instructors develop courses, obtain equipment, and contact assisting Instructors for courses.
h. Maintain complete and accurate Instructors records and contact lists.
i. Provide Instructors with copies of all ECC Training Bulletins and written updates within the time frame outlined in the information accompanying the Training Bulletin/update. (Website access is acceptable.)
j. Transfer Instructor records to other TCs within 30 days of receiving a record transfer request form.
k. Provide at *least one* Training Center Faculty (TCF) per discipline taught through the TC. (Attachment B).
l. Provide adequate administrative capability and space to support the Training Network which includes but not limited to the issuance of cards, maintenance of class rosters, tests, skills check offs and course evaluations, submission of training reports, maintenance of instructor files, etc. (see policy on AHA TC Record Maintenance)
m. Issue the appropriate Provider and Instructor Course completion cards within 30 days of successful completion of AHA ECC courses.
n. Accept all responsibility for the administration, management, and quality assurance, including dispute resolution, for the portion of the ECC Training Network it establishers (e.g.. Training Sites, independent Instructors, etc.).
o. Writes, reviews and revises administrative policies and procedures that address quality assurance, including dispute resolution, card maintenance and issuance, equipment maintenance/decontamination, Training Site management/relations, and management of Instructor communications and updates. These standards must be consistent with current AHA recommendations and guidelines.
p. Strive to expand the AHA ECC training program through number of Instructors as well as course offered in the community.
q. Offer classes to the community through Instructors or directly.
r. Support the Chain of Survival initiatives in its community by maintaining an adequate number of Instructors to meet core requirements.
s. Accept non-employee Instructors and/or Training Sites in its Training Network to help support number 12.
t. Conduct adequate and timely courses/meetings for Instructors and Training Sites to keep them up on any new or updated information about National, Regional, or TC policies, procedures, course content, or course administration that could potentially affect an Instructor in carrying out his/her responsibilities.
u. Monitor and evaluate new (initial) and existing (ongoing) Instructors and Training Sites on a regular basis to assure they perform within all AHA ECC guidelines.

B. **FORM(S):**
1. AHA Position Descriptions of Training Center Coordinator

2. AHA Position Descriptions of Training Center Faculty
3. AHA Position Descriptions of ACLS PALS Lead Instructor
4. AHA Instructor Agreement with TCMC Training Center
5. AHA Lead Instructor Responsibilities
6. AHA Training Center Faculty (TCF) Candidate Application
7. AHA Training Center Course Monitoring Review
8. AHA TCMC Training Center – Fee List
9. AHA Program Administration Manual

~~A. **APPROVAL PROCESS**~~
~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

SUBJECT: AHA TRAINING CENTER: COURSE CONTENT REQUIREMENTS

ISSUE DATE: 07/05
REVISION DATE(S): 05/07, 03/10; 04/13

Department Approval Date(s):	**02/17**
Medical Executive Committee Approval Date(s):	**n/a**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	**07/13**

A. **POLICY:**

1. Any **American Heart Association** (AHA) courses will be taught in the manner that upholds the most current AHA core curriculum and guidelines.
2. For each course full or renewal, each student must have access to the current provider manual appropriate for the course before, during and after the course. Textbooks are designed for individual use and are an integral part of the student's learning process. Each student must have access to a computer to complete the online pretest for **Advanced Cardiac Life Support** (ACLS) and **Pediatric Advanced Life Support** (PALS).
3. Instructors must use the most current edition of AHA course materials in all courses.
4. The course Instructor(s) must be a current AHA-recognized Instructor in good standing with their **Training Center** (TC) and the AHA Network.
5. Specialty Faculty (e.g., an anesthesiologist who teach airway) with expertise in a particular content area with prior approval of the course Director or Training Center Coordinator (TCC) may assist AHA Instructors in advanced life support courses (ACLS, **Advanced Cardiac Life Support for Experienced Providers** [ACLS EP], and PALS). Specialty staff may not make up more then 50% of the total Instructors for any Advance life support course.
6. Course Director and/or Lead Instructor is responsible for monitoring the Specialty Faculty.
7. A course evaluation form must be used in all courses to solicit feedback from students on course content and Instructors. The Instructor may use the AHA Course Evaluation Form or prepare its own form containing the same information. Each form must indicate a mechanism for the student to send the form to the Regional **Emergency Cardiovascular Care** (ECC) office.
8. Smoking is prohibited in classrooms and training facilities during all AHA ECC trainings programs.
9. ~~TCMC~~ **Tri-City Healthcare District (TCHD)** TCs offers CE credits for AHA course using ~~TCMC~~ **TCHD** Education provider number as follows:
   a. Full ACLS ~~&~~ **and** PALS course (two days) 12.0 CE
   b. One day ACLS ~~&~~ **and** PALS renewal course 6 CE
   c. Instructor courses 8 CEs
   d. No CEs are awarded for BLS Provider Course
   e. NO CE's are awarded by ~~TCMC~~ **(TCHD)** for online ACLS ~~&~~ **and** PALS courses. The AHA awards CE.
10. Course Equipment should be used according to the course instructor manual for each discipline.
11. All equipment used in an AHA course must be clean, proper working order and good repair.
12. Each AHA course must have a Course Director and/or Lead Instructor; either or both must be physically present on-site throughout the course. The Course Director and/or Lead Instructor are responsible for course logistics and quality assurance.
13. All Course curriculum and objectives must meet with the current guidelines in the course Instructor's manual or the AHA website, http://www.americanheart.org/.

14. Course length and format maybe varied to meet the experience and learning needs of the students as long as all core content and minimum evaluation time requirements outlined in the Instructor manual are meet.
15. All courses should be interactive learning and evaluation. Each student will be offered the opportunity to practice his or her skills under the supervision of an Instructor who will provide ongoing feedback of competency.
16. Student-to-Instructor and Student-to-manikin rations as outlined in the course discipline Instructor's manual will be maintained at all times.
17. Only the most current version of the AHA written exam will be used in any AHA course. These exams are to be given in a traditional instructor-led course, and the exam is to be taken in a proctored setting. Failure to follow these standards of the written testing process may jeopardize the ~~TCMC~~ **TCHD** Training Center (TC) and faculty in their Agreement with the AHA.
18. Students must score 84% or higher on Provider Course written exam for course completion. If a student scores less then 84% they must be given time to study the material and then retake another version of the test.
19. AHA developed computer-based course, testing maybe used in place of the video, Q&A, updates, and written test, but manikin skills check off must still be completed in the presence of an AHA recognized Instructor with the prior consent of the **Training Center Coordinator (**TCC**)**.
20. Each student will be evaluated for his or her didactic knowledge and proficiency in all core skill of the particular course. ACLS and PALS students are expected to be proficient in BLS HCP skills.
21. Successful course completion is achieved when a student meets the course cognitive and skills demonstration required as descried in the Instructor's manual or on the website. It is the responsibility of the Course Director/Lead Instructor to oversee this process and assure that the quality of the core objectives is maintained.
22. AHA clearly states the following regarding course *completion "in no way warrants performance, guarantees future actions, qualifies or authorizes a person to perform any procedures, and is unrelated to licensure."*
23. The goal of an AHA course is to prepare a student to deliver effective resuscitation. If a student does not meet the course objectives, remediation in the deficient areas will be provided during, and if needed after the course.
24. Remediation may be accomplished by monitoring and mentoring the student to identify and resolve weaknesses, requesting additional skills practice, assigning additional reading, referring the student to other course, or having the student retake the examination or assessment stations to the satisfaction of the Course Director.
25. If remediation is unsuccessful, the Course Director may require the student to repeat entire course or refer the student to a different course (a recert candidate may be referred to a repeat a full provider course).
26. AHA renewal interval for all AHA courses is two years.
27. Providers entering a renewal course must show a current provider card as entrance into a renewal course.
28. The Course Director is responsible for allowing a student to proceed in an initial or renewal course if he/she does not have a current Provider card.
29. Students who present an expired Provider card or do not possess an AHA Provider card may challenge a renewal course but will not be given the option of remediation. They will need to repeat the entire Provider Course if they cannot successfully meet the course completion requirements when evaluated.

B. **EXTERNAL LINK(S):**
1. http://www.americanheart.org/

C. **REFERENCES ~~LIST~~:**
1. Chapter 7 in of the AHA PAM and AHA Instructor Manuals

~~D. APPROVAL PROCESS~~
~~1. Clinical Policies & Procedures Committee~~

~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

SUBJECT: **AHA TRAINING CENTER: DISPUTE RESOLUTION/DISCIPLINARY ACTION**

ISSUE DATE: 07/05
REVISION DATE(S): 06/07, 03/10, 04/13

Department Approval Date(s):	**02/17**
Medical Executive Committee Approval Date(s):	**n/a**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	**07/13**

A. **POLICY:**

1. All disputes, complaints, or allegations within the ~~TCMC~~ **Tri-City Healcare District (TCHD)** Training Network are to be handled in a clear, respectful, impartial and organized fashion, consistent with the ethics, values, policies and procedures of ~~TCMC~~ **TCHD** and AHA. Each dispute or complaint will be resolved at the lowest level of the Network.
2. It is the responsibility of ~~TCMC~~ **TCHD Training Center** (TC) to manage all aspects for any disputes, complaints, or problems that arise from a course offered by an Instructor employed by or aligned with the TCMC TC.
3. Complaints regarding the issues outlined in section C may be submitted to TCMC TC in writing by:
   a. A student who attended the course in which the problem arose
   b. An Instructor, Course Director, TC Faculty member, or TC with information about the problem.
   c. An AHA volunteer or staff member with information about the problem.
4. ~~TCMC~~ **TCHD** TC will respond back to the individual(s) involved in the dispute, complaint, or problem in question within 5 Business days after receipt of the concern in writing. At this time an action plan or steps of further investigation will be discussed.
5. ~~TCMC~~ **TCHD** TC investigation will involve all individuals felt to have first hand knowledge of the occurrence. All measures will be handled with respect and confidentiality manner to the extent that is appropriate for process of resolution.
6. If a dispute, complaint or problem involves a ~~TCMC~~ **TCHD** employee's performance, ~~TCMC~~ **TCMHD** HR or employee's Clinical Manager will be included in the investigative process as appropriate per TCMC AP 427.
7. If after 30 days of diligent efforts ~~TCMC~~ **TCHD** TC is unable to resolve any problems involving the following the TC must turn the dispute, complaint, or problem over to the AHA:
   a. Course content/curriculum
   b. Instructor qualifications
   c. AHA administrative policies and procedures
   d. AHA **Emergency Cardiovascular Care** (ECC) science issues
   e. AHA Training Center agreement and program guidelines
8. ~~TCMC~~ **TCHD** will send a detailed description of the dispute/complaint in writing to the Regional ECC Office (. This written description will include all of the following:
   a. The name and address of the person making the complaint ("complainant"). The AHA will not permit the individual(s) making the complaint to remain anonymous.
   b. The name and address of the person and/or organization against which the complaint is made ("Respondent").

c. A detailed written description of the dispute, complaint, or problem (i.e., who, what, when, where, and why). For TC-related issues, the complaint should contain information on the attempts of the TC to resolve the matter. The TC coordinator must sign the statement.
d. Reference to the appropriate rule, standard, and/or guidelines related to the matter.
e. Copies of all related correspondence, records and other documentation.
f. Within 10 business days after receipt of notification of the dispute, AHA ECC Committee will issue a written notice to the TC, Complainant, and Respondent that the matter has been referred to the AHA for review.
g. Respondent will be invited to provide a response to the complaint in writing to the Review Committee within 30 days by registered or certified mail receipt of notice.
h. Once the response is received in writing the AHA Review Committee will review and provide in writing their decision and recommendation to the TC within 60 days as described in PAM on page 66.

B. **REFERENCES ~~LIST~~:**

1. AHA PAM 2012 Chapter 9

~~C. **APPROVAL PROCESS**~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE:	**09/09**	**SUBJECT:**	**Conflict of Interest Policy for Medical Staff**
REVISION DATE(S): 09/09		**POLICY NUMBER:**	**8710-555**

Department Approval Dates(s):	**03/17**
Medical Staff Department Approval Date(s):	**09/09**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**~~09/09~~03/17**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	**09/09**

A. **PURPOSE:**

1. To safeguard the integrity and reputation of ~~Tri-City Medical Center~~**Tri-City Healthcare District (TCHD)** and their medical staffs by fostering the proper and unbiased conduct of all medical staff activities.
2. To encourage unbiased, responsible management and decision-making.

B. **DEFINITIONS**

1. Conflict of Interest: a divergence between an individual's private interests and his/her professional obligations to the medical staff, hospital, patients, and employees, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by considerations of personal gain, financial or otherwise.
2. Immediate family: Spouse, children, parents, siblings, or equivalents by marriage, or others residing in the physician's household.
3. This policy serves to:
   a. Describe situations that are prohibited.
   b. Educate medical staff members about situations that generate conflicts of interest.
   c. Provide means for the medical staff and the Hospital to disclose and manage conflicts of interest.
   d. Promote the best interests of patients, their families, employees, and other practitioners.

C. **POLICY:**

1. Medical Staff members shall conduct their affairs so as to avoid or minimize conflicts of interest, and must respond appropriately when conflicts of interest arise. The following are representative, but not inclusive, of conflict of interest situations:
   a. Influence on purchases of equipment, instruments, materials, or services for ~~TCMC~~ **TCHD** from the private firms in which the medical staff member, or an immediate family member, has a financial interest.
   b. Unauthorized disclosures of patient or Hospital's information for personal gain.
   c. Provide, offer, or promise anything of value, as a representative of ~~TCMC~~ **TCHD** to any government official to enhance relations with that official or the government.
   d. Transmit to a private firm or other use for personal gain of ~~TCMC~~ **TCHD** supported work, products, results, materials, record, or information that are not generally made available.
   e. Influence upon the negotiation of contracts between ~~TCMC~~ **TCHD** and private organizations with which the medical staff member, or immediate family member, has consulting or other significant relationships, or will receive favorable treatment as a result of such influence.
   f. Improper use of institutional resources for personal financial gain.

g. Accept compensation or free services from a vendor, service provider, or contractor of ~~TCMC~~**TCHD**, when the medical staff is in a position to determine or influence ~~TCMC's~~ **TCHD's** purchases from those persons.

2. All members of the Medical Staff shall complete a general disclosure statement upon appointment and reappointment.
3. Candidates for Medical Staff elected offices must submit a Conflict of Interest statement.
4. Whenever a medical staff member is in a situation where he/she may have a potential conflict of interest, he/she shall make a full disclosure in writing to the Chief of Staff with details of the situation to request an exception.
   a. For any conflict of interest disclosed, the Chief of Staff shall evaluate and determine how the conflict of interest may be managed or avoided.
   b. Confirmed conflict of interest may be disclosed to the Medical Executive Committee by the Chief of Staff.
5. Suspected violations of this policy shall be reported to and evaluated by the Chief of Staff. Reports are confidential and shall remain anonymous.
6. Disciplinary action, if indicated, shall be taken in accordance with the Medical Staff Bylaws.
7. A confirmed conflict of interest shall result in one or more of the following:
   a. Disclosure of the conflict of interest to the Medical Executive Committee;
   b. Abstention from voting on the matter to which the conflict relates;
   c. Recusal from the decision-making process and participation in, including the receipt of information related to the matter to which the conflict relates.

D. **REFERENCES:**

1. Joint Commission Standards, Leadership 02.02.01 and Leadership 04.02.01
2. Conflict of Interest Guidelines for Organized Medical Staffs. American Medical Association.

~~**Approvals:**~~
~~**Medical Department Approval: 09/09**~~
~~**Medical Executive Committee Approval: 09/09**~~
~~**Board of Directors Approval: 09/09**~~

Tri-City Medical Center

Conflict of Interest Form

Practitioner Name:_____ **Date:**_____
Print

Do you have any relationships that may be considered as potential conflict of interest which may include, but may not be limited to, other care providers, educational institutions, manufacturers, and payers? (See Medical Staff Policy, *Conflict of Interest Policy for Medical Staff, 8710-555*)

Yes _____ **No**_____

If you answered "YES," please disclose them in the space provided below.

_____

_____

Practitioner Signature

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 11/10	**SUBJECT: Conflict Resolution Medical Staff**
REVISION DATE(S): 11/10	**POLICY NUMBER: 8710 – 562**

Department Approval Dates(s):	**03/17**
Medical Staff Committee Approval Date(s):	**n/a**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**~~09/10~~03/17**
Professional Affairs Committee Approval Date(s):	**10/10**
Board of Directors Approval Date(s):	**11/10**

A. **PURPOSE:**

1. The Medical Staff, ~~Tri-City Medical Center~~**Healthcare District (TCHD)**, and the District Board, will each use their best efforts to address and resolve all conflicts between the Board, Medical Center, and the Medical Staff in the best interests of patients, the Medical Staff, ~~Tri-City Medical Center~~**TCHD**, and the District Board.

B. **POLICY:**

1. Prior to the District Board taking any action contrary to a recommendation made by the Medical Executive Committee ("MEC") relating to patient safety or quality, the Chair of District Board, or a designee and management shall meet with representatives of the MEC, including the Chief of the Medical Staff, and seek to resolve the conflict through informal discussions.
2. If these informal discussions fail to resolve the conflict, the Chief of Staff or the Chairperson of the District Board may request ~~a formal conflict resolution process.~~**the issue be addressed by the JCC. If a resolution is agreed upon in the JCC, the resolution will be forwarded to the MEC for approval.**

~~2.~~**3. If after consideration at the JCC the conflict is still unresolvable, then the Chief of Staff and the Chairman of the District Board or the Chief Executive Officer may request a formal conflict resolution process.**

C. **PROCEDURE:**

1. The formal conflict resolution process will begin with a meeting of an Ad Hoc Committee within 30 days of the initiation of the formal conflict resolution process. The Ad Hoc Committee will be composed of:
   a. The Chief of Staff, past Chief of Staff, and at the discretion of the Chief of Staff either the Medical Staff Professional Behavioral Chair or the Chair for Quality Assurance/Performance improvement/Patient Safety
   b. The Chair, Secretary, and Vice Chair of the District Board
   c. The Chief Executive Officer or his/her designee
2. If the Committee cannot produce a resolution to the conflict that is acceptable to the MEC and the Board within 30 days of the initial meeting, the MEC and the District Board shall enter into Mediation as that term is defined by California Evidence Code Section 1115. The MEC and the District Board shall together select the third-party mediator. The MEC and the District Board shall use their best efforts to collaborate with the third-party mediator to resolve the conflict. The District Board Chair and the MEC shall each designate at least three people to participate in the mediation. Any resolution arrived at during such a meeting shall be subject to the approval of the MEC and the District Board. The Mediation proceedings shall be confidential pursuant to Evidence Code Section 1119.
   a. If, after 90 days from the date of the initial request for Mediation the MEC and the District

Board cannot resolve the conflict in a manner agreeable to all parties, the District board shall have the authority to act on the issue that gave rise to the conflict in a manner consistent with the Medical Staff Bylaws and California law.

b. With respect to membership, privileges and peer review matters governed by Articles IV, V, VI and VII of the Medical Staff By-laws, this Conflict Resolution Policy shall not be utilized until the procedures set out in the By-laws have been exhausted. This Policy shall also be used for the meet and confer requirements of California Business & Professions Code Section 2282.5.

c. If the Board determines, in its reasonable discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in an attempt to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of ~~Tri-City Medical Center~~**TCHD**, the District Board may take action subject to subsequent review, and any necessary revision, through the conflict resolution process described above.

~~d. In addition to the formal conflict resolution process herein described, the Chair of the District Board or the Chief of Staff may call for a meeting of the Professional Affairs Committee at any time and for any reason to seek direct input from the Professional Affairs Committee, clarify any issue, or relay information directly to the MEC, the District Board, or management.~~

D. **REFERENCES:**

1. Joint Commission Standards 2010 MS.01.10.01
2. Joint Commission Standards 2010 LD.02.04.01

~~**Approvals:**~~
~~**Medical Executive Committee: 09/10**~~
~~**Professional Affairs Committee Approval: 10/10**~~
~~**Board of Directors Approval: 11/10**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 02/07	**SUBJECT:** Credentialing Criteria, Chronic Non Healing Wound Care
REVISION DATE(S): 03/07; 03/10; 07/11; 07/12	**POLICY NUMBER:** 8710 – 523

Department Approval Dates(s):	03/17
Credentials Committee Approval Date(s):	~~07/12~~03/17
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	~~07/12~~03/17
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	07/12

A. **PURPOSE:**

1. The following sites have been designated as locations with adequate resources to allow the performance of the designated privileges:
   a. 161 Thunder Drive, Suite 112, Vista, California
   b. 6260 El Camino Real, Carlsbad California
   c. 4002 Vista Way, Oceanside, California

B. **POLICY:**

1. Physicians/physician assistants/podiatrists who request wound care privileges **must work within their scope of practice (*Podiatrists scope of practice means foot and ankle only) and** shall demonstrate the ability to care for chronic non-healing wounds, including but not limited to: pressure, diabetic, venous, arterial, collagen vascular, autoimmune, and oncologic, and provide assessment and evaluations for patients with chronic non-healing wounds inclusive of:
   a. Routine review of patient record and recent labs
   b. Physical examination of all patient's bony prominences for evidence of excessive pressure or skin breakdown
   c. Determination of the number of observed chronic non-healing wounds and definition of their acuity
   d. Evaluation and management of any medical problems that would prevent wound healing
   e. Development of a treatment plan that facilitates wound healing
2. Physicians/physician assistants/podiatrists shall be knowledgeable and capable of managing:
   a. Wound colonization and infection
   b. Appropriate antibiotics usage
   c. Prescription of needed support surfaces
   d. Advisement on off-loading techniques
   e. Enzymatic, mechanical and sharp debridement
   f. Wound biopsy techniques
   g. Pain management
   h. Indications for the use of adjunctive chronic wound care therapy such as, but not limited to: Vacuum Assisted Closure Devices, Collagen Matrix Implants, Platelet Derived Growth Factor, Oxidized Regenerated Cellulose, Living Dressings, Selective Impedance Electrical Stimulation and other adjunctive therapy which may, from time to time, become available.
   i. Referrals - demonstrate proficiency in knowing when and to whom to refer a patient requiring specialized care outside of his/her area of expertise.

C. **CREDENTIALING CRITERIA:**

1. Initial Criteria:

a. Surgeon: The applicant must have completed an ACGME accredited residency program in one of the following: Orthopedic Surgery, General Surgery, Vascular Surgery, Plastic Surgery or possess Board Certification in Podiatric Medicine.
b. Non-Surgeon: The applicant must have completed an ACGME accredited residency program in one of the following areas: Family Practice, Internal Medicine, Infectious Disease, Emergency Medicine, Physical Medicine and Rehabilitation, Interventional Cardiology, Interventional Radiology, a fellowship in a field that includes the care of wounds, or completion of applicable course work within specified time frame.
c. Physician Assistant: The applicant must be licensed by the Physician Assistant Committee of the Medical Board of California and have completed hands-on training that includes the care of wounds or completion of applicable course work within specified time frame.

2. Proctoring Criteria:
   a. Non-Surgeon: The proctoring of five (5) cases of debridement must be done by a physician or surgeon who routinely performs unsupervised debridement at ~~TCMC~~ **Tri-City Healthcare District (TCHD)** or at another Joint Commission-approved facility.
   b. Physician Assistant: The proctoring of five (5) cases of debridement must be done by a physician or surgeon who routinely performs unsupervised debridement at ~~TCMC~~ **TCHD** or at another Joint Commission-approved facility.
   c. Surgeon: Does not require proctoring.
3. Reappointment Criteria:
   a. Twenty (20) documented procedures of chronic wound care per two-year reappointment cycle.
   b. Physician/Physician assistant - specific quality data outcomes for reappointment time frame as defined by the Chronic Wound Care Program.- If a physician's wound healing outcomes, healing rates and debridement rates fall below the 65th percentile success rating, his/her reappointment shall then be based on a thorough review of his or her performance by physician(s) who hold unsupervised wound care privileges and compliance with any and all recommendations arising from that review.

~~**Approvals:**~~
~~**Credentials Committee Approval: 07/12**~~
~~**Medical Executive Committee Approval: 07/12**~~
~~**Board of Directors Approval: 03/07; 03/10; 07/11; 07/12**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 02/07	**SUBJECT:** Credentialing Criteria, Hyperbaric Medicine Oxygen Therapy
REVISION DATE(S): 03/07, 03/11, 01/12, 07/12, 12/13	**POLICY NUMBER:** 8710 – 523A

Department Approval Dates(s):	03/17
Credentials Committee Approval Date(s):	~~11/13~~03/17
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	~~11/13~~03/17
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	12/13

A. **PURPOSE:**

1. The following sites have been designated as outpatient chronic non-healing wound care centers ("WCCs") with adequate resources to allow the performance of the designated privileges:
   a. 161 Thunder Drive, Suite 112, Vista, California
   b. 6260 El Camino Real, Carlsbad, California
2. The following criteria shall be used in credentialing physicians who request privileges for Hyperbaric Medicine Oxygen Therapy in the WCCs.

B. **CREDENTIALING CRITERIA:**

1. Initial Criteria:
   a. M.D., D.O., or DPM
   b. The applicant must have completed an ACGME accredited residency program in one of the following areas: Family Practice, Internal Medicine, Infectious Disease, Emergency Medicine, Physical Medicine and Rehabilitation, Orthopedic Surgery, Interventional Cardiology, Interventional Radiology, General Surgery, Vascular Surgery, Plastic Surgery, or hold a license to practice Podiatric Medicine.
   c. The applicant must have malpractice insurance that includes coverage for hyperbaric medicine.
   d. In addition to the above, the applicant must have one of the following:
      i. Completion of a Residency or Fellowship Training in hyperbaric medicine.
      ii. Completion of a hyperbaric medicine Training course approved by the American College of Hyperbaric Medicine (ACHM) or the Undersea and Hyperbaric Medical Society (UHMS)
      iii. Certified by the American Board of Preventive Medicine or the American Board of Emergency Medicine, in the subspecialty of Undersea and Hyperbaric Medicine.
   e. If more than two years has elapsed since completion of training, documentation of a minimum of sixteen (16) hours of CME related to hyperbaric medicine must be submitted.
2. Proctoring Criteria:
   a. A TCMC physician with unsupervised privileges in hyperbaric medicine, or a physician who holds hyperbaric medicine privileges at another Joint Commission-approved facility will proctor the first five (5) hyperbaric medicine therapy consults for practitioners with newly approved hyperbaric medicine privileges.
3. Reappointment Requirements:
   a. A minimum of sixteen (16) hours of CME related to hyperbaric medicine must be documented per two-year reappointment cycle. Half of this requirement can be met by reading hyperbaric literature, with the rest being fulfilled through attending meetings and

making presentations on hyperbarics.

b. Hyperbaric Medicine Oxygen Therapy: twelve (12) documented cases per two-year reappointment cycle.

c. Physician specific quality outcome data will be evaluated on an on-going basis as defined in Medical Staff Policy #8710-509.

~~**Approvals:**~~
~~**Credentials Committee Approval: 11/13**~~
~~**Medical Executive Committee Approval: 11/13**~~
~~**Board of Directors Approval: 03/07; 03/11; 01/12; 07/12; 12/13**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 06/08	**SUBJECT:** Credentialing Policy, Expedited Credentialing and Privileging Process
REVISION DATE(S): 06/08; 03/14	**POLICY NUMBER: 8710 – 550**

Department Approval Dates(s):	**03/17**
Credentials Committee Approval Date(s):	**~~03/14~~03/17**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**~~03/14~~03/17**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	**03/14**

A. **PURPOSE**:
1. An expedited Board of Directors approval process may be used for initial appointments, reappointments, and granting privileges when the Board of Directors is unable to meet and established criteria is met.
2. The Professional Affairs Committee of the Board shall be responsible for granting membership and privileges when the Chief of Staff or designee, Department Chair/Division Chief, Credentials Committee, and the Medical Executive Committee have recommended the applications for the expedited approval process.

B. **EXPEDITED PROCESS:**
1. Schedule for Initial Applications:
   a. All expedited initial applications will be processed as outlined in Medical Staff Policy, Credentialing Policy, Processing Medical Staff Applications #8710-543.
2. Schedule for Reappointment Applications:
   a. All expedited reappointment applications will be processed as outlined in Medical Staff Policy, Credentialing Policy, Processing Medical Staff Reappointments #8710-548.

C. **POLICY:**
1. The Medical Executive Committee will determine which applications meet the expedited criteria.
   a. An applicant for privileges is ineligible for the expedited process if any of the following has occurred:
      i. The applicant submitted an incomplete application.
      ii. The applicant reports an unacceptable health status.
      iii. The Medical Executive Committee makes a final recommendation that is adverse or has limitations.
      iv. There is a current challenge or previously successful challenge to licensure or registration.
      v. The applicant has received an involuntary termination of medical staff membership at another hospital.
      vi. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.
      vii. The Medical Staff determines there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.
2. Each credentialing application will be considered on a case-by-case basis.

3. The expedited application/reappointment reports will be forwarded the following month as an informational agenda item to the Board of Directors.

~~**Approvals:**~~
~~**Credentials Committee Approval: 03/14**~~
~~**Medical Executive Committee Approval: 03/14**~~
~~**Board of Directors Approval: 06/08; 03/14**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 02/07	**SUBJECT:** Credentialing Policy, Processing Medical Staff Applications
REVISION DATE(S): 01/09; 04/09; 09/09; 06/10; 01/12; 01/13; 03/13	**POLICY NUMBER:** 8710-543

Department Approval Dates(s):	03/17
Credentials Committee Approval Date(s):	~~03/13~~03/17
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	~~03/13~~03/17
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	03/13

A. **PURPOSE:**

1. To provide an objective, evidence-based credentialing process that enables the Medical Staff to make informed recommendations to the governing body ensuring candidates for Medical Staff membership are credentialed according to The Joint Commission, CMS, and Medical Staff Bylaw requirements.
   a. If the Medical Staff determines during the review process that more information is required to complete an applicant's application, the applicant shall be notified immediately to provide additional documentation and the application shall be deemed incomplete until such information is received and the Medical Staff considers the application complete.

B. **POLICY:**

1. Applications shall be processed in accordance with the timeframes set by the Medical Staff Bylaws to the extent possible.
2. Each individual medical staff member or applicant shall have a separate credentials file.
3. Telemedicine applicants shall be fully privileged and credentialed according to ~~TCMC~~ **Tri-City Healthcare District (TCHD)** Medical Staff policies, rules and regulations, and bylaws.
4. The applicant's ability to perform privileges requested shall be evaluated and documented in the applicant's credentials file.
   a. If there is a concern about the applicant's ability to perform privileges requested, an evaluation by an external and internal source may be required to ascertain that the applicant can perform the requested privilege(s).
5. Requests for peer recommendations should address the following competencies:
   a. Medical/Clinical knowledge
   b. Technical and clinical skills
   c. Clinical judgment
   d. Interpersonal skills
   e. Communication skills
   f. Professionalism
   g. Ability to perform the requested privilege (e.g., physical and mental health status)
6. Requests for verification of internship, residency, fellowship, hospital affiliations and employment verification should address the following competencies:
   a. Patient care
   b. Medical/Clinical knowledge
   c. Practice-Based learning and improvement
   d. Interpersonal and communication skills

e. Professionalism
f. Systems-based practice

7. The following Joint Commission/CMS approved primary source verification sources shall be utilized:

Item Requiring Primary Source Verification	The Joint Commission/CMS Approved Verification Source
i. Medical education	AMA or AOA Physician Masterfile, ECFMG certificate for foreign medical schools, or directly from source.
ii. Postgraduate Training (Internship, residencies, fellowships)	AMA or AOA Physician Masterfile, or directly from source.
iii. Board Certification	ABMS or services designed by ABMS as an official display agent.
iv. Current Licensure	Directly from state licensing board. LVS system or the Osteopathic Medical Board of California for any 805 reports.
v. Sanctions against licensure	Directly from the state Medical Boards and/or National Practitioner Data Bank (NPDB).
vi. Peer Recommendation/Current Competence	Peer Reference forms that include the six areas of "General Competencies." Directly from the peer reference provided by the applicant.
vii. Medicare/Medicaid Sanctions	NPDB, AMA/OIG, and SAM (System for Award Management)
viii DEA Certificate	National Technical Information Service (NTIS) website query or the Drug Enforcement Agency verification website

8. The following additional queries shall be performed:
   a. Criminal background check via contracted agency
   b. NPDB (Claims history, OIG)
   c. Hospital Affiliations/Medical Staff Membership (past and present)
      i. Telemedicine applicants – If more than 10 affiliations/medical staff memberships, randomly select ten (10) entities to query. If necessary, more entities may be queried.
   d. Work History (within the past five (5) years)
9. The applicant shall explain all time gaps greater than thirty (30) days in writing.
   a. If clinical privileges are being requested and a time gap away from medicine is identified, the Credentialing Specialist shall collect as much information as possible to assist the Medical Staff in making a determination of competence.
   b. If the applicant identifies an entity that can be queried to verify the gap, the Credentialing Specialist shall attempt to contact that source.
   c. If a gap of a year or longer away from the applicant's practice is identified, the applicant must provide documentation of medical practice activity and/or CME within two (2) years of the application date to determine the applicant's competency.
10. The applicant shall explain in writing any convictions or guilty pleas to a criminal offense (felony or misdemeanor other than minor traffic violations).
    a. The applicant shall be referred to the Physician Well-Being Committee for evaluation in cases when the applicant's conduct or substance use is in question. His/her application will not be considered complete until an initial evaluation is completed and reported to the Credentialing Specialist.
11. The applicant's identity shall be verified using the "Positive ID" form in accordance with The Joint Commission Standard MS.06.01.03 (EP 5). Appropriate identification includes a valid state-issued identification card, driver's license, or a valid military ID. (This element shall be completed onsite by an authorized individual prior to final approval. Verification of the identity of telemedicine practitioners who will not be entering the facility may be performed by a Joint Commission accredited organization, with verification provided by the organization.)

~~**Approvals:**~~
~~**Credentials Committee Approval: 03/13**~~
~~**Medical Executive Committee Approval: 03/13**~~
~~**Board of Directors Approval: 01/09; 04/09; 09/09; 06/10; 01/12; 01/13; 03/13**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 02/01	**SUBJECT:** Credentialing Standards for Catheter-Based Peripheral Vascular* Interventional Procedures
REVISION DATE(S): 09/07; 10/09	**POLICY NUMBER:** 8710-504
Department Approval Dates(s):	03/17
Medical Staff Division Approval Date(s):	~~10/09~~03/17
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	~~10/09~~03/17
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	10/09

A. **PURPOSE:**

1. The following criteria shall be used in credentialing physicians who request privileges in catheter-based peripheral vascular interventional procedures.
   a. Catheter-based peripheral vascular interventional procedures include diagnostic angiography, balloon angioplasty, atherectomy, stent placement, and/or thrombolysis of the non-coronary native vasculature or grafts, either arterial or venous. (Refer to Appendix 1)
   b. Criteria for privileging and maintenance of privileges encompass four general areas:
      i. Didactic education in the diagnosis and treatment of patients with peripheral vascular disease;
      ii. Training in the technical aspects of the performance of peripheral vascular interventional procedures;
      iii. Proctoring;
      iv. Compliance with reappointment criteria.

B. **CREDENTIALING CRITERIA:**

1. Body of Knowledge:
   a. The applicant must have completed an accredited residency program and possess board certification or board eligibility in general internal medicine, diagnostic radiology or general surgery.

   *Non-Cardiac

   b. The applicant must have additional fellowship training, board/CAQ eligibility or certification in interventional radiology, neuroradiology, peripheral vascular surgery or interventional cardiology. Individuals who completed their training prior to the establishment of fellowship programs in the above mentioned disciplines but who are engaged in the active practice of peripheral vascular interventions may be granted privileges established on the basis of guidelines described below with acceptable documentation of success and complication rates as defined in Appendix II and Appendix III.
   c. The applicant must be trained and licensed in fluoroscopy.
2. Basic Training
   a. Applicants for this privilege should have extensive training in the diagnosis and treatment of patients with peripheral vascular diseases to include anatomy, natural history, clinical manifestations, non-invasive assessment, indications and contraindications to catheter-based intervention, risks and benefits of catheter-based

intervention, alternative therapies and recognition and management of complications including catheter directed thrombolysis.

i. For individuals who have completed fellowship training in interventional radiology neuroradiology, or peripheral vascular surgery, ACGME accreditation of their fellowship and documentation of satisfactory completion of the fellowship will provide adequate documentation of this training.

ii. For individuals completing fellowship training in interventional cardiology, there must be both ACGME accreditation of the fellowship training, documentation of satisfactory completion of the fellowship and evidence that the fellowship includes formal didactic education in all aspects of peripheral vascular disease.

iii. For individuals who are practicing peripheral vascular surgery, interventional radiology or interventional cardiology but completed their training prior to the establishment of fellowship training program or inclusion of material on peripheral vascular in those fellowship training programs, documentation of 100 hours of CME approved credit directly pertaining to peripheral vascular disease or the equivalent of 20 days of such course instruction must be provided.

3. Specific Procedural Training and Experience:
   a. Applicants must be knowledgeable regarding appropriate use and options of x-ray imaging techniques for peripheral vascular applications.
   b. Individuals applying for this privilege must be able to document the performance and interpretation of the following:
      i. 100 Diagnostic peripheral arteriograms
      ii. 50 Peripheral arterial angioplasties
      iii. 10 Cases of peripheral stent placement
      iv. 10 Cases of catheter-directed peripheral thrombolysis
   c. The individual must be able to document that he/she was the primary operator (defined as the physician who physically performed the procedure and dictated the operative report) in the above listed procedures. For an individual trained in an approved fellowship, a standard procedural log indicating procedure, the individual's role in the procedure, outcome and complications, will be adequate documentation. For individuals whose training occurred outside of a fellowship setting, the above procedural log must be provided as well as copies of the dictated procedural reports.
4. Proctoring Criteria:
   a. Ten cases performed during the first six months after granting of the privilege(s) will be proctored. These cases should include two cases of peripheral arterial stent placement and two cases of catheter-directed peripheral thrombolysis. The proctor must be privileged for the specific procedure that he/she is proctoring.
5. Reappointment Criteria:
   a. Maintenance of peripheral vascular credentialing requires ongoing experience in performing these procedures with acceptable success and complication rates. In order to qualify for reappointment, the minimum number of cases to be performed in a two-year period for each procedure is:
      1) Peripheral transluminal angioplasty 25 cases
      2) Intravascular stent placement 10 cases
      3) Catheter-Directed Peripheral thrombolysis 10 cases
   b. Reappointment of privileges is also dependent on the active participation in the hospital's Quality Improvement program. The QI program will monitor indications, success rates and complications. The acceptable complication rates are outlined in Appendix II and Appendix III. Each physician QI data will be reviewed using the same criteria. If a physician's indications, success, and complication rates deviate from Appendix II or Appendix III, then these privileges may be revoked or not reappointed. It is recommended that any practitioner with this privilege maintain a database to record accurate information regarding numbers of procedures, indications and outcomes for quality assessment purposes.

C. **REFERENCES:**

1. White R.A. Training and Credentialing Requirements for Endovascular Procedures. Stanford Vascular Symposium: Frontiers in Vascular Disease 1999. (Abstract)
2. Levin DC, Becker GJ, Dorros G, et al. Training Standards for Physicians Performing Peripheral Angioplasty and other Percutaneous Peripheral Vascular Interventions – American Heart Association Medical/Scientific Statement Position Statement. Circulation. 1992;86(4):1348-1350.

~~**Approvals:**~~
~~**Medical Division Approval: 10/09**~~
~~**Medical Executive Committee Approval: 10/09**~~
~~**Board of Directors Approval: 09/07, 10/09**~~

[1] The criteria above are minimum criteria. Departments or Divisions performing these procedures may elect to require more stringent criteria.

APPENDIX I

For the purposes of these standards, a diagnostic angiogram is defined as the percutaneous passage of a catheter into an artery under fluoroscopic guidance with subsequent injection of contrast material and imaging of the entire vascular distribution in question using conventional serial film changers or large field digital imaging systems. For example, peripheral angiography of lower-extremity vessels must image the vessels of both lower extremities from the distal aorta to at least the ankles. Conventional cineradiography or video fluoroscopy alone is not sufficient for the routine recording of peripheral angiographic studies. Measurements of intra-arterial pressure gradients are a useful adjunct and may be necessary to fully assess the significance of vascular occlusive disease as well as the outcome of an interventional procedure.

Angioplasty is defined here as a percutaneous transluminal balloon dilation procedure or similar procedure using an atherectomy, stent or other interventional device. Such a procedure would generally involve percutaneous vascular access, transluminal passage of a balloon catheter or other interventional device and treatment at the appropriate sites. The angioplasty process includes angiographic and hemodynamic documentation of the result and appropriate clinical follow-up during the patient's hospitalization.

APPENDIX II

The following complications are the indicators of the safety of catheter-based diagnostic peripheral vascular procedures. If these threshold levels are exceeded, a QI review may be possible.

Puncture site complications:	
Hematoma (requiring transfusion, surgery or delayed discharge)	<3.0%
Occlusions	<0.5%
Psuedoaneurysm	<0.5%
Asteriovenous fistula	<0.1%
Contrast extravasation	<1.0%
Non-puncture site complications	
Distal emboli	<0.5%
Unintended dissection/occlusion of selected vessels	<2.0%
Neurologic complications (during carotid or cerebral angiography)	
All neurologic deficits	<4.0%
Permanent neurologic deficits	<1.0%
Contrast Reactions	
All idiosyncratic reactions	<3.0%
Major reactions (respiratory symptoms)	<0.5%
Contrast-related death	<0.01%
Non-idiosyncratic reactions (hypertension, nausea, vomiting, bradycardia)	<10.0%
Contrast-induced renal failure (increase in serum creatmine by 50% or by 1 mg/dl within 48 hours of the procedure resulting in an abnormal serum creatimine level)	
Transient	<10.0%
Permanent	<2.0%

REFERENCES:

1. Hessel SH, Adams DF, Abrams HL. Complications of angiography, Radiology 1981;138:273-281.
2. Abrams HL. The opague media: Psychologic effects and systematic reactions. In Abrams's Angiography: Vascular and interventional Radiology 3rd ed, Boston, Little & Brown 1983,15-39.
3. Sigstedt B, Lunderquist A. Complications of angiographic examinations. AJR 1978;130;455-460.
4. Shehadi WH, Tamolo G. Adverse reactions to contrast media. Radiology 1980;137:299-302.
5. Shehadi WH. Contrast media adverse reactions: occurrence, recurrence and distribution patterns. Radiology 1982;143:11-17.
6. Byrd L, Sherman RL. Radiocontrast-induced acute renal failure: a clinical and pathophysiologic review. Medicine 1979;58:270-279.
7. Earnest F. Forges G, Sandek BA, et al. Complications of cerebral angiography: Prospective assessment of risk. AJNR 1983;4:247-253.
8. Gomes AS, Baker JD, Martin-Paredero VWM, et al. Acute renal dysfunction after major anteriography AJR 1985;45:1249-1256.

APPENDIX III

The following complications are the indicators of the safety of percutaneous transluminal angioplasty procedures. If these threshold levels are exceeded, a QI review may be possible.

	Threshold
Emergency surgery	<3.0%
Severe bleeding or hematoma (requiring transfusion, surgery, or delayed discharge)	<4.0%
Puncture site occlusion	<0.5%
Angioplasty site occlusion	<3.0%
Distal Embolization causing tissue damage	<0.5%
Vessel perforation requiring surgery	<0.5%
Vessels perforation, no surgery required (Laser angioplasty)	<15.0%

For contrast reactions and contrast-induced nephropathy, refer to Appendix II

REFERENCES:

1. Johnson KW, Rae M, Hogg-Johnston S.A, et al. 5 year result of a prospective study of percutaneous study of percutaneous transluminal angioplasty. *Ann Surg* 1987; 206:403-413.
2. Spence RR< Freiman DB, Gatenby R. Long-term results of transluminal angioplasty of the iliac and femoral arteries. *Arch of Surg* 1980; 116:1377-1386.
3. Sos TA, Peckering TG, Sneiderman K, et al. Percutaneous transluminal angioplasty in renovascular hypertension due to atheroma and fibromuscular dysplasia. *NEJM* 1983; 309:274-279.
4. Rooke TW, Stanson AW, Johnson CM, Sheedy PF, Miller WE, Hollier LH, Osmundson PJ. Percutaneous transluminal angioplasty in the lower extremities: a 5-year experience. *Mayo Clinic Proc* 1987; 5:85-915.
5. Welbull H, Bergovist D, Jonsson K, Karlsson S, Takolander Complications after percutanious transluminal angioplasty in the iliac, femoral, and popliteal arteries. *J of Vasc Surg* 1987; 5:681-686.
6. Schwarter DE, Yune HY, Klatte EC, Grim CE, Weinberger MH. Clinical experience with percutanious transluminal angioplasty of stenotic renal arteries. *Radiology* 1980; 135:601-604.
7. Cumberland DC, Sanborn TA, Taylor DI, et al. Percutaneous laser thermal angioplasty: initial clinical results with a laser probe in total peripheral occlusions. *Lancet* 1986; 1:1457-1459.
8. McCowan TC, Ferris EJ Barnes RW, Baker ML. Laser thermal angioplasty for the treatment of obstruction of the distal superficial femoral or popliteal arteries. *AJR* 1988; 150:1169-1173.
9. Sanborn TA, Cumberland DC, Greenfield AJ, Welsh CI, Guben JK. Percutanious laser angioplasty: initial results and 1 year follow up in 129 femoropopliteal lesions. *Radiology* 1988; 168:121-125.
10. Gardiner GA, Meyerovitz MF, Stokes KR, Clouse ME, Harrington DP, Bettman MA. Complications of transluminal angioplasty. *Radiology* 1986; 158:201-208.
11. Bergquist D, Jonsson K, Weibull H. Complications after percutaneous transluminal angioplasty of peripheral and renal arteries. *Acta Radiological* 1987; 28:3-12.
12. Schwarter DE, Cutcliff WB. Arterial occlusive disease below the knee: treatment with percutanious transluminal angioplasty performed with low profile catheters and steerable guide wires. *Radiology* 1988; 169:71-74.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 02/05	**SUBJECT:** Documentation Requirements for Emergency Department Residents
REVISION DATE(S): 03/07	**POLICY NUMBER:** 8710 – 532

Department Approval Dates(s):	03/17
Emergency Medicine Approval Date(s):	03/17
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	~~03/07~~03/17
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	03/07

A. **PURPOSE:**

1. To establish documentation requirements for Emergency Department Residents.

B. **POLICY:**

1. The Emergency Medicine residents evaluating patients in Tri-City Healthcare District's Emergency Department and responding to codes in the Medical Center are to do so under the supervision of the Emergency Medicine staff.
2. The resident will document the patient encounter in the same manner that ~~the~~ **a** staff emergency physician would document the patient encounter when seeing a patient without the resident. A dictation, or ~~PowerNote~~**electronic note**, meeting ~~department guidelines~~**Emergency Medicine standards** ~~or completed in some other appropriate manner,~~ is to be completed by the resident for each patient evaluated.
3. All patients evaluated in the Emergency Department by a resident will also be personally evaluated by a staff physician. The staff physician in turn will document his/her shared encounter with the patient and ~~may utilize a similar guideline as the resident or~~ **will**~~elect to dictate~~ **create** a summary dictation, or **create an electronic summary note, that meets Emergency Medicine standards.** ~~document the encounter in some other appropriate manner.~~
4. The staff physician is responsible for authenticating all resident dictations and orders.
5. The Medical Records Department will review all Emergency Department records for the documentation requirements outlined above to ensure timely completion of all records.

C. **ATTACHMENT(S):**

1. Dictation Format (example)
2. Attending Summary Dictation (example)

~~**Approvals:**~~
~~**Graduate Medical Education:**~~
~~**Department of Emergency Medicine Approval:**~~
~~**Medical Executive Committee Approval:** 3/07~~
~~**Board of Directors Approval:** 3/07~~

~~DICTATION~~ DOCUMENTATION FORMAT

DEMOGRAPHICS:
~~Physician~~ **Resident** name, **Attending Physician name,** patient name ~~(Spell),~~ Medical Record Number, and admit date. ~~Statement "I am a resident physician seeing this patient along with Dr ?"~~

MODE OF ARRIVAL:
Triage or Ambulance, police, helicopter, etc.

~~**TIME OF REGISTRATION:**~~

CHIEF COMPLAINT:

PRE-HOSPITAL CARE:
Summarize EMS run information if any

HISTORY OF PRESENT ILLNESS:
Detailed history of present illness with duration and course of illness including pertinent negatives.

PAST MEDICAL HISTORY:

Pertinent diseases important to HPI. Also other important diseases like diabetes, TB, hypertension.

FAMILY HISTORY:
Relevant to present illness. Also, include heart, lung, and kidney disease, etc.

SOCIAL HISTORY:
Pertinent work status, marital status, smoking history, use or abuse of alcohol or drugs, foreign travel, etc.

MEDICATIONS:
~~If possible, list strength and doses.~~

ALLERGIES:
Type of reactions, if possible.

REVIEW OF SYSTEMS:

VITAL SIGNS:

DICTATION FORMAT (cont)

PHYSICAL EXAM:
- General Appearance
- Pertinent aspects of the exam including pertinent negatives

RESULTS:
- Lab and X-ray results and their significance
- EKG results, ABG results, ultrasound results, etc.

ED COURSE:
- Summary of evaluation and treatment done in the Emergency Department, Including conversations with consultants or other facilities

~~(DISCUSSION OR ASSESSMENT:)~~MEDICAL DECISION MAKING:
- ~~Sometimes optional depends on the uncertainty of the case~~
- ~~Reasons for this patient's diagnosis or~~ differential diagnosis
- Medical necessity for each exam ordered
- Reasons for this patient's particular treatment and disposition

CLINICAL IMPRESSION:
- List the primary or most acute diagnosis first

PLAN:
- Admission
- Treatment as an outpatient
- Referral

CONDITION ON DISCHARGE OR TRANSFER

- ~~**COPY TO DR. _____ (_____)**~~
- ~~**Sign Off: This is Dr. _____ ending dictation on Name of Patient. Thank you!**~~

ATTENDING SUMMARY DICTATION (WHEN RESIDENT DICTATES)

~~I. Patient Demographics~~**Summary is generally included at the end of the Resident's documentation and ~~should~~may include:**

I.

~~II. This patient was seen in conjunction with:~~
~~Name of Resident~~

~~III.~~**A.** Pertinent History
~~A. HPI~~
~~B. Pertinent ROS, PH, FH, SH~~

~~IV.~~**B.** Pertinent Physical Exam
~~A. Summary Positive findings~~**Pertinent**
~~B. Pertinent negatives~~

~~V.~~**C.** ~~Lab~~**lab**/X-ray **findings**
~~A. Important Positive or negative findings~~
~~B. Interpretation of ABG's oximetry, peak flows, EKG~~

~~VI. ED course~~
~~A. Clinical~~
~~B. Procedures:~~
~~"Procedure was performed by _____ under my supervision~~
~~Name of Resident~~

~~VII. Clinical Impression~~

~~VIII.~~ Assessment

D.

~~IX.~~**E.** Plan

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 10/04	**SUBJECT:** Election Process of Member(s) at Large for the Medical Executive Committee
REVISION DATE(S): 04/08; 08/12	**POLICY NUMBER:** 8710 – 531

Department Approval Dates(s):	03/17
Medical Staff Committee Approval Date(s):	n/a
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	~~08/12~~03/17
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	08/12

A. **PURPOSE:**

1. To provide direction for the nomination and election process for the Member(s) at Large position on the Medical Executive Committee.

B. **PROCEDURE~~SS~~:**

1. All Active Medical Staff members of may submit their names to the Medical Staff Office two months prior to the June General Staff Meeting.
2. Interested Active Medical Staff members are required to complete a Conflict of Interest form before being added to the ballot.
3. Candidates will be provided the opportunity to speak at the General Staff Meeting.
4. Voting will be by ballot.
5. A quorum of voting members is required to elect Members-at-Large.
6. Each voting member will be allotted two votes. A member may vote twice for any one candidate or vote once for any two candidates or withhold one or both votes.
7. For a Member-at-Large to be elected, the candidate must be the candidate receiving the most votes. If there are two vacancies being elected, then the candidates receiving the highest and second highest number of votes cast will win.
   a. If one or both of the available Member-at-Large Medical Executive seats are not filled, the seat(s) will remain vacant.
8. Vacant seat(s) after original appointment on the Medical Executive Committee shall remain vacant until the next June General Medical Staff Meeting.
9. Members-at-Large will serve a one year term and no member shall serve more than two successive terms.

~~**Approvals:**~~
~~**Medical Executive Committee Approval:** 08/12~~
~~**Board of Directors Approval:** 04/08; 08/12~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 05/02	**SUBJECT:** Emergency Room Call: Duties of the On-Call Physician
REVISION DATE(S): 07/10; 11/10; 05/14	**POLICY NUMBER: 8710 – 520**
Department Approval Dates(s):	03/17
Medical Staff Committee Approval Date(s):	n/a
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	~~05/14~~03/17
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	05/14

A. **PURPOSE:**

1. To define timely attention to patients in the Emergency Department (ED), including the timely response and duties of the on-call physician.

B. **DEFINITION(S):**

1. Emergency Department:

a. The Emergency Department is a specially equipped and staffed department, designed to provide monitoring, close observation, skilled emergency medical/nursing care, and/or respiratory therapy to the acutely injured or critically ill surgical, medical, or cardiac patient.

2. On-call Physician:

~~b.~~**a.** The on-call physician is the individual physician available for his/her specialty who responds to the Emergency Department when his/her specialty is needed. The on-call physician is a resource to the hospital to assist in the screening evaluation and stabilization of a patient with emergency medical conditions. The on-call physician's duties mirror the hospital's three main duties under the law: medical screening, stabilization, and acceptance of appropriate transfers.

3. Emergency Medical Condition (EMC):

~~c.~~**a.** A medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to severe pain, psychiatric disturbances, and/or symptoms of substance abuse), such that the absence of immediate medical attention could reasonably be expected to result in:

i. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or the unborn child) in serious jeopardy;
ii. Serious impairment to any bodily function;
iii. Serious dysfunction of any bodily organ or part or;
iv. With respect to a pregnant woman who is having contractions, inadequate time to affect a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child.

4. Medical Screening Examination (MSE):

~~d.~~**a.** The screening, examination, and evaluation by an emergency physician or other practitioner qualified to determine whether the patient is in active labor or has an emergency medical condition. It also includes the care, treatment, and surgery by a physician necessary to stabilize that emergency medical condition, within the capability of this facility (TCMC). A triage nurse exam is not a medical screening exam.

~~e.~~**b.** An MSE is required on all patients who present to the ED/hospital campus with a medical complaint.

~~f.~~**c.** A request for an MSE will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, the individual needs an examination or treatment for a medical condition.

~~g.~~**d.** The MSE is an ongoing process, not an isolated event.

5. Capacity:

~~h.~~**a.** The ability of the hospital to accommodate the individual requesting examination or treatment. In certain circumstances (e.g., redirecting an individual to an alternate location for a MSE pursuant to an emergency preparedness plan or a transfer as necessitated in the instance of a declared emergency), the hospital may be eligible to request a waiver.

~~i.~~**b.** Includes the hospital's past practices of accommodating patients in excess of occupancy limits.

~~2.~~**6.** Stable:

a. Stable for Transfer:

i. With respect to an emergency medical condition, to provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during the transfer of the individual from a facility, or that the woman has delivered the child or placenta. A patient will be deemed stabilized if the treating physician attending the patient in the emergency department/hospital has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.

b. For transfer between facilities:

~~ii.~~**i.** a patient is stable for transfer if the patient is transferred from one facility and the treating physician attending to the patient has determined, within reasonable clinical confidence, that the patient is expected to leave the hospital and be received at the second facility, with no material deterioration in his/her medical condition; and the treating physician reasonably believes the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of that condition.

i. If the patient is determined by the treating physician to require a higher level of care than can be provided at TCMC, the transfer can be accomplished by mutual agreement between the sending and receiving physicians. This may be accomplished even if the patient is "unstable," if the physicians determine that the benefits of the transfer outweigh the risks.

ii. Transfers should only be made in the following circumstances:

1) For care that exceeds the capabilities of the transferring hospital

2) Upon patient request

c. Stable for Discharge:

~~iii.~~**i.** **M**~~m~~eans the treating physician has determined within reasonable clinical confidence that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, may be reasonably performed on an outpatient basis or a later inpatient basis and the patient has been given a plan for appropriate follow-up care with the discharge instructions.

~~iv.~~**ii.** The emergency medical condition that caused the individual to seek care in the Emergency Department must be resolved (although the underlying medical condition may persist).

d. Psychiatric Patients Stable for Transfer:

~~v.~~**i.** A psychiatric patient is considered stable when he/she is protected and prevented from injuring himself/herself or others. For purposes of discharging a patient (other than for the purpose of transfer from one facility to a second facility), for psychiatric conditions, the patient is considered stable when he/she is no longer considered an imminent threat to himself/herself or to others.

~~vi.~~**ii.** Psychiatric patients who are being transferred on a psychiatric hold will be placed in restraints, solely for the duration of the transfer, in order to minimize the risk of elopement.

~~b.~~**e.** Stable for transfer or Stable for Discharge: does not require the final resolution of the emergency medical condition.

7. Inpatient:

~~c.~~**a.** A person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services.

8. Outpatient:

~~d.~~**a.** A person who has come to a hospital outpatient department for the purposes of keeping a previously scheduled appointment. This shall include any patient presenting to the ED with a medical complaint.

C. **GUIDELINES:**

1. The goal is every ED patient will be seen by a physician or physician assistant within 30 minutes after the patient is placed in a bed and assessed by a nurse; this should occur in the majority of cases.
2. The appropriate on-call physician will be called when the Emergency Medicine physician:
   a. Does not have the expertise or capability to treat the EMC; or,
   b. Needs the on-call physician to stabilize the patient in the ED; or,
   c. Needs the on-call physician to admit the patient for further stabilizing treatment; or,
   d. Needs the on-call physician to help stabilize the patient in the ED prior to transfer to a tertiary facility or another acute care facility.
   e. Requires assistance of the on-call physician to determine if an EMC exists.
3. The on-call physician is expected to respond telephonically to the Emergency Department within 30 minutes for STAT calls, and within 60 minutes for routine calls. The on call physician will come to the Emergency Department to see the patient if the Emergency Medicine physician determines it is necessary, and within the timeframe reasonably determined by the Emergency Department physician. In any event, the on-call physician must be able to respond in person to the Emergency Department within 30 minutes of the request to respond in person.
4. If the personal physician is treating his/her patient in the ED, that physician is expected to see the patient in the ED or consult by telephone with the Emergency Medicine physician within 30 minutes of being notified the patient is in the ED, and see the patient in the ED less than 60 minutes after notification the patient is in the ED.
   a. If the on-call physician or a personal physician meets the patient in the ED, that physician's evaluation of the patient constitutes the MSE. The examination, the treatment, and the documentation of the encounter must comply with EMTALA exactly as if the Emergency Medicine physician were caring for the patient. The on-call or personal physician shall inform the Emergency Medicine Physician of the MSE.
   b. If a personal physician wishes to see their patient in the ED, but is unable to respond within 60 minutes, or if the Emergency physician or Emergency Room nurse feels the patient is potentially unstable, the MSE will be performed by the Emergency Medicine physician.
5. A patient will not be sent to the on-call (or personal) physician's office for an examination or treatment, unless deemed stable and appropriate by the Emergency Medicine physician. Notwithstanding the above, if specialized equipment exists in the practitioner's office, which would be necessary for care, the on-call physician may confer with the Emergency Medicine physician to determine if further treatment in the office would be safe for the patient and beneficial for care.
6. With regard to ED patients and inpatients, the physician on the ED call panel at the time consultant/specialist/surgical services are needed is the physician responsible for ensuring the related needs of the patient are met during that service encounter/admission.
   a. If a patient presents to the ED with an Emergency Medical Condition and the on-call specialist is unavailable, the Emergency Medicine Physician will proceed as defined in section C.12 below.

7. Duties Of The On-Call Physician:
   a. Respond to the ED to medically screen and/or stabilize emergency patients.
   b. Respond to inpatient unit of the hospital to stabilize patients as requested. The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. See required timeframes under "duties of the on-call physician to inpatients" below.
   c. Accept transferred patients, from other hospitals, with an emergency medical condition on behalf of the hospital .If the hospital can provide the requested care for an emergency medical condition, and the transferring facility cannot provide this care, the hospital/on-call physician is obliged to accept the transfer.
   d. Report suspected EMTALA violations by other hospitals to the hospital's legal counsel and provide the necessary documentation.
8. Duties of the On-Call Physician to Inpatients
   a. Any member of the Medical Staff may request the services of the on-call physician to help stabilize and manage an inpatient in accordance with acceptable standards. All such requests shall indicate it is an urgent/emergent request (requiring a 30 minute telephone response) or non-emergent/urgent (requiring a 2-hour telephone response). The in-person consultation must be completed by the on-call physician or designated alternate within a clinically appropriate time frame and not to exceed 48 hours of request. Insurance Status:
   b. The hospital's normal registration process may be followed so long as a screening or stabilizing treatment is not delayed. The process may include discussion of insurance or payment obligations.
   c. The hospital will not require authorization from an individual's insurance company before providing a screening or initiating any necessary stabilizing treatment.
9. Mechanisms for maintaining the call roster:
   a. The rules and regulations of each applicable Department/Division will address credentials and qualifications regarding on-call services.
   b. The Emergency Department Roster for each specialty will:
      i. Be submitted to the Medical Staff Office at least two weeks in advance of the first day of the month.
      ii. Include the full month of coverage
      iii. List a specific physician's name for each day on call
         1. Every physician listed must be a member of the Medical Staff at TCMC and a member of the Department/Division responsible for the specialty's emergency coverage.
   c. Each on-call physician is solely responsible for arranging trades or temporary coverage of on-call duties. The on-call physician must notify the ED and the Medical Staff Office of any changes in advance.
   d. The Medical Staff Office will provide the ED on-call schedule to each physician who is taking call during the month.
   e. The Medical Staff Office will provide the ED on-call schedule to the ED and the TCMC Operators prior to the schedule starting.
10. Dispute Resolution:
   a. If an on-call physician disagrees with the Emergency Medicine physician about the need to come to the ED, he/she must still come to the ED to examine and treat the patient.
   b. The appropriateness of the Emergency Medicine physician's request for assistance can be reviewed through the regular Medical Staff processes after the patient has been treated (see Sections C.13 and 14).
11. Lack of Timely Response or refusal of the on-call to respond or unexpected lapses in on-call coverage:
   a. If the Emergency Medicine physician or any member of the Medical Staff pursuant to item #8 above determines the patient requires the services of a physician listed by the hospital on its roster of on-call physicians, and if after being notified, the on-call physician fails or refuses to respond as described above, the Division Chief or

Department Chair for the requested specialty shall be contacted to enforce the on-call obligation, or designate an alternative. A Quality Review Report (QRR) shall be completed regarding the failure/lack of timely response by the on-call physician, and submitted to Risk, Legal and Regulatory Services and the Medical Staff Office for follow-up.

b. If the failure/lack of timely response results in the Emergency Medicine physician ordering the transfer of the individual because without the services of the on-call physician the benefits of the transfer outweigh the risks of transfer; the Emergency Medicine physician responsible for transfer shall provide the name and address of the on-call physician to the receiving medical facility at the time of transfer. A QRR shall be completed for this event as well and submitted to Risk, Legal and Regulatory Services and the Medical Staff Office for follow-up.

c. In the event the on-call physician is unavailable as he/she is otherwise detained providing medical care, the on-call physician or his/her designee should inform the Emergency Medicine physician of the status of his/her availability. The Division Chief or Department Chair (for the requested specialty) shall be contacted to designate an alternative specialist to respond. If an alternative specialist is not available, the hospital's transfer policy will be invoked.

12. Disciplinary proceedings for failure to comply:
    a. Any QRR received due to failure to comply, will be referred to the respective Department Chair/Division Chief or designee for review and consideration. Investigation and subsequent actions may be instituted as described in the Medical Staff Bylaws, Article VI. At a minimum, a letter of inquiry should be sent to the non-compliant on-call physician requesting an explanation of his/her failure/lack of timely response to the request of the Emergency Medicine physician.
13. Quality Assurance Monitoring:
    a. Physician delay(s) as defined in this policy will be reviewed.
    b. Patient transfer(s) due to lack of response of on-call physician(s) or refusal to respond to Emergency Medicine physician when notified
14. CME:
    a. Provide a copy of current policy to each physician executing an agreement to provide on-call services.

D. **REFERENCES:**

1. 42 Code of Federal Regulations 489.24,Special Responsibilities of Medicare Hospitals in emergency cases. Medicare State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospital in Emergency Cases, Rev. 60, 07-16-10.
2. California Hospital Association, EMTALA – A Guide to Patient Anti-Dumping Laws, 2012.
3. EMTALA Field Guide, Third Edition, Stephen A. Frew, JD and Kris Giese, MHA, CHC, MT(ASCP).

~~**Approvals:**~~
~~**Medical Executive Committee Approval: 05/14**~~
~~**Board of Directors Approval: 07/10; 11/10; 05/14**~~

Tri-City Health Care District
Oceanside, California

Medical Staff Policy Manual

ISSUE DATE: 12/19	**SUBJECT:** Liability Insurance Requirements
REVISION DATE(S): 12/09, 03/11	**POLICY NUMBER:** 8710 – 558
Department Approval Date:	03/17
Credentials Committee Approval Date:	~~03/11~~03/17
Pharmacy and Therapeutics Approval Date:	n/a
Medical Executive Committee Approval Date:	~~03/11~~03/17
Professional Affairs Committee Approval Date:	
Board of Directors Approval Date:	03/11

A. **PURPOSE:**

1. To require professional liability insurance or approved form of financial security.

B. **POLICY:**

1. Consistent with Article VIII of the Tri-City Healthcare District Bylaws and Sections 2.2-1(c) and 4.5-1(g) of the Tri-City Medical Center Medical Staff Bylaws, every Practitioner on the medical staff or with privileges to attend patients at Tri-City Medical Center must, as a condition of holding staff membership or privileges, either carry professional liability insurance with an insurance company admitted to transact business in California in limits of not less than one million dollars ($1,000,000.00) per occurrence or claim/three million dollars ($3,000,000.00) annual aggregate, or furnish an approved form of equivalent financial security as described below in subsection 3.
   a. The Medical Executive Committee may, without the need to obtain the approval of the staff, modify the foregoing limits from time to time as may be appropriate to meet the needs of the Hospital and the Medical Staff and to reflect developments in the insurance industry, with the approval of the Board of Directors.
2. Each insured Practitioner must cause a current certificate of insurance or other acceptable evidence of liability coverage to be furnished to the Hospital. The certificate or other evidence of liability coverage must specify the expiration date of the policy, the amount of insurance, and reflect coverage for the privileges sought/granted.
   a. If the insurance policy or other coverage is restricted in any manner, the Practitioner must furnish a copy of such restrictions to the Hospital.
   b. The Practitioner shall not perform at the Hospital any procedure excluded from the insurance policy or other coverage. The Practitioner shall immediately notify the Hospital if the Practitioner's insurance or equivalent coverage expires, is reduced below the limits then in effect at the Hospital, or is canceled or terminated.
3. For purposes of this policy, an "approved form of equivalent financial security" means either:
   a. Insurance coverage that is written by or issued in connection with the Practitioner's membership in a cooperative, as defined in Section 1280.7 of the California Insurance Code; or successor legislation with minimum coverage conforming to the then applicable requirements; or
   b. Insurance coverage from an irrevocable trust established by an incorporated professional group to insure its members against damages and defense costs arising out of malpractice claims or litigation, and which has been actuarially determined to meet minimum coverage requirements then applicable.
   c. Self insurance coverage established by an incorporated professional group or other entity to insure the Practitioner against damages and defense costs arising out of

malpractice claims or litigation and which has been actuarially determined to meet minimum coverage requirements then applicable.

4. The "approved" forms of equivalent security shall be subject to review and approval by the Medical Executive Committee and Board of Directors.

~~**Approvals:**~~
~~**Credentials Committee Approval: 03/11**~~
~~**Medical Executive Committee Approval: 11/09; 03/11**~~
~~**Board of Directors Approval: 12/09; 03/11**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 05/12	**SUBJECT:** Management of Conflict between Medical Staff and the Medical Executive Committee (MEC)
REVISION DATE(S):	**POLICY NUMBER:** 8710 – 567
Department Approval Date:	03/17
Credentials Committee Approval Date:	03/17
Pharmacy and Therapeutics Approval Date:	n/a
Medical Executive Committee Approval Date:	~~05/12~~03/17
Professional Affairs Committee Approval Date:	
Board of Directors Approval Date:	05/12

A. **PURPOSE:**

1. To define the process for resolution of conflicts that may arise between the organized Medical Staff and the Medical Executive Committee.
2. Nothing in this policy is intended to prevent Medical Staff members from communicating with the Board of Directors on a rule, regulation, or policy adopted by the organized Medical Staff or the Medical Executive Committee. The Board of Directors shall determine the method of communication, and shall provide timely notification to the Medical Executive Committee, through the Chief of Staff, of any such communications.

B. **POLICY:**

1. In the event that a member of the Medical Staff has an issue or concern regarding a proposed Medical Staff Bylaws addition/amendment, the provisions of Article XIV of the Medical Staff Bylaws shall apply.
2. In the event that a member of the Medical Staff has an issue or concern regarding a proposed Medical Staff Rules and Regulations addition/amendment, the provisions of Section 13.1 of the Medical Staff Bylaws shall apply.
3. In the event that a member of the Medical Staff has an issue or concern regarding a proposed or adopted Medical Staff Policy or other issues not encompassed within items 1 and 2 above, the following process shall apply:
   a. The Medical Staff member shall provide a written description of the specific issue/concern to the Chief of Staff. The Chief of Staff may request further information, and may attempt to resolve the issue/concern through informal discussion.
   b. If the Chief of Staff' is unable to resolve the issue/concern pursuant to informal discussion described above, the specific issue/concern will be placed on the Medical Executive Committee agenda for discussion at the next scheduled meeting.
   c. The Chief of Staff will discuss the outcome of the MEC meeting discussion with the referring Medical Staff member.
   d. If the referring Medical Staff member feels the issue/concern is not resolved, the member may have the issue/concern addressed at a meeting of the MEC at which up to three (3) representatives may attend, upon submission of a petition signed by at least ten percent (10%) of the Medical Staff members eligible to vote.
   e. If after such MEC meeting the issue/concern still has not been resolved to the members' satisfaction, the matter shall be referred to the Joint Conference Committee.

C. **REFERENCES:**

1. The Joint Commission, Hospital Accreditation Standards, MS.01.01.01. EP 10

~~**Approvals:**~~
~~**Credentials Committee: 05/12**~~
~~**Medical Executive Committee Approval: 05/12**~~
~~**Board of Directors Approval: 05/12**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE:	**7/01**	**SUBJECT:**	**Medical Record Documentation Requirements**
REVISION DATE:	**7/07, 3/08, 9/08, 6/09, 9/09 11/09; 7/11; 05/12; 08/12, 2/15, 12/15**	**POLICY NUMBER:**	**8710-518**

Department Approval Date:	**03/17**
Medical Staff Committee Approval Date:	**n/a**
Pharmacy and Therapeutics Committee Approval Date:	**n/a**
Medical Executive Committee Approval Date:	**~~10/15~~03/17**
Governance Committee Approval Date:	**12/15**
Board of Directors Approval Date:	**12/15**

A. **PURPOSE:**
1. To establish the policy, procedure, and responsibilities for the completion of medical records.

B. **POLICY:**
1. It is the policy of Tri-City **Healthcare District**~~Medical Center~~ **(TCHD)** that all medical records are current, authenticated, legible, and complete.
2. The intent does not support delay of care or rendering of services to the patient.

C. **RESPONSIBILITIES:**
1. General responsibilities are delegated as indicated in the following subsections:
   a. Hospital administration, with medical staff approval, will determine the criteria for current, authenticated, legible, and complete medical records.
   b. The Medical Records/Health Information Department will monitor records to aid the physicians and other medical services in the Medical Center in trying to ensure that medical records meet the requirements for completeness as set in this policy.

D. **PROCEDURE:**
1. Electronic signature:
   a. It is expected that all members of the medical staff will authenticate documents maintained in Cerner electronically through use of a physician identifier.
   b. All members of the medical staff will be required to complete an Electronic Signature Certification Statement to document their acknowledgement of the proper use of their identifier in the authentication of documents.
   c. Dictated reports will be transcribed into the Medical Records Chartscript transcription system. Upon completion of transcription the report will be saved and sent electronically to the Cerner system (Clinical Notes folder).
   d. Paper-based documents will be scanned to the Clinical Notes section in Powerchart (Cerner) and will be signed electronically, if not already signed
   e. The Report Status in Cerner will be reflected as "Transcribed"
      i. Transcribed status reflects that the dictating physician has not yet authenticated the document.
   f. Physicians will utilize the Cerner Message Center function to authenticate transcribed documents in a timely manner.
   g. The Message Center feature supports the following actions to be taken by the physician:
      i. Sign/Review

1) Physician reviews the transcribed/scanned document and selects the OK button that updates the status of the report from "Transcribed" to "Auth (Verified)."
2) Only the responsible physician is eligible to sign a transcribed report.
   a) Physician Assistants will sign their reports in addition to the report being signed by the supervising physician.
   b) Resident reports will be signed by the supervising physician.
   c) All mid-level practitioners (e.g., Nurse Practitioners, Midwives) sign their reports in addition to the report being signed by the supervising physician.

ii. Modify/Sign
1) Physician may modify the transcribed document PRIOR to signature to correct/clarify any elements of the report.
2) Modifications are to follow the structure of new information being Bolded and deleted information noted as a Strike-through
3) Once modified and signed any new revisions to the document are noted as an Addendum

iii. Refuse
1) Physician identifies that he/she is not responsible for the report as well as a reason for refusal and redirects the report to Medical Records/Health Information (Med Rec Inbox) for review and reassignment of the deficiency to the correct physician.
2) Electronic signature of the transcribed and scanned reports by the physician will update the Medical Records/Health Information Profile system to eliminate the signature deficiency assigned by the department.

2. Written Signatures:
   a. It is expected that all members of the medical staff will utilize acceptable written signatures, including credentials (e.g., MD, PA, NP, CNM) for all paper documents being authenticated.
      i. This expectation relates to orders submitted for outpatient ancillary services as well as emergency, day surgery, and inpatient documentation.
   b. Acceptable written signatures are as follows:
      i. Legible full signature
      ii. Legible first initial and last name
      iii. Illegible signature over a typed or printed name
      iv. Illegible signature where the letterhead or other information on the page indicates the identity of the signer
         1) Example: an illegible signature appears on a prescription. The letterhead lists multiple physicians' names. One of the names is circled.
      v. Initials over a typed or printed name
      vi. Unsigned handwritten orders where other entries on the same page in the same handwriting are signed
   c. Unacceptable written signatures are as follows:
      i. Signature stamps alone
         1) These are not recognized as valid authentication for Medicare signature purposes and may result in payment denials by Medicare.
      ii. Reports or any records that are dictated and/or transcribed, but do include valid signatures "finalizing and approving" the documents are NOT acceptable for reimbursement. Reports or any records that are dictated and/or transcribed, but do include valid signatures "finalizing and approving" the documents are NOT acceptable for reimbursement.
      iii. Unsigned typed note with provider's typed name
      iv. Unsigned typed note without provider's typed/printed name
      v. Unsigned handwritten note, the only entry on the page
3. The following criteria must be met before a chart is considered complete:

a. A medical record must be legible for each patient; its content shall be pertinent and current. This record shall include:
   i. Identification data
   ii. Legal status if mental health patient;
   iii. Emergency care given prior to arrival if any;
   iv. Findings of assessment;
   v. Conclusions or impressions from history and physical;
   vi. Diagnosis or diagnostic impression;
   vii. Reasons for admission or treatment;
   viii. Goals of treatment and treatment plan;
   ix. Known advance directives;
   x. Informed consent for procedures and treatment;
   xi. Diagnostic and therapeutic procedures and tests and their results;
   xii. Operative and other invasive procedures performed;
   xiii. Progress notes;
   xiv. Reassessments if needed;
   xv. Clinical observations;
   xvi. Response to care;
   xvii. Consultation reports;
   xviii. Every medication ordered; every dose administered and any adverse reaction;
   xix. Every medication dispensed to inpatient at discharge or to ambulatory patient;
   xx. All relevant diagnoses established during care;
   xxi. Any referrals/communications to other providers.

4. All patient medical record entries must be legible, completed, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided.
   a. All handwritten documentation is to be without the use of Do Not Use Abbreviations.
      i. A reference of Do Not Use Abbreviations is available in multiple locations.
         1) Physician Order Forms
         2) Progress Notes
         3) ~~TCMC~~**TCHD** Intranet – Administrative Policy 367

5. A complete history and physical examination shall be recorded by the attending physician within twenty-four (24) hours of admission and/or prior to any surgical or invasive procedure.
   a. When the report is dictated it must be completed within twenty (20) hours of admission to allow for transcription and charting of the document.
   b. Legible, handwritten history and physicals are acceptable provided they meet the documentation requirements.
   c. All history and physical examinations will be validated and authenticated by the attending physician with appropriate privileges.

6. The history and physical shall include the following elements:
   a. Chief complaint;
   b. Personal, past medical and surgical history;
   c. Allergy history;
   d. Current medications;
   e. Family history;
   f. History of present illness;
   g. All important findings resulting from a review of systems;
   h. Physical examination;
   i. Diagnosis or diagnostic impression;
   j. Plan of treatment.

7. A medical history and physical examination must be completed no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

a. An updated examination of the patient, including any changes in the patient's condition must be completed and documented within 24 hours after admission or registration. This is to occur prior to surgery or for a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration.
b. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, oral maxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy.
c. If, upon examination, the licensed practitioner finds no change in the patient's condition since the H&P was completed, he/she may indicate in the patient's medical record the:
    i. H&P was completed
    ii. H&P was reviewed
    iii. The patient was examined and "No Change" has occurred in the patient's condition since the H&P was completed.
d. The Physician Pre-Procedure Documentation form must be recorded on the patient's medical record prior to patient admission to the Operating Room or Procedural areas regardless of the date and time the history and physical was completed.
e. A history and physical document completed outside ~~Tri-City Medical Center~~**TCHD** is required to reflect date and time of the examination.
    i. Dictated documents are to reflect the date and time of both the dictation and transcription.

8. A history and physical dictated over 30 days prior to admission is not valid and must be re-dictated
9. When the required history and physical examination is not recorded on the chart before the time stated for the operation, the operation shall be canceled until the surgeon has documented a history and physical in writing or documented that such a delay would constitute a hazard to the patient.
10. History and Physical for Hospital Outpatient Procedures:
    a. Ambulatory surgery patients undergoing anesthesia shall have a complete H&P as defined above prior to surgery.
    b. Hospital outpatients undergoing invasive procedures with a significant level of risk shall have at least a limited History and Physical.
11. A limited History and Physical shall contain the same elements as an H&P, except the review of systems and physical examination elements may be abbreviated to include only that which is relevant, appropriate or pertinent to the procedure or intervention to be performed.
12. Dentists who are members of the Medical Staff may only admit patients if a physician member of the Medical Staff conducts or directly supervises the admitting history and physical examination (except the portion related to dentistry) and assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside the limited license practitioner's lawful scope of practice.
    a. A history and physical completed by the medical physician in addition to the history and physical completed by the dentist are necessary to be documented on the chart prior to any surgical procedure.
    b. A qualified oral surgeon or podiatrist with specifically delineated clinical privileges may admit patients without significant underlying or potentially complicating medical problems, may perform the history and physical examination of those patients, and may assess the medical risks of proposed surgical procedures for such patients.
        i. Completion of a history and physical examination by an oral surgeon or podiatrist who has the special privileges will NOT require completion of a history and physical by another qualified physician.
13. Medication reconciliation:
    a. Admission
        i. The admitting physician is required to review, complete and reconcile Admission Medication Reconciliation information in Cerner collected upon admission of the patient within 24 hours.

ii. If new information is later obtained, the physician or nurse may update the Medication by History List in Cerner.

b. Transfer:
   i. All medications will be reviewed and revised as appropriate when patient is being transferred to the next level of care.
      1) Electronic Orders
         a) The physician will access the Transfer Medication Reconciliation function and will reconcile each medication on the active medication list to either be continued or not continued for the next level of care.

c. Discharge:
   i. All medications will be reviewed against HOME medications in Cerner.
      1) Electronic Orders
         a) The physician will reconcile each medication on the active medication list and home list to either be continued or not continued upon discharge. New medications will be added as required.
         b) Prescriptions to be completed
            i) ePrescribe – electronic prescription transmitted to the patient's pharmacy
            ii) Printed on the unit and handed to the patient
            iii) Handwritten on personal (physician's) prescription pad
      2) Written Orders
         a) Physician handwrites prescriptions on personal (physician's) prescription pad.
         b) Physician updates physician medication changes on the electronic Medication List through the Medication Reconciliation tool.

14. Daily progress notes must be documented by the attending member on all acute patients in the hospital.
   a. Progress notes for Behavioral Health unit patients, will be written six days per week by the attending member.
   b. All members of the medical staff will document progress notes in any of the following methods:
      i. Written on the progress notes form placed in the patient's active record;
      ii. Electronic note may be a Progress Note typed by the physician or a Progress Note generated using a voice recognition software application (e.g. Dragon)
   c. All Progress Note entries shall be timed, dated, and electronically signed by the physician recording the note. Electronic notes shall be signed electronically.
      i. The electronic Progress Note shall not be printed, signed and placed in the hard copy chart (this is duplicate documentation that may require both documents to be maintained in the legal record (i.e. scan document as well as maintain electronic version).
   d. Progress Notes recorded by Residents and/or Physician Assistants are required to be co-signed by the attending physician member.
   e. Interdisciplinary Notes recorded by the other care providers are available in the Cerner system for review by the physician.
      i. These notes are recorded by non-physicians within the Power Note application in the Cerner system.
   f. Physician evaluation of Occupational Health patients (Work Partners) and Wound Care Center patients may result in an electronic note captured directly into the Cerner system.
      i. Voice Recognition/Dragon application may be utilized by practitioners in these areas to generate a note summarizing the patient's history, assessments, and treatments.
      ii. These notes will be authenticated by the examining physician and will be displayed as part of Clinical Notes.

15. Consent for Photography will be obtained from the patient when a patient will be photographed while receiving treatment at the Medical Center. The term "Photograph" includes video or still

photography, in digital or any other format, and any other means of recording or reproducing images.

16. All surgical operations, invasive and diagnostic procedures (including blood transfusions) shall be performed with documented informed consent except in an emergency. The informed consent for hysterectomies and sterilization procedures must meet specific requirements as set forth in Title XXII.
    a. The informed consent documented will include the following:
        i. Discussion about potential benefits, risks, and side effects of the patient's proposed care, treatment, and services.
        ii. The likelihood of the patient achieving his or her goals
        iii. Any potential problems that might occur during recuperation
17. Physicians shall discuss a patient's Do Not Resuscitate (DNR) status with the patient and/or decision-maker prior to a surgery or procedure that requires anesthesia. The discussion shall include possible temporary suspension of the DNR status during the surgery or procedure. The DNR status shall be reevaluated immediately after the procedure. This discussion shall be documented in the medical record and an appropriate order entered/written.
18. A pre-sedation or pre-anesthesia assessment is performed for each patient before beginning moderate or deep sedation and before anesthesia induction within forty-eight (48) hours prior to surgery.
19. A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia within forty-eight (48) hours after surgery for an inpatient.
20. Operative or other high risk procedure reports shall be dictated immediately after surgery and shall include:
    a. Pre-operative diagnosis
    b. Date of procedure
        i. If the procedure is canceled, the operative report should include the reason and time of the cancellation.
    c. Anesthesia type
    d. A detailed account of the findings;
    e. Technical procedure performed
    f. Estimated blood loss
    g. Specimen removed;
    h. Post-operative diagnosis;
    i. Name of the primary surgeon and any assistants.
    j. Complications
    k. Patient status
21. An Operative Note shall be documented immediately following surgery or other high-risk procedures. Use of the pre-printed Operative Note is necessary to document all required elements.
    a. Procedure performed
    b. Pre-Operative diagnosis
    c. Post-Operative diagnosis
    d. Patient status
    e. Estimated blood loss
    f. Name of primary surgeon and any assistants
    g. Anesthesia type
    h. Specimen collected
    i. Complications
    j. Findings
22. An intraoperative anesthesia record containing the following elements shall be completed by an anesthesiologist:
    a. Name and hospital ID number of the patient
    b. Name of anesthesiologist who administered the anesthesia
    c. Vital signs reflecting patient status just prior to induction
    d. Name, dosage, route, and time of administration of drugs and anesthesia agents

e. Techniques used and patient position(s), including the insertion/use of any intravascular or airway devices
f. Names and amounts of IV fluids, including blood or blood products
g. Time-based documentation of vital signs as well as oxygenation and ventilation parameters, and
h. Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.

23. The Operative Note shall be completed and signed by the surgeon prior to the patient being discharged or transferred from PACU.
24. All orders, including verbal orders, must be dated, timed, and authenticated.
    a. All orders shall be completed, legible, dated and signed within forty-eight (48) hours for medication orders and fourteen (14) days post-discharge for all other orders.
25. Medical Records/HIM will assign a deficiency to unsigned orders via the Inbox/Message Center.
26. It is acceptable for physicians involved in the care of the patient to sign orders given by other physicians unless they object to the order. A physician may proxy Message Center to another physician for coverage purposes.
    a. Verbal orders are to be used infrequently, only to meet the immediate care needs of the patient when it is impossible or impractical for the ordering practitioner to write/enter the order without delaying treatment. Every effort is to be made by the ordering physician to enter orders into Cerner or in writing.
    b. All orders for treatment shall be entered. An order for treatment is considered entered if dictated by a member or his designee to a registered nurse and signed by the attending member through the Message Center. When orders are dictated over the telephone, they shall be signed by the responsible physician within forty-eight (48) hours for medication orders and fourteen (14) days post-discharge for all other orders.
    c. Physician orders for neonatal and pediatric populations will contain weight based dosing (e.g., mg/kg) along with the calculated dose and the patient's current weight with the exception of the following defined medication classes:
        i. Medications that are not determined by the patient's weight (e.g., iron sulfate).
        ii. Vaccines
        iii. Intravenous fluids
        iv. Medication doses that if weight based would equal or exceed normal adult doses.
27. When a patient is transferred from one level of care to another the physician is required to complete one of the following options:
    a. Electronic Orders
        i. Utilize the Merge View in Cerner to review and update all orders for the next level of care.
        ii. Complete the Transfer Medication Reconciliation function
    b. Written Orders
        i. Rewrite all orders OR document the following, "I have reviewed all orders, and they are appropriate for this patient at this level of care."
        ii. The physician is not required to rewrite orders when a patient is undergoing one of the following minor procedures and returns to the same level of care
            1) Heart Catheterization
            2) Interventional procedures including PICC line placement
            3) Endoscopy including bronchoscopies
            4) Inpatient dialysis
            5) Pain management
28. Consultations and recommendations shall include examination of the patient and a review of the patient's record by the consultant. The consultation shall be made a part of the patient's record. When operative procedures are involved, a consultation, except in an emergency, shall be recorded prior to the operation.
29. Current obstetrical records shall include complete prenatal records, including a copy of the actual lab reports. The prenatal record may be a legible permanent copy of the attending practitioner's

office record transferred to the Medical Center before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

30. All patients evaluated by an Emergency Department physician are to have a documented report outlining the history of present illness, assessment, and treatment rendered.
    a. Records for patients evaluated by both a resident and an ED physician will include documentation by each of the evaluators. The attending ED physician is responsible for authenticating ED reports dictated by a resident.
    b. Records for patients evaluated by an ED Physician Assistant (PA) will include only documentation by the PA which will be authenticated/signed by both the PA and ED supervising physician.
31. All clinical entries in the patient's medical record shall be accurately dated and authenticated.
32. Discharge/Depart Process
    a. Electronic orders for discharge and follow-up care (including: activity, diet, equipment, follow-up, and medications) will be entered into the Depart Process application.
    b. Written orders for discharge and follow-up care (including: activity, diet, equipment, and follow-up) will be recorded on the Physician Order sheet.
        i. Nursing will enter into the Depart Process application
        ii. Medication orders must be entered by the physician for Discharge Medication Reconciliation process (see section D.11.c.2)
33. A Discharge Summary shall be dictated at all deaths regardless of length-of-stay, and in addition on all patients hospitalized over forty-eight (48) hours, except for normal obstetrical deliveries, and normal newborn infants. A discharge summary must contain:
    a. Discharge Diagnosis
    b. Reason for hospitalization
    c. Significant findings
    d. Procedures performed and treatment given
    e. Condition on discharge
    f. Instructions given to the patient or patient representative
        i. Follow-up instructions
        ii. Diet instructions
    g. Discharge medications
    h. A written or dictated discharge note is acceptable for patient with a length-of-stay less than forty-eight (48) hours, normal obstetrical deliveries, and normal newborn infants.
        i. Requirements of the Note include:
            1) Discharge Diagnosis
            2) Follow-up instructions
            3) Diet Instructions
            4) Discharge Medications
    i. Physicians having a Discharge Summary that requires dictation will be notified via the Message Center in Cerner. All physicians will be required to complete all pending dictations and/or signature within 14 days of discharge.
34. Physicians will be notified of outstanding charts requiring signature via their Message Center as well as via letter and call to their office.
    a. Physicians will be suspended per Medical Staff Policy #8710-519 for Delinquent Medical Records and Medical Staff Bylaws Section 6.4-4(a).
35. Late Entry:
    a. Documentation shall be recorded timely within the patient's medical record. When this is not possible a late entry will be made with the following required elements documented:
        i. The date and time of the observation
        ii. A note clearly identifying the documentation as "Late Entry"
    b. It is not permitted to have entries "backdated" or "predated".
    c. The chart shall be completed within fourteen (14) days of discharge; it is expected no Late Entries will appear after this time period.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 06/04	**SUBJECT:** Medical Staff Governance Documents Development and Review and Approval Mechanism
REVISION DATE(S):	**POLICY NUMBER:** 8710 – 500
Department Approval Date:	03/17
Medical Staff Committee Approval Date:	n/a
Pharmacy and Therapeutics Approval Date:	n/a
Medical Executive Committee Approval Date:	~~09/11~~03/17
Professional Affairs Committee Approval Date:	
Board of Directors Approval Date:	09/11

A. **PURPOSE:**

1. To provide guidelines for development, review, revision and approval of Medical Staff self-governance documents.

B. **DEFINITION(S):**

1. For purposes of this policy, Medical Staff governance documents are the Medical Staff Bylaws and documents that supplement them, including but not limited to, rules and regulations, policies, protocols, and standardized procedures.
2. Standardized Procedures are as defined by Title 22 and Title 16 for the performance of medical procedures outside the normal scope of practice for a Registered Nurse.
3. Protocols are developed when the supervising physician adopts standards to govern the performance of a physician assistant for some or all tasks.
4. Process is a series of steps taken to accomplish a goal.
5. Policy describes a deliberate plan of action to guide decisions and achieve rational outcome(s).
6. Procedure describes how each step in the process is to be carried out.
7. Rules and Regulations refer to the rules and regulations that describe the privileges, competency, and other requirements of each Medical Staff Department and/or Division. The General Medical Staff Rules and Regulations apply to all Medical Staff Members regardless of Medical Staff status.
8. Medical Staff Bylaws define the Medical Staff as a self-governing body.
   a. Issues that must be addressed in the Medical Staff Bylaws are as required by:
      i. The Medicare Conditions of Participation
      ii. The Joint Commission Standards pertaining to the Medical Staff.
      iii. California Code of Regulations, Title 22 pertaining to the Medical Staff
   b. The Criteria used to identify the issues that must be addressed in the Medical Staff Bylaws are as required by the:
      i. Medicare Conditions of Participation
      ii. Joint Commission Standards pertaining to the Medical Staff
      iii. California Code of Regulations, Title 22, pertaining to the Medical Staff
      iv. Specific issues reviewed and determined to be appropriate by the Medical Staff Bylaws Committee
      v. Specific issues as presented by Medical Staff members.

C. **GUIDELINES:**

1. Medical Staff governance documents are developed as needs are identified. They may relate to regular operations or functions of the Medical Staff and are used to assure consistency for

Medical Staff processes. Medical Staff governance documents are approved by the Medical Executive Committee and the Board of Directors. Medical Staff governance documents that are related to specific departments, divisions or committees will also be reviewed and approved by that respective group.

2. Standardized Procedures are developed when the physician is authorizing nurses to assist in certain patient care activities under the general supervision of physicians. Standardized Procedures are approved by the Division and/or Department level, the Pharmacy and Therapeutics Committee (if necessary), the Interdisciplinary Practice Committee, the Credentials Committee, the Medical Executive Committee and the Board of Directors of the hospital. Standardized Procedures are reviewed as provided in the standardized procedure, and updated as necessary.
3. Department and Division Rules and Regulations are subject to the approval process outlined in the Medical Staff Bylaws (Section 9.4(l) and 9.5).
4. The General Medical Staff Rules and Regulations are subject to the approval process outlined in Section 13.1 of the Medical Staff Bylaws.
5. Medical Staff Bylaws are reviewed and approved per Medical Staff Bylaws (Article 14).
6. The minimum content of protocols shall be as provided in California Business & Professions Code Section 3502. Protocols must be authenticated and dated by the supervising physician and the physician assistant, with a copy provided to the Medical Staff. The supervising physician shall review, counter-authenticate, and date a minimum of 10% sample of medical records of patients treated pursuant to protocols within thirty (30) days of the date of treatment. Protocols are approved by the Division and/or Department level, the Pharmacy and Therapeutics Committee (if necessary), the Interdisciplinary Practice Committee, the Credentials Committee, the Medical Executive Committee and the Board of Directors of the hospital. Protocols are reviewed and updated as necessary.

D. **REFERENCES:**

1. The Joint Commission 2011 Medical Staff Standards

~~**Approvals:**~~
~~**Medical Executive Committee Approval: 09/11**~~
~~**Board of Directors Approval: 09/11**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 10/01	**SUBJECT:** Name Tags for Health Care Practitioners
REVISION DATE(S): 09/11, 11/14	**POLICY NUMBER:** 8710 – 521

Department Approval Date:	03/17
Medical Staff Committee Approval Date:	n/a
Pharmacy and Therapeutics Approval Date:	n/a
Medical Executive Committee Approval Date:	~~10/14~~03/17
Professional Affairs Committee Approval Date:	
Board of Directors Approval Date:	11/14

A. **PURPOSE:**

1. To outline the requirements for name badges for Medical Staff members and Allied Health Professionals (AHP) in accordance with the provisions of California Business & Professions Code Section 680.

B. **REQUIREMENTS:**

1. All health care practitioners who have been granted membership and/or clinical privileges must wear name badges.
2. The name badge must disclose his/her name per license/credential, licensure status as granted by the State, and photo.
3. This name badge must be in at least 18-point type font.
4. The name badge must be worn and visible while providing care in the hospital.

~~**Approvals:**~~

~~Medical Executive Committee Approval: 10/14~~
~~Governance Committee Approval: 11/14~~
~~Board of Directors Approval: 09/11; 11/14~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 1/07	**SUBJECT:** Peer Review Process: OPPE and FPPE
REVISION DATE: 3/08, 5/08, 06/08, 07/~~20~~15	**POLICY NUMBER:** 8710 – 509

Department Approval:	03/17
Medical Staff Committee Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/27/2015~~03/17
~~**Governance Committee Approval:**~~	~~09/17/2015~~
Board of Directors Approval:	09/~~24/20~~15

A. **POLICY:**

1. Medical Staff members, departments, divisions and committees participate in peer review activities in accordance with this policy as well as the Medical Staff Bylaws, Medical Staff Rules and Regulations, Department/Division Rules and Regulations, and as required by licensure regulations, accreditation standards and conditions of participation in Federally funded programs. Peer review includes all evaluation activities involving members of the Medical Staff ("Practitioners"), including quality improvement, utilization review, monitoring, proctoring, focused review, Focused Professional Practice Evaluation (FPPE), On-going Professional Practice Evaluation (OPPE) and medical record review. The results of peer review activities are utilized to assess a Practitioner's professional practice as part of the credentialing, privileging, and corrective action processes.

B. **ONGOING PROFESSIONAL PRACTICE EVALUATION ("OPPE"):**

1. Ongoing Evaluation: At eight (8) month intervals, every Practitioner will undergo ongoing evaluations defined by each Department/Division. Relevant data is collected and assembled for review by the applicable Department Chair/Division Chief, who shall determine whether the Practitioner is performing: 1) well/within desired expectations and that no further action is warranted; or 2) that an issue exists that requires a focused evaluation; or 3) recommending revocation of a privilege because it is no longer required, recommending suspension of a privilege; or 4) that there has been zero performance of a privilege thereby triggering focused review (proctoring) whenever the practitioner performs the privilege; or 5) determining that a privilege should be continued without change because the organization's mission is to be able to provide the privilege to its patients. Ongoing evaluations shall be included in the Practitioner's credential file as part of the reappointment process. This process will evaluate a Practitioner's professional performance on an on-going basis, utilizing the following six (6) areas of General Competencies:
    i. Patient Care
    ii. Medical / Clinical Knowledge
    iii. Practice-based learning and Improvement
    iv. Interpersonal and communication skills
    v. Professionalism
    vi. Systems / Based Practice
2. Routine Individual Case Review is initiated based on department/division established criteria, reported deviations from expected care, statistical analysis showing (i) important single events, levels of performance, or patterns or trends varying significantly from expected; (ii) performance

varying significantly from other organizations; (iii) performance varying significantly from recognized standards, variances from utilization practices, (iv) risk management concerns involving quality of care, complaints from patients/family or staff relating to quality of care, (v) notices from regulatory bodies, accreditation agencies or third party payors involving quality of care, or if an appropriate, (vi) medical staff officer determines a need.

a. Initial Review: will be performed by the applicable department, division or committee (or designee thereof in accordance with the Medical Staff Bylaws or Rules and Regulations). Review findings will be documented and rated in accordance with a system established by the Medical QA/PI Committee.

b. Review Timelines: Peer review of a particular matter shall be conducted as soon as reasonably possible based on when the matter is discovered and the complexity of the matter to be reviewed. In general, initial review of those circumstances identified herein should be carried out within thirty (30) days of discovery. Completion of the peer review process of a particular circumstance should occur within ninety (90) days of discovery, unless unusual events interceded, include but not limited to, focused review or referral to another department/division. Delays in review shall be reported to the Medical Executive Committee. Expedited reviews are appropriate in the event there may be an imminent threat to the health or safety of an individual.

c. Reporting Findings: The findings of peer review activities are reported through the department/division/quality review committee to the QA/PI/PS Committee and on to the Medical Executive Committee within forty-five (45) days of completion.

d. Action: Consistent with the provisions of the Medical Staff Bylaws, the department/division/quality review committee/chair/chief may take action or make recommendations for action, including implementation of monitoring, proctoring and focused evaluation activities. Any recommendations for corrective action which may give rise to hearing rights shall be processed in accordance with the Medical Staff Bylaws.

C. **FOCUSED PROFESSIONAL PRACTICE EVALUATION("FPPE"):**

1. FPPE includes monitoring, proctoring and focused review activities. These activities are intended to evaluate the privilege-specific competence of a practitioner granted new/initial privileges, where activity is insufficient to evaluate competence at time of privilege renewal, or when questions arise regarding a practitioner's ability to provide quality care.
2. Monitoring: Monitoring shall consist of the on-going scrutiny of a Practitioner's practice without limitations or obligations on the monitored Practitioner. Examples include, but are not limited to, retrospective chart review, concurrent chart review, and concurrent observation.
3. Proctoring:
   a. Concurrent proctoring is when a Practitioner is obligated to arrange for another Practitioner to be present during a patient care episode and, except in the case of an emergency, when the Practitioner may not proceed with the specific patient care unless the proctor is present.
   b. Retrospective proctoring is when a Practitioner's provision of care and treatment is evaluated through review of the medical record. In the case of newly or initially granted privileges, all Practitioners shall be subject to such proctoring requirements as set for the in the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department/Division Rules and Regulations. In addition, in cases where a Practitioner has insufficient activity in a particular privilege to evaluate competence at time of renewal, the proctoring process may be utilized.
   c. The provisions of the Bylaws and Rules and Regulations shall be followed with regard to the methods of proctoring, duration of proctoring, criteria for conclusion of proctoring, process for conclusion of proctoring, etc.
4. Focused Review: In case where, based on the evaluation of a Practitioner's current clinical competence, compliance with standards, or ability to perform requested privileges, questions arise regarding a Practitioner's ability to provide quality care, focused review may be initiated.

Circumstances which may give rise to focused professional practice evaluation include, but are not limited to, provision of inappropriate care, including a single egregious incident or a clinical practice trend; mortality/morbidity complication rates at variance with applicable standards; failure to comply with hospital or medical staff policies, procedures, rules, regulations, bylaws, laws, regulations or standards; action by a licensing agency or other governmental entity; a significant pattern of malpractice claims; and a significant number or dollar amount of malpractice settlements, judgments or arbitration awards.

a. INITIATION PROCESS: Request for a FPPE must be in writing, submitted to the MEC, with supported reference to the specific activities or conduct alleged. Monitoring for the FPPE may include but is not limited to periodic chart review, concurrent chart review, direct observation, monitoring diagnostic and treatment techniques, interviews with staff.
b. Time frame for the FPPE: The Medical Executive Committee will approve the time frame required for monitoring
c. Monitoring Plan: If the MEC initiates the request for an FPPE, the Practitioner will be notified in writing within five business days. The initial written notice shall include a statement of facts demonstrating the request for FPPE was reasonable and warranted. This communication must also include what is wrong with the performance and what improvements are expected.

D. GENERAL RULES SURROUNDING PEER REVIEW ACTIVITIES:

1. Participants in the Peer Review Process:
   a. Peer: Within the context of this policy, a "peer" is one with similar clinical competence and scope of responsibility, and to the extent possible, in the same or related specialty, with the experience to render technically sound judgment of the clinical circumstances under review.
   b. Reviewer(s): The Department/Division/Committee Chair/Chief shall appoint Practitioners to perform case screening. The reviewer shall not be personally involved in the care of the patient, and to the extent possible should not be a member of the same practice group or have other personal or professional conflicts.
   c. Affected Practitioner: A Practitioner whose practice is being reviewed shall participate in the peer review process at the earliest reasonable time to afford the affected Practitioner with an opportunity to provide additional information or obtain education regarding the particular circumstances. This participation may include, but is not limited to, written response or attendance at a meeting, as determined by the Department/Division/Committee. In cases where the peer review process advances to the investigation for corrective action stage, the process shall comply with the provisions of the Medical Staff Bylaws.
   d. Support Staff: Employees of the hospital may be designated to assist the Medical Staff with its peer review activities. Employees acting in such roles shall be under the direction and supervision of the Medical Staff, and shall comply with all Medical Staff confidentiality requirements with regard to peer review materials.
   e. Data Sources/Collection: The cases for peer review are derived from quality review form, patient satisfaction surveys, department specific criteria and reports generated from coded medical records.
   f. Criteria shall be reviewed by each department/committee/ annually. The criteria can be changed before the annual review with request from Department Chair.
   g. Cases involving more than one discipline are referred to other areas for additional input or action. These are tracked in the original committee until completed.
   h. Incomplete case reviews are referred to the next scheduled meeting.
   i. Cases referred for review shall be reviewed by the Practitioner screener of each committee (or designee), who shall determine whether to refer the case to the full committee for discussion, and make the preliminary assignment of category.
   j. Cases referred for discussion shall be summarized in sufficient detail to ascertain the salient facts of the case, the issue under discussion, and the reasoning underlying the

committee(s) decision.

k. Peer Review results are used in the reappointment process and in ongoing performance improvement activities for all members of medical staff.

l. Cases requiring immediate action or intervention are shared directly from Risk Manager to Department Chairman or Chairman of Quality Assurance/Performance Improvement/Patient Safety Committee and may require direct intervention.

m. For cases of Practitioner comportment, refer to Medical Staff Policy 511.1, Physician Behavior Policy.

E. **CATEGORY OF ASSIGNMENTS:**

1. Not Physician Related
   a. These events are casually related to the patient, to support care provided within the hospital, or care provided outside the hospital. Trending data from this category would not enhance or identify opportunities to improve physician-specific performance but may demonstrate trends useful for departmental or hospital wide management.
2. Within The Standard of Care
   a. These events reflect care that is within the contemporary standards of the specialty or expected standards of the department.
   b. These events reflect care that resulted in a complication and or prolonged clinical course, but the care remained within the contemporary standards of the specialty or the department.
3. Departure From The Standard of Care
   a. In each occurrence below, the physician will be notified:
      i. Minimal Variance
         a. These events reflect care that is minimally outside the contemporary standards of the specialty or expected standards of the department, and which might be to the detriment of the patient. There could be review, response or further study by the committee.
      ii. Moderate Variance
         a. These events reflect care that is clearly outside the contemporary standards of the specialty or expected standards of the department to the detriment of the patient. There must be review, response, trending, or further study by the committee.
      iii. Significant Variance
         a. These events represent gross departures from expected standards, raise immediate questions about judgment or technique and require an immediate response from the committee or department. In each occurrence, the physician will be notified.
      iv. Violation of Hospital Policy Includes poor communication or inadequate documentation.
      v. Violation of Physician Code of Conduct These behavioral events will initiate an immediate response. The physician will be notified.

F. **APPEAL PROCESS:**

1. Practitioner(s) asked for information by a reviewing committee with regard to quality events of a particular case(s) must respond within 30 days of receipt of such request. If no response is received within 30 days, the committee will make its determination without that physician(s) input.
2. If the Practitioner disagrees with the category assigned, he/she may request appeal from the committee where the assignment is made. If the appeal is not resolved to the satisfaction of the Practitioner, the Medical Executive Committee shall serve as the final appeal body.
3. The Medical Staff member may review his/her file on request.
4. Quality Assurance/Performance Improvement/Patient Safety Committee oversees and supervises all medical staff peer review activity. When a subsidiary peer review body is not

performing appropriately, the Quality Assurance/Performance Improvement/Patient Safety Committee is responsible for resolving issues.

5. When the Quality Assurance/Performance Improvement/Patient Safety Committee disagrees with an assigned significance category, the case will be referred back to the Department Quality Peer Review Committee for reconsideration. If no agreement is reached, referral will be made to the Medical Executive Committee for final arbitration.
6. Any evaluation of a quality event that is not completed within six (6) months of initial review will be assessed by the Chairman of the Quality Assurance/Performance Improvement/Patient Safety Committee.

G. **REFRENCES:**

1. Medical Staff Standards, Joint Commission 2008
2. The compliance Guide to JCAHO Medical Staff Standards.
3. Effective Peer Review A Practical Guide to Contemporary Design, 2nd Edition, Robert Marder, May 2008

~~Addendum A~~

~~CRITERIA FOR PRACTITIONER PEER REVIEW~~
~~ALL RECORDS FOR ALL DIVISION/DEPARTMENTS ARE REVIEWED FOR:~~

~~GENERIC SCREENING~~

~~Re-admission with 30 days (usually 7 days or less unless significant related event)~~
~~Death with code, unexpected, coroner's case~~
~~Patient complaints (Incident reports, patient surveys)~~
~~Complications CVA, MI~~
~~Delay in service, physician not being available~~
~~Transfusion reactions, major blood loss requiring unplanned transfusion~~
~~Drug reaction~~
~~Unplanned transfer to ICU~~
~~CPR~~
~~Nosocomial infection~~
~~Random review~~
~~Quality Review Reports~~

~~SURGICAL CASES~~
~~(GVS, UROLOGY, OB/GYN, ORTHOPEDICS, NEUROSURGERY, SUB SPECIALITY)~~

~~Unexpected return to OR~~
~~Unexpected peri-operative injury~~
~~Excessive blood loss~~
~~Death in OR~~
~~Wound dehiscence~~
~~Intra-operative complication~~

~~CARDIOTHORACIC~~

~~Mortality~~
~~New renal failure requiring Dialysis~~
~~Stroke~~
~~Deep Sternal Wound Infection~~
~~Peri op MI~~

~~Neurosurgery~~

~~CNS Leak following surgery~~
~~Worsening neurological symptoms following surgery~~
~~All generic surgical criteria~~

~~ANESTHESIA~~

~~PACU stay over 4 hours~~
~~Anesthesia related event: Pneumothorax, aspiration, esophageal intubation, cardiac arrest, MI, seizure, malignant hyperthermia, transfusion reaction, neurological deficit~~
~~Death in OR or within 48 hours of surgery~~
~~Injury~~

~~EMERGENCY ROOM~~

~~Re-admission to ER within 72 hours~~
~~Patient complaints~~
~~Deaths (coded within the ED)~~
~~EMTALA concerns~~

~~OBSTETRICS~~

- ~~Apgar less than 4 at 5 minutes~~
- ~~Eclampsia~~
- ~~LOS over 3 days Vaginal Delivery~~
- ~~LOS over 5 days Cesarean Section~~
- ~~Injury to infant~~
- ~~Transfer to ICU~~
- ~~Stillborn or neonatal deaths greater than 2500 grams~~

~~PEDIATRICS~~

- ~~LOS over 5 days~~
- ~~Apgar less than 5 at 5 minutes~~
- ~~Injury~~
- ~~Seizures within first 24 hours~~
- ~~Meconium aspiration resulting in NICU stay~~
- ~~Neonatal deaths over 2500 grams~~
- ~~Neurological deficits~~
- ~~Readmissions within 72 hours~~

~~UTILIZATION REVIEW~~

- ~~PRO denial~~
- ~~Discharge planning~~
- ~~Referral by UR physician advisor~~
- ~~Admission denial~~
- ~~Continued stay denial~~

~~TISSUE REVIEW~~

~~There are three broad categories into which all surgical pathology and cytophology cases will be reviewed, A, B, or C. The pathologists will assign all cases to one of these classes at the time of microscopic sign-out. The case definitions are as follows:~~

~~Group A:~~

- ~~Gross exam only~~
- ~~A diagnostic procedure for clinical workup only, (e.g. no specimen)~~
- ~~The tissue pathology substantiates the clinical impression and / or the operative diagnosis~~
- ~~The tissue pathology does not confirm or support the clinical diagnosis, but significant pathology is present to justify the surgical procedure.~~

~~Group B:~~

- ~~All cases with normal tissue removed as identified by the pathologist, excluding appropriate incidental organ removal.~~

~~Group C:~~

- ~~All cases where the pathologic findings do not appear to justify removal of tissue~~
- ~~All cases where the pathologic diagnosis differs from pre- or post-op diagnosis, and does not fit under A-4~~
- ~~All cases where the pre-op clinical diagnosis differs greatly from the post-op diagnosis.~~
- ~~The pathology findings suggest either too little or too much tissue was removed by the surgical procedure.~~
- ~~The tissue pathology does not support the clinical diagnosis.~~
- ~~The pathology and / or operative procedure warrants review for reasons other than those stated above.~~

~~All cases falling into group B, and C will be referred to the Tissue Committee. Bases on its review of the cases, the Tissue Committee will have the option of disposing of cases at its level, or referring them~~

~~back to the appropriate Divisions or departments, with a report of their findings to Tissue Committee.~~

~~SUMMARY~~

~~Most Practitioners will have sufficient cases reviewed through the above generic screen fall out to meet credentialing requirements. Random reviews are also done to supplement those physicians who have not had enough case review generated to adequately demonstrate their management of patient care. Random reviews are also generated to intensify review of Practitioners who have demonstrated some area of concern to their department or division quality review committees.~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 11/03	**SUBJECT:** Physician Orders/Family Members
REVISION DATE(S): 09/11. 12/14	**POLICY NUMBER:** 8710 – 529

Department Approval Date:	03/17
Medical Staff Committee Approval Date:	n/a
Pharmacy and Therapeutics Approval Date:	n/a
Medical Executive Committee Approval Date:	~~11/14~~03/17
Professional Affairs Committee Approval Date:	
Board of Directors Approval Date:	12/14

A. **PURPOSE:**

1. To outline the ethical and compliance issues for a physician who wants to order tests or therapies on themselves or their family members.

B. **POLICY:**

1. It is the policy of the Medical Staff of ~~TCMC~~ **Tri-City Healthcare District (TCHD)** that it is inappropriate for physicians to evaluate and treat themselves or immediate family members except in emergency settings, isolated settings where there is no other qualified physician available, or in situations in which routine care is acceptable for short-term, minor problems.
2. The AMA issued a statement, E-8.19 regarding physicians treating themselves or members of their immediate families and the Medical Staff supports that statement. (See attached AMA Statement)
3. The Code of Federal Regulations states that Medicare will not cover charges for services provided to a patient who is an immediate family member of the physician or a member of the physician's household.
4. ~~TCMC~~ **TCHD** follows Medicare rules with regard to compliance issues.

C. **DEFINITIONS OF TERMS:**

1. Immediate family members are defined as follows:
   a. Husband or wife
   b. Natural or adoptive parent, child or sibling
   c. Stepparent, stepchild, stepbrother, stepsister,
   d. Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law.
   e. Grandparent or grandchild
   f. Spouse of grandparent or grandchild.
2. Member of the household means:
   a. Any person sharing a common abode as part of a single-family unit.
   b. Domestic employees and others who live together as part of a family unit, not a roomer or boarder.
3. Physician:
   a. Immediate family member
   b. Member of household
   c. MD, DO, DDS with membership to **TCHD**~~TCMC~~ Medical Staff
4. Patient means whoever of the following is receiving the tests or therapies:
   a. Physician
   b. Immediate family member
   c. Member of household

D. **PROCESS:**

1. Medical Staff members can only order tests and prescribe treatment for themselves, their immediate family members, and members of their household in an emergency, if there is no other qualified physician available, or in situations in which routine care is acceptable for short-term, minor problems.
2. Per Code of Federal Regulations and other ~~TCMC~~ **TCHD** contractual agreements, the patient may be responsible for charges incurred.

E. **GUIDELINES:**
1. AMA Ethical Opinion E-8.19.
2. 42 C.F.R. § 411.12

~~**Approvals:**~~
~~**Medical Executive Committee Approval: 11/14**~~
~~**Board of Directors Approval: 09/11; 12/14**~~