TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE PROFESSIONAL AFFAIRS COMMITTEE
OF THE BOARD OF DIRECTORS
February 9, 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	1-2	2 min.	Chair
3.	Public Comments NOTE: During the Committee's consideration of any Agenda item, members of the public also have the right to address the Committee at that time regarding that item.		5 min.	Standard
4.	Ratification of minutes of the January 2017 Meeting	3-10	2 min.	Committee
5.	New Business			
a.	Consideration and Possible Approval of Policies and Procedures	11		All
	Patient Care Services			
	1. Child Passenger Restraint System Education Policy	12-13		
	2. Consent for Operative or Other Procedures	14-19		
	3. Diabetes Education Procedure	20-21		
	4. In Custody Patients' Policy	22-25		
	5. Knee Immobilizer Application and Range of Motion (ROM) Brace Procedure	26		
	6. Swallow Screening in the Adult Patient Procedure	27-28		
	Administration Policies and Procedures			
	1. Administrator-On Call-281	29		
	2. Lost and Found Articles – 202	30-32		
	Unit Specific **Infection Control**			
	1. Transmissible Spongiform Encephalopathies (TSE)	33-41		
	Surgical Services			
	1. Block Time Policy	42-43		
	2. Bumping Surgery Procedures Policy	44-45		
	3. Disaster and Emergency Preparedness Policy	46-50		
	4. OR Committee Policy	51-52		
	5. Pre-Operative Requirements Policy	53-55		
	6. Safe Medical Device Act – Tracking and Reporting Policy	56-57		
	7. Scheduling Surgical Procedures Policy	58-62		
	8. Scope of Service for Surgical Services Policy	63-65		
	Telemetry			
	1. Assignments	66-69		
	Women and Newborn Services			
	1. Hydralazine Hydrochloride	70-72		
	2. Neonatal Team Attendance at a Delivery	73-75		
	3. Standards of Care: Newborn	76-87		

	4. Standards of Care: Postpartum	88-99		
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 March 9, 2017.		1 min	Chair
12.	Adjournment		1 min	Chair

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
January 12, 2017

Members Present: Director Laura Mitchell (Chair), Director Jim Dagostino, Director Leigh Anne Grass, Dr. James Johnson, and Dr. Gene Ma.

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

Others present: Jody Root, General Counsel, Marcia Cavanaugh, Sr. Director for Regulatory and Compliance, Jami Piearson, Director for Regulatory Compliance, Cli. Quality and Infection Control, Sherry Miller, Kathy Topp, Chris Michieowski, Nancy Myers, Aimee Hardt, Isabel Escalle, Lisa Mattia, Rowena Okumura, Kathy R. Topp, Mary Diamond, Oska Lawrence, Merebeth Richins, Sharon Davies, Ingrid Stuiver, Patricia Guerra, Sonia Coleman and Karren Hertz.

Members Absent: Dr. Scott Worman and Dr. Contardo.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell called the meeting to order at 12:06 PM in Assembly Room 1.		Director Mitchell
2. Approval of Agenda	The committee reviewed the agenda and there were no additions or modifications. Director Mitchell briefly introduced Director Leigh Ann Grass to the committee as the new Board member for PAC.	Motion to approve the agenda was made by Director Dagostino and seconded by Director Grass.	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 October 2016.	Director Mitchell called for a motion to approve the minutes from October 13, 2016 meeting.	Minutes ratified. Director Dagostino moved and Dr. Ma seconded the motion to approve the minutes from October 2016. Director Grass abstained from voting since she was not present in the previous month's meeting.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:** 1. Abduction Shoulder Splint Procedure 2. Abduction Splint Application 3. Allied Health Students in Patient Care Areas Policy 4. Cardioversion, Elective	It was noted, as implied by Director Dagostino's question, that the splints in the units are located in the Pyxis supply. There was no discussion on this policy. A clarification made by Director Dagostino indicated that the PT and OT students are covered in this policy as well. The sedation reference component should be added to this policy as Cardioversion procedure almost always requires moderate sedation.	**ACTION:** The Patient Care Services policies and procedures were approved. Director Dagostino moved and Director Grass 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
5. Continuous Passive Motion (CPM) Machine Procedure	It was discussed that the regular hospital beds are equipped with extenders for heavy patients.		
6. Epidural or Intrathecal Catheter Infusion in the Non-Laboring patient Procedure	On the PCEA infusion, it should say epidural analgesia; not anesthesia. This procedure is primarily done by anesthesiologists but some neuro physicians do it too on rare occasions.		
7. Fall Risk Procedure and Score Tool Procedure	The hospital uses the Morse Code fall risk scoring system for inpatients while the Emergency Department uses Kinder. The falls assessment are done once a shift and as needed throughout the shift for the purpose of assuring patient safety in the hospital.		
8. Interpretation and Translation Services	It was clarified that the units call in an expert for hearing impaired services. Tablets are still being used for NSL.		
9. Medication Reconciliation Policy	The term Allied Health worker should be changed. CSU is the only unit that AHP is considered since they do their drug administration and reconciliation in the unit. Minor editorial changes were also made to this policy.		
10. Neutropenic Precautions Policy	There was no discussion on this policy		
11. Nursing Students in Patient Care Areas	The checklist of skills that the nursing students need to learn are being tracked by		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Policy	the school rather than the clinical sites. In the chart for the RN Students Skills List, there was a suggestion to make the NOs bold for easier differentiation.		
12. Surgical Skin Stapling	The word "utilize" should be used instead of "fire" in descrbing the automatic staple gun.		
13. Swallowing, Food and Nutrition Considerations for Patients with Oropharyngeal Dyspagia Policy	It was noted that various thickening agents are available on all the units of the hospital.		
Administrative Policies and Procedures:			
1. Decorative Material	There was no discussion on this policy.	**ACTION:** This Administrative policy was approved. Director Dagostino moved and Director Grass seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Unit Specific Emergency Operations Procedure (EOP)			
1. Emergency Operations Plan	Kevin reported that the hospital has a satellite phone for emergency situations in the hospital. If the computers shut down, the facility has enough paper forms that will last for 96 hours. Kevin also added that he had worked with CDCR to devise a plan for the PCU patients admitted in the unit. Sheriff will coordinate the evacuation and care of this population in case a disaster hits the hospital.	**ACTION:** This EOP policy was approved. Director Dagostino moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Engineering 1. Equipment Repair 2008 2. Maintenance and Inspection of Medical Gas 2003 3. New Equipment Inventory and Inspection 2007 4. Pre-Purchase Evaluations 2009 5. Purchasing Procedure 2011 6. Scheduled Equipment Maintenance 2006 7. Utility Management Plan 2003 8. Work Order Requests 2010	No discussion on these policies. Chris briefly explained that that the hospital has a computerized system to track all the valves in the hospital.	**ACTION:** The Engineering 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
Infection Control 1. Aerosol Transmissible Diseases and Tuberculosis Control Plan 2. Standard and Transmission-Based Precautions	It was noted that all of the Infection Control policies are lined up to meet the Joint Commission plan. The discussion centered on rare diseases such as scarlet fever or measles as they present to the ED. Practitioners face a challenge since the incidence of many of these illnesses has declined and many practioners are unfamiliar with some of the	**ACTION:** The Infection Control policies and procedures were approved. Director Schallock moved and Director Grass seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	signs and symptoms. Since measles and scarlet fever include rashes, the committee was reassured that staff have access to pictures from a variety of sources to aid in the in the assessment process.		
3. Waterborne Illness	Engineers in the hospital test air duct system annually for Legionellosis. There was a suggestion that air samples need to have random checks as precautionary measure for the hospital.		
4. Zika Virus	Lisa mentioned that a couple of Zika cases were reported and sent out straight to CDPH although there were no results given yet.		
Medical Staff			
1. Disaster Privileges	There was a brief discussion on the functions of the practitioners in the event of a disaster. Sherry mentioned that it could take the Medical Staff Department up to 3 days to credential a physician. The Incident Commander will assign the physician according to the needs of the community at the time of the disaster.	**ACTION:** Director Dagostino moved, Dr. Ma seconded and this Medical Staff policy was moved and approved to move forward for Board approval.	Patricia Guerra
NICU			
1. Amphotericin-B Liposome (AmBisome), Ordering and Infusion of	There was no discussion on this policy.	**ACTION:** The NICU policies and procedures were approved. Director Dagostino moved and Director Grass seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Consultation to Perinatal Unit	There was no discussion on this policy.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Women's and Newborn Services 1. Epidural Spinal Management	There was a brief conversation on the epidural procedure; Dr. Johnson mentioned that some RNs are not familiar with the process of assisting when the epidural needs to be done. Sharon Davies will look into this.	**ACTION:** Director Dagostino moved, Director Grass seconded and this Medical Staff policy was moved and approved to move forward for Board approval.	Patricia Guerra
2. Laminaria	The Laminaria is used in the Women's and Children's Services.		
3. Scheduling Process for Procedures	This policy is good as it is being done for a year now.		
4. Shift Change Responsibilities			
5. Vacuum Extraction			
Formulary Requests 1. Fomulary Line Item Additions/ Deletions Deletions: • Albuterol Tablets • Erythromycin/ Sulfixoxazole 200 mg/600 mg suspension • Formoterol 12 mcg (Foradil Aerolizer)	The hospital will stop using the oral Albuterol. This drug has not been in the market for a year now. This medication was stopped 2-3 months ago and the hospital pharmacy is just implementing it right now. The addition of this medication will provide	**ACTION:** The formulary requests were approved. Director Dagostino moved and Dr. Ma seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Zarxio- Admission to Formulary	the hospital with a $60,000 savings for a year.		
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 the Committee	No comments.		Director Mitchell
11. Adjournment	Meeting adjourned at 2:15 PM.		Director Mitchell

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PROFESSIONAL AFFAIRS COMMITTEE
February 9th, 2017

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Child Passenger Restraint System Education Policy	practice change	
2. Consent for Operative or Other Procedures	practice change	
3. Diabetes Education Procedure	3 year review, practice change	
4. In Custody Patients Policy	3 year review, practice change	
5. Knee Immobilizer Application and Range of Motion (ROM) Brace Procedure	3 year review, practice change	
6. Swallow Screening in the Adult Patient Procedure	3 year review, practice change	
Administrative Policies & Procedures		
1. Administrator On Call - 281	3 year review, practice change	
2. Lost and Found Articles - 202	3 year review, practice change	
Department Specific		
Infection Control		
1. Transmissible Spongiform Encephalopathies (TSE)	3 year review, practice change	
Surgical Services		
1. Block Time Policy	3 year review, practice change	
2. Bumping Surgery Procedures Policy	3 year review, practice change	
3. Disaster and Emergency Preparedness Policy	3 year review, practice change	
4. OR Committee Policy	3 year review, practice change	
5. Pre-Operative Requirements Policy	DELETE	
6. Safe Medical Device Act - Tracking and Reporting Policy	DELETE	
7. Scheduling Surgical Procedures Policy	3 year review, practice change	
8. Scope of Service for Surgical Services Policy	3 year review, practice change	
Telemetry		
1. Assignments	3 year review, practice change	
Women & Newborn Services		
1. Hydralazine Hydrochloride	DELETE	
2. Neonatal Team Attendance at a Delivery	3 year review, practice change	
3. Standards of Care: Newborn	3 year review, practice change	
4. Standards of Care: Postpartum	3 year review, practice change	

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

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

Department Approval:	**08/16**
Clinical Policies & Procedures Committee Approval:	**~~05/15~~09/16**
Nurse Executive Council Approval:	**~~05/15~~09/16**
Department of Pediatrics Approval	**~~02/16~~11/16**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~02/16~~01/17**
Professional Affairs Committee Approval:	**04/16**
Board of Directors Approval:	**04/16**

A. **PURPOSE:**

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

B. **POLICY:**

1. Before an infant or young child is discharged, the parents or authorized caregiver to whom the child is being released, will be verbally informed of the need to have an age-appropriate child passenger safety seat, about Car Seat Safety and the importance that all children under 13 years of age ride in the back seat and be properly buckled when being transported.
   a. This information shall be provided to all parents of children receiving care in the Emergency Department and in Women and Newborn Services.
      i. Infants must be properly buckled in a rear-facing car seat in the back until they are at least ~~1 year old AND 20 pounds.~~ **2 years old (except for those that are 40 inches tall or 40 pounds or more).**
         ~~1) The American Academy of Pediatrics (AAP) recommends rear facing until the age of 2 or the maximum weight of the car seat for rear facing.~~
      ii. If a child is too large for a safety seat, the AAP recommends children who are 4 feet 9 inches tall or shorter ride in a belt positioning booster seat, regardless of age.
      iii. Children **age 8 or older, or** who are over 4 feet 9 inches **or taller may**~~can~~ use a lap~~/~~-shoulder belt if:
         1) The child can sit all the way back/ hips against the seat.
         2) The child's knees bend comfortably at the edge of the seat.
         3) The shoulder strap should cross **the center of the chest**~~over the shoulder between the neck and the arm~~.
         4) The belt fits low and flat on the hips.
         ~~4)~~**5) Child remains seated.**
         ~~5)~~**6)** If the answer is no to any of the following, then a booster is still required according to the California Law.

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

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

b. Other regulatory recommendations:
   i. Toddlers should remain rear-facing until they reach 2 years of age ~~or until they reach the upper weight and height limit of the car seat~~ **except if they are 40 inches tall or weigh 40 pounds or more**. Always follow the manufacturer's instructions for proper use and fit.
   ii. Do not buy a used car seat if you do not know if it has been in a crash.
   iii. Do not buy a car seat that is older than 6 years or has been in a crash.
   iv. Children should ride in the back seat until they are 13 years old.
   v. Never allow your child to place the shoulder belt behind his/her back or under the arm.
   vi. Never seat a child in front of an airbag.
   vii. Never leave your child alone in or around cars.

2. Literature available in both English and Spanish will be provided outlining current state laws regarding ~~this issue,~~ proper use of safety seats, and risk of death/injury associated with non-use or misuse, including air-bag issues.
3. Prior to the discharge of the child, parent/conservator or guardian shall provide a signature that this information was reviewed and discussed.
   a. Person receiving information outlining current law requiring child passenger restraint system, will sign the "release of a child under 8 years of age" form. The original will be kept in the medical record and a copy will be given to the person to whom the child is released.
4. Hospitals are required only to provide and discuss information concerning child passenger restraint system laws.
   a. Hospitals are not required to, and should not attempt to prevent a parent (or other authorized person) from transporting a child in a vehicle which does not have a child passenger system.
   b. Hospitals also should not instruct parents regarding how to install a car seat or help parents install a car seat, for liability reasons. A parent with questions about appropriate car seat installation should be referred to a local police or fire station, a local CHP office or loan program. Parents may also call (866) SEAT-CHECK or visit www.seatcheck.org to locate free car seat inspection facilities.
5. Facilities that provide the required information to the person to whom the child is released cannot be held legally responsible for the failure of that person to use a child passenger restraint system.

C. **REFERENCES:**

1. California Highway Patrol www.chp.ca.gov, retrieved January 2017
2. Following California Laws Will Keep You Child Safe in the Car, https://www.cdph.ca.gov/HealthInfo/injviosaf/Documents/ParentBrochure-English.pdf, retrieved January 2017
3. www.Kohlscarsafety.org.
4. National Highway Traffic Safety Administration www.safercar.gov/Air+Bags, retrieved January 2017
~~1.~~**5.** Pacific Safety Council, 9880 Via Pasar, Suite F, San Diego, CA 92126, Phone: 858-621-2313 or http://www.safetycouncilonline.com/full/url/

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**11/94**	**SUBJECT:**	**Consent for Operative or Other Procedures**
REVISION DATE:	**9/95; 11/96; 10/97; 7/99; 6/03; 1/06; 2/06; 2/07; 04/09; 12/10; 01/16**	**POLICY NUMBER:**	**8610-359**

Clinical Policies and Procedures Committee Approval:	**~~08/15~~08/16**
Nurse Executive Committee Approval:	**~~09/15~~09/16**
Operating Room Committee Approval:	**11/16**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/15~~01/17**
Professional Affairs Committee Approval:	**01/16**
Board of Directors Approval:	**01/16**

A. **PURPOSE:**

1. To comply with legal and regulatory standards by defining Tri-City Healthcare District's (TCHD) process to obtain a valid consent prior to diagnostic or therapeutic invasive procedures.

B. **DEFINITIONS**

1. Adult: An individual who has reached the age of 18 years, or a minor who has entered a valid marriage (whether or not the marriage was terminated by dissolution), who is on active duty with the armed forces of the United States of America, or who has been declared emancipated pursuant to Family Code section 7122et.seq. (Family Code, section 7002), or self sufficient minor (15 years or older, living apart from his/her parents, and manages his/her own financial affairs) pursuant to Family Code section 6922.
2. Consent Form: A document that verifies a patient has been informed of a pending diagnostic or therapeutic invasive procedure; understands the information and has given consent to the physician/Allied Health Professional.
3. Informed Consent:
   a. Voluntary consent given by a person or a responsible proxy (e.g., legal guardian, responsible party) for invasive diagnostic or therapeutic procedure after being informed of:
      i. The purpose, methods, benefits, and risks.
      ii. The likelihood of the patient achieving their goals
      iii. Any potential problems that might occur during recuperation
      iv. Reasonable alternatives to the patient's proposed care, treatment, and services
      v. Side effects related to alternatives
      vi. Risks related to not receiving the proposed care, treatment or services
   b. The essential criteria of informed consent are
      i. The subject has both knowledge and comprehension.
      ii. Consent is freely given without duress or undue influence.
      iii. The right of withdrawal at any time is clearly communicated to the subject and documented by the physician/Allied Health Professional in the patient's medical record.
   c. **Informed consent should be obtained prior to the consent form being signed unless there is an emergency event.**
4. Emergency: A situation in which immediate services are required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable medical conditions are required to prevent serious disability or death.
5. Minor: For minors see Patient Care Services (PCS) Policy: Consent for Minors

6. Procedures/Treatments Requiring Informed Consent/Consent forms: Informed consent and a consent form are required for any procedure or medical treatment that is considered complex and involve risks that are not commonly understood. The final determination of the "complexity" of the procedure/treatment is the responsibility of the physician/Allied Health Professional, in accordance with the criteria listed below:
   a. Any procedure that requires pre-medication for sedation/analgesia
   b. Any invasive procedure which involve incision, percutaneous puncture or insertion, and requires the services of the Endoscopy Lab, Operating Room, Cardiac Catheterization Laboratory, Interventional Radiology
   c. As required by law including but not limited to:
      1) Blood Transfusion
      2) Human Immunodeficiency Virus (HIV) Blood Tests
      3) Investigational drugs or devices
      4) Human Experimentation
      5) Treatment for breast or prostate cancer
      6) Use of psychotropic medications
      7) Electroconvulsive Therapy

C. **PROCEDURE:**

1. A signed consent form is required prior to invasive diagnostic or therapeutic procedures.
   a. After the physician/Allied Health Professional has obtained the patient's informed consent, a consent form for a procedure must be signed by the patient.
   b. The completed consent for Operative or Other Procedures shall be placed on the patient's chart under *Operative/Consents.*
   c. A copy of the signed form shall be given to the patient/legal representative.
2. Consent must include:
   a. Nature of the proposed care, treatment, services, medications, interventions, or procedures
   b. Potential benefits, risks, or side effects of the procedure including potential problems that may occur during recuperation
   c. Likelihood of achieving care, treatment, and/or service goals
   d. Reasonable alternatives
   e. Relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, or service
   f. Limitations of the confidentiality of information learned from or about the patient as indicated
   g. Any independent medical research or significant economic interests the physician/Allied Health Professional may have related to the performance of the proposed operation/procedure
3. The consent form must be signed prior to the administration of narcotics or mind-altering drugs.
   a. The physician/Allied Health Professional must determine if the patient is competent to sign the consent or if the procedure must be delayed if the consent is not obtained before the administration of narcotics or mind-altering medications.
      i. The decision to continue with the procedure must be documented by the physician in the medical record.
4. If, in the opinion of the physician/Allied Health Professional, the patient is permanently or temporarily incapable of giving consent, consent is obtained from one of the following, in the order listed
   a. Surrogate decision maker who has been verbally designated to the physician/Allied Health Professional who has undertaken primary responsibility for the patient. This verbal designation must be documented in the medical record and is valid:
      i. During the duration of the hospitalization
      ii. The course of illness
      iii. 60 days, whichever is shorter
   b. Agent identified in an advanced directive

c. When both an agent and surrogate are appointed by the patient, the surrogate takes precedence over the agent for the limited duration previously stated.
d. Conservator, who has been authorized by the court to make health care decisions or guardian;
e. Court appointed surrogate decision maker or court order
f. Closest available relative when appropriate to rely on the consent of this person (the person has capacity, trustworthy motives, likely that patient would consent if able, no objections from close relatives). The physician/Allied Health Professional should determine appropriateness for procedures requiring informed consent.

5. The consent form must include:
   a. Full terminology of the procedure (in lay terms) without the use of abbreviations.
      i. The terminology is obtained from the physician/Allied Health Professional order.
      ii. Right or Left shall be indicated when appropriate
   b. Document the date and time when the patient signs the consent form.
   c. The name of the surgeon/physician/Allied Health Professional performing the procedure and the name of the attending physician/Allied Health Professional must be listed on the consent (first and last names).
      i. If there is the possibility that some in the medical group may cover for the procedural physician/Allied Health Professional (i.e., call, vacation, availability, etc.) list **all** the primary physician/Allied Health Professional **that may perform procedure on the consent form** ~~and the name of the medical group or "Primary physician/Allied Health Professional and associates", whichever is applicable~~.
      ii. When two physician/Allied Health Professionals are listed on the orders as performing the procedure together, both surgeons are listed on the consent.
   d. When two physician/Allied Health Professionals are performing two different procedures on the same patient, a separate consent form shall be completed for each physician/Allied Health Professional and corresponding procedure
   e. Blank lines are not permissible on the consent form.
6. The consent form may not be altered once the patient has signed.
   a. If the physician/Allied Health Professional alters the order, a new consent must be obtained.
   b. In the case of a clerical error on the consent, the consent must be rewritten. The patient must sign the revised consent.
7. The consent form must be signed by a competent adult patient and witnessed by a hospital employee.
   a. A mark may be placed on the consent if the patient is physically unable to sign his/her name.
      i. Two hospital employees shall sign as witnesses to the mark.
   b. Elective surgery/procedures shall be delayed/cancelled if the patients voluntarily indicates doubt or confusion about the indicated procedure, until the physician/Allied Health Professional obtaining informed consent has an additional opportunity to talk to the patient
8. If the patient or patient representative cannot communicate with the physician/Allied Health Professional or hospital representative due to a language barrier, interpretive services shall be obtained
   a. Staff and/or family members shall only be used as interpreters in emergent situations until a medical interpreter is contacted.
      i. For the complete policy governing use of interpreters, please refer to Patient Care Services Policy: Communication with the Sensory Impaired and/or Persons with Language Barriers.
   b. If an interpreter is used, documentation shall include the name of the interpreter, the person's position (when appropriate) and that person's relationship to the patient.
   c. When telephone/video translation service is used, the following must be documented on the consent form:
      i. The name of the patient/legal representative receiving translation.
      ii. The patient's/legal representative's primary language.

iii. The medical interpreter identification/number.

d. If the consent form is not available in the patient's or patient representative's primary language, the interpreter shall verbally translate the form and ask the patient to sign the English form if the patient or the patient's representative agrees to the terms and conditions.

9. State and Federal regulation mandate special informed consent requirements for reproductive sterilization which is primarily for the purpose of rendering the person incapable of reproducing ("elective sterilization"), and elective sterilization may be performed only when the following conditions are met:
   a. Informed consent has been obtained from the patient
   b. The patient shall be able to understand the content and nature of the informed consent process
   c. The patient shall not be in a condition or mental state in which judgment is significantly altered
   d. The patient shall not be in labor, or less than 24 hours postpartum or post abortion
   e. The patient shall not be seeking to obtain or obtaining an abortion
   f. Medi-Cal or Federally funded patient shall have the following additional requirements
      i. Patient shall be 21 years of age or older
      ii. Patient shall not have been declared mentally incompetent by a court of competent jurisdiction, unless a limited conservator has been appointed and specific criteria have been met
      iii. The patient shall not be involuntarily confined or detained in a correctional or rehabilitative facility, or confined, under a voluntary commitment in a facility for the care and treatment of mental illness
   g. The sterilization consent has been signed by the necessary parties and is available on the chart prior to procedure
   h. The required waiting period has been satisfied
      i. Thirty (30) days, but not more than 180 days shall pass after the appropriate sterilization consent was signed by patient or conservator
      ii. Elective sterilization shall be performed less than 30 days after the patient has signed the consent form only in the following circumstances:
         1) Private (pay status) patient voluntarily requests in writing that the 30-day waiting period be waived to no less than 72 hours
         2) The elective sterilization is performed at the time of emergency abdominal surgery or at the time of a premature delivery, AND the physician/Allied Health Professional certifies that informed consent was given and the sterilization consent form was signed at least 30 days before the intended date of sterilization and that at least 72 hours have actually passed since consent was given and the form was signed, and the physician/Allied Health Professionals describes the nature of the emergency, or indicates the prior expected delivery date on the sterilization consent form.

10. State regulations mandate special requirements for physician/Allied Health Professionals regarding informed consent for hysterectomies.
   a. The Authorization for and Consent to Hysterectomy shall be used to document these requirements.
      i. The Hysterectomy Consent form is needed <u>in addition to</u> the Consent for Operative or Other Procedures form.
   b. These regulations outline specific requirements for physician/Allied Health Professionals that must be documented in the medical record, including that the physician/Allied Health Professional must obtain "verbal and written" consent prior to the performance of the hysterectomy.
   c. The informed consent procedure by the physician/Allied Health Professional, shall provide that at least all of the following information is given to the patient verbally and in writing:
      i. Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the hysterectomy without affecting the right to future care or

treatment and without loss or withdrawal of any state or federally funded program benefits to which the individual might be otherwise entitled.

ii. A description of the type or types of surgery and other procedures involved in the proposed hysterectomy, and a description of any known available and appropriate alternatives to the hysterectomy itself.

iii. Advice that the hysterectomy procedure is considered to be irreversible, and that infertility will result if the patient is not already sterile or postmenopausal.

iv. A description of the discomforts and risks that may accompany or follow the performance of the procedure.

v. A description of the benefits or advantages that may be expected as a result of the hysterectomy.

vi. Approximate length of stay in the hospital.

vii. Approximate length of time for recovery.

viii. Financial cost to the patient of the physician/Allied Health Professional's and surgeon's fees.

11. A signed consent form is in effect until the patient changes his/her mind, or the physician/Allied Health Professional alters the nature of the procedure (in which case a new consent is required).

12. Consent for a medical emergency:
    a. In the case of a medical emergency where a procedure is immediately required and necessary to prevent deterioration or aggravation of the patient's condition, treatment may proceed without the patient's consent.
    b. The physician/Allied Health Professional must document the determination of the medical necessity in the medical record.
    c. The physician/Allied Health Professional does not sign the consent on behalf of the patient.
        i. The unsigned consent is maintained in the medical record.
        ii. TCHD personnel shall document on the consent "See progress notes dated _____ for physician/Allied Health Professional documentation of medical emergency indicating need to proceed with procedure."

13. Telephone/Facsimile/Email Consent
    a. Informed consent may be obtained by telephone, facsimile, or email when the person having the legal capability to consent for the patient is not otherwise available.
        i. TCHD staff must validate the person is authorized to give consent.
    b. When a telephone is used, the responsible physician/Allied Health Professional must provide the patient's legal representative with the same information as would be presented to the individual in person.
    c. Two individuals (either two TCHD staff personnel or the physician/Allied Health Professional and one TCHD staff member) must witness the consent conversation.
        i. The patient's legal representative must be informed the conversation is being witnessed.
        ii. The person(s) witnessing the conversation must sign and date documentation of the conversation on the Telephone Consent Form.
        iii. The telephone consent, with the signature of the two witnesses, is placed in the medical record.
    d. Physician/Allied Health Professional instructions may be telegraphed or emailed to the legal representative.
        i. In cases of electronically transmitted consent, the following occurs:
            1) Specific instructions regarding where the consent will be wired or emailed shall be provided by the person who is legally able to consent for the patient.
            2) Written confirmation proceeding the procedure and documentation of the patient's name, secured to the cover sheet if applicable, are maintained in the medical record.
    e. In cases of facsimile consent:
        i. Direct discussion with the legal representative giving consent must first occur.

ii. The legal representative may fax the consent after receiving full information regarding the procedure.

iii. The facsimile document(s), along with the cover sheet, is placed in the medical record.

1) Request the legal representative to send the original signed document to TCHD. This document is filed in the patient's medical record upon receipt.

14. Consent for an incompetent patient:

a. If a patient is incompetent or otherwise unable to give informed consent and does not have a conservator or holder of a durable power of attorney for healthcare decisions, the physician/Allied Health Professional may proceed by obtaining consent of the closest available relative.

b. The physician/Allied Health Professional must document in the medical record that there is no known conservator or durable power of attorney for healthcare and that the procedure is necessary.

c. If there is no relative available, and if the procedure is not an emergency, the Director of Risk Management is contacted to assist.

D. RELATED DOCUMENTS:

1. Patient Care Services Policy: Communication with the Sensory Impaired and/or Persons with Language Barriers
2. Patient Care Services Policy: Consent for Minors

E. REFERENCES:

1. Comprehensive Accreditation Manual, (2015), The Joint Commission
2. Health & Safety Code §1690 – 1691
3. California Code of Regulations (CCR) Title XXII §51305.6 & 70707.5
4. California Hospital Association Consent Manual

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**DIABETES EDUCATION AND DISCHARGE PLANNING**
Purpose:	To outline Nursing's responsibility for providing survival skill diabetes self-management education
Supportive Data:	American Diabetes Association (ADA), American Association of Diabetes Educators (AADE) guidelines and The Joint Commission Certification Compliance/Standards.
Supplies	Diabetes Patient Education Booklets, selected medication education leaflets, blood glucose meters with test strips.

A. **DIABETES EDUCATION**:

1. It is not necessary to obtain an order for Diabetes Education from the physician.
2. All patients **with diabetes** should be assessed for diabetes self-management deficits deemed to be survival skills by the Joint Commission's education compliance standards.
3. This includes patients who are newly diagnosed or patients who have a history of diabetes whether it is Type 1, Type 2, Gestational Diabetes, or pre-diabetes.
4. The required elements of education are all included in the Diabetes Patient Education Booklets.
5. The Tri-City Medical Center (TCMC) Type 1 Diabetes Booklet should be used for patients newly and previously diagnosed. Patients admitted with **diabetic ketoacidosis (**DKA**)** will most likely, though not always, fall into this category.
6. The TCMC Type 2 Diabetes Booklet should be used for patients newly and previously diagnosed with Type 2 Diabetes, pre-diabetes, and Gestational Diabetes.
7. Every patient admitted to TCMC as an inpatient is assessed by a Registered Dietitian (RD). Education on meal planning ~~is~~**may be** provided by the RD, **depending on the circumstances of admission to the hospital, e.g. DKA** ~~at a minimum, according to.~~ **T**the content in the Patient Diabetes Education Booklets **serves as the basis for meal planning education by the RDs**. This **same** content ~~can also be~~ **is used** ~~reinforced~~ by the Registered Nurse.
8. Each diabetic patient or at risk patient should have an A1c done on admission. **If the A1c is not done, obtain order from physician.**
   ~~a. The result should be written in the patient's booklet and documentation that the result was shared with the patient should be included on the Diabetes portion of the Education All Topics Ad Hoc form.~~
   ~~b.~~**a.** An A1c greater than 8% warrants a change in medication and/or better self-management.
9. The Interdisciplinary Plan of Care (IPOC) should include "Adult Diabetes Endocrine" from which all education elements can be accessed for documentation.
10. **All education is documented on the Education All Topics Ad Hoc Form or in IView.**

~~10. The Family Risk Assessment can be completed by using the Diabetes Risk Test written by the ADA and found in the education booklets.~~

B. **TEACHING SUPPLIES:**

1. Supplies should be obtained as soon after admission as possible so that there is enough time for learning
2. The Diabetes Education Booklets contain all of the topics required for teaching in an inpatient setting.
3. The Inpatient Diabetes Educator is available to all nursing staff for complex patient education and management. Examples include:
   a. Repeated hypoglycemic episodes
   b. Persistent hyperglycemia
   c. Patients with insulin pumps
   d. Patients with frequent readmissions
   e. Patients with learning difficulties

Department Review	Clinical Policies & Procedures	Nursing Executive Committee	Diabetes Task Force	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
2/06; 1/10; 2/13	1/06; 3/09; 2/10; 3/13, **10/16**	2/06; 5/09; 2/10;3/13, 10/16	12/16	**n/a**	2/06; 5/09;3/10; 1/14, **01/17**	3/06; 6/09; 4/10; 2/14	3/06; 6/09; 4/10;2/14

4. The Diabetes Task Force is a multidisciplinary committee that generally meets every other month. Diabetes care issues may be brought to this committee for discussion and resolution.

4.C. **DIABETES DISCHARGE PLANNING:**

1. **Prior to discharge, a diabetes care follow-up appointment is made with the provider who cares for the patient's diabetes.**
   a. **The appointment is documented in the electronic health record (EHR) including the provider, date and time.**
      i. **If unable to schedule an appointment document reason in EHR.**
2. **Outpatient Diabetes Self-Management Education classes are encouraged. Registration information is found in the Diabetes Education Booklets.**
3. **The A1c is shared with the patient and documented in EHR.**
4. **The Family Risk Assessment (found on the back cover of the Diabetes Education Booklets) is provided to the patient with an explanation that siblings and children of the patient assess their risk for diabetes.**
5. **Prescriptions for diabetes supplies should be written for patients as needed, especially patients who are newly diagnosed with diabetes. These include:**
   a. **Glucose meter, lancets, and strips**
   b. **Glucagon emergency kit if patient is prone to severe hypoglycemia**
   c. **Ketone test strips for patients admitted for dka**
   d. **Syringes and/or pen needles**

~~C. DIABETES EDUCATIONAL TOPICS:~~

~~1. Document any education provided to the patient/caregiver and/or family member regarding the patient's diabetes in the Diabetes section of the Education All Topics Powerform.~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 4/97	**SUBJECT:** ~~In-Custody Patients~~**Justice Involved Patients**
REVISION DATE: 10/99, 6/03, 8/05, 8/07, 4/12	**POLICY NUMBER:** VI.B.2

Department Approval:	**11/16**
Clinical Policies & Procedures Committee Approval:	**~~04/12~~12/16**
Nurse Executive Council Approval:	**~~10/12~~01/17**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~01/13~~01/17**
Professional Affairs Committee Approval:	**02/13**
Board of Directors Approval:	**02/13**

A. **PURPOSE**

1. To establish guidelines for the responsibility of patients who are **justice involved individuals**~~in-custody, prisoners~~ receiving medical care, and/or are admitted to Tri-City **Healthcare District**~~Medical Center~~ **(TCHD**~~MC~~**)**.

B. **DEFINITIONS**

1. **Law Enforcement Personnel**~~Custody Officer~~: Any Federal, State, or Local Peace Officer or **Correctional** ~~ustody~~ Officer or their contract agencies **that has the responsibility for the custody of justice involved individual**.
2. **Justice Involved Individual:** ~~Prisoner: a~~ **A**ny individual who is under lawful physical arrest and in the custody of a **Law Enforcement Officer** ~~Custody Officer~~ and brought to ~~Tri-City Medical Center~~**TCHD** to receive medical care, evaluation, treatment, or admission.

C. **POLICY**

1. Law Enforcement personnel, in consultation with ~~Tri-City Medical Center~~**TCHD** personnel, are responsible for considering issues related to the use of restraint for non-clinical purposes; imposition of disciplinary restrictions and the restriction of rights.
2. Law Enforcement shall be responsible for maintaining the security and the detention of any **justice involved individual** ~~prisoner~~ seen or admitted for medical care of the duration of the admission. The ~~Tri-City Medical Center~~**TCHD** Security Department shall be the contact liaison between the custodi**al**~~y~~ agency and the Medical Center. ~~Tri-City Medical Center~~**TCHD** Security Department personnel shall not assume any custodial duties as they relate to **justice involved individual**~~the prisoner~~.
3. The Admitting Physician is responsible for determining the **justice involved individuals**~~prisoner's~~ plan of care while in the Medical Center, including the length of stay for medical treatment, the discharge plan, and consulting with the **law enforcement** ~~custodial~~ agency in the continuing care and discharge plan.
4. Patient care shall be delivered to the **justice involved individual** ~~prisoner~~ as determined by the Clinical Staff, following the admitting Physician's orders and hospital or departmental standards of care, that also meets and respects security concerns and restrictions
5. ~~Tri-City Medical Center~~**TCHD** recognizes the American Civil Liberties Union and will ensure that **justice involved individuals**~~prisoners~~ receive adequate medical care while **admitted to** ~~TCMC~~**TCHD**.~~in custody.~~

6. Registration Department Responsibilities:
   a. The Registration Department shall notify Security (via **Private Branch Exchange (PROGRESSIVE CARE**PBX) when a~~n~~ **justice involved individual** ~~in-custody prisoner~~ is admitted to either the Emergency Department or the Medical Center with the following information:
      i. Patient Name
      ii. Location of ~~Prisoner~~ **justice involved individual**
      iii. **Law Enforcement** ~~Custodial~~ Agency responsible for patient
7. Security Department Personnel Responsibility:
   a. Security personnel shall:
      i. Contact the **Law Enforcement Officer**~~Custodial Officer~~ responsible for guarding the **justice involved individual**~~prisoner~~.
      ii. Establish communications.
      iii. Orient the **Law Enforcement** ~~Custodial~~ Officer using the "~~Forensic~~**Progressive Care** Service Training" form (attachment 1).
      iv. Obtain Custodial Officer's signature indicating they have read the "Forensic Services Training" form.
   b. Security shall liaison with the Assistant Nurse Manager (ANM) or designee and the Administrative Supervisor **(AS)** to verify that the proper measures are being used by the agency responsible for the **justice involved individual** ~~prisoner~~ as it relates to the safety, security, and welfare of all patients, visitors, and staff members.
   c. Any situation that puts the safety, security, and welfare of any patient, visitor, or staff member at risk shall be immediately reported to the Lead Security Officer on duty. The Lead Security Officer shall inform the Security Supervisor and Risk/Legal Services.
8. **Law Enforcement Officer** ~~Custodial Officer~~ Responsibilities:
   a. **Law Enforcement** ~~Custodial~~ Officers shall **maintain custodial**~~use forensic~~ restraints on the **justice involved individual** ~~prisoner~~ at all times, unless the medical condition or prescribed treatment indicates otherwise.
   b. Should **medical** restraints or seclusion of a **justice involved individual** ~~custody patient~~ for behavioral or medical issues become necessary, ~~Tri-City Medical Center~~**TCHD** policies shall be followed.
9. Security Supervisor Responsibilities:
   a. If the Lead Security Officer informs the Security Supervisor of a safety issue, the Security Supervisor shall contact the **law enforcement agency** ~~custodial agency~~ involved in the incident to resolve the issue.
   b. The Security Supervisor shall contact the **Administrator of the Law Enforcement agency** ~~custodial agency~~ responsible for the **Law Enforcement Officer**~~Custodial Officer~~ regarding any violation of this policy.
   c. The Security Supervisor shall maintain a file regarding the **involved Law Enforcement Officer** ~~Custodial Officer~~ and incident.

D. RELATED DOCUMENTS:

~~c.~~**1. Progressive Care Services Training**

Tri-City Medical Center

Forensic Services Training

"Custody Officer Orientation"

~~Attachment 1~~

1. **Medical Evaluation and Treatment:**
   The primary concern for ~~Tri-City Medical Center~~**TCHD**'s Clinical Staff is the proper treatment and care of the **justice involved individual** ~~prisoner~~ and the safety, security, and welfare of all ~~P~~patients, ~~V~~visitors, and **s**~~S~~taff **m**~~M~~embers.
2. **Custodial ~~Forensic~~ Restraints:**
   Law Enforcement ~~Custody~~ Officers are required to remain with the **justice involved patient** ~~prisoner~~ at all times while in the Medical Center. The **justice involved patients** ~~prisoner~~ must remain in **custodial** ~~forensic~~ restraints at all times and the **Law Enforcement** ~~Custody~~ Officer must have a key in his/her possession.
3. **Evacuation:**
   Medical Center personnel are familiar with the evacuation routes. In the event an evacuation becomes necessary, the **Law Enforcement** ~~Custody~~ Officer must remain with the **justice involved patients** ~~prisoner~~ at all times. ~~TCMC~~**TCHD**~~Medical Center~~ personnel shall direct you and the **justice involved patients** ~~prisoner~~ out of the Medical Center.
4. **Facility Orientation:**
   The Security Officer conducting this orientation shall show you where the restrooms, phones, and exits are located. Smoking is not permitted inside the Medical Center and only permitted in designated areas on the campus.
5. **Cell Phones:**
   The use of personal cell phones shall follow ~~TCMC~~TCHD policy as well as the Law Enforcement Agency
   Policy regarding use while on duty. Cell phones may not be used to photograph patients or any Individual including self without permission from ~~TCMC~~TCHD admistration.
6~~5~~. **Security Codes:**
   Internal and external disasters or security codes are communicated to Medical Center personnel by overhead paging using the below listed codes. -It is not necessary for the Custody Officer **Law Enforcement Officer** to respond in any way to a code unless directed by a ANM or designee, Security, or the Administrative Supervisor.

Code Blue:	Adult Arrest/Medical Emergency	Code Adam:	Infant Abduction
Code Pink:	Infant Arrest/Medical Emergency	Code Gray:	Hostage Situation
Code Yellow:	Radiation Disaster	Code Orange:	Internal/External Disaster
Code Green:	Oxygen Emergency	Code Red:	Fire
Dr. Strong:	Violent Person	Code Caleb:	Severely ill infant
Code OB	STAT Team Mobilization	Code Silver:	Active shooter situation

7~~6~~. **Phones:**
   To contact the operator in case of an emergency dial "66." Dial "80" and then "911" to contact the local police department in case of an emergency. Dial "80" for an outside line for non-emergency calls. Personal calls are not allowed. The **custodial Law Enforcment Officer** ~~Custody Officer~~ is required to call Security and notify them if the **justice involved patient**~~prisoner~~ is ~~moved~~ **transferred** within the Medical Center. To contact the operator, Administrative Supervisor, or Security, dial "0."
8~~7~~. **Relief:**
   The **custodial Law Enforcement** ~~Custody~~ Officer's agency is responsible for providing relief for the on-duty Officer. Medical Center staff, including Medical Center Security Officers, may not take custody of any prisoner. The on-duty **custodial Law Enforcement** ~~Custody~~ Officer must call the Security Department and have an Officer dispatched to your location to orientate the relief **custodial Law Enforcement** ~~Custody~~ Officer. Each **custodial Law Enforcement** ~~Custody~~ Officer shall be required to sign a copy of the "~~Forensic~~**Progressive Care** Services Training" form.
9~~8~~. **Patient Confidentiality:**
   In the course of medical treatment for the prisoner, the **custodial Law Enforcement** ~~Custody~~ Officer may become aware of the **justice involved patient's** ~~prisoner's~~ personal history, medical history, diagnosis, and treatment plan. This information is confidential and may not be shared with anyone

including the **Law Enforcement** ~~Custody~~ Officer's agency. Violations of the justice involved individual's confidential information could result in legal action.

I certify that I have read and understand the above requirements and that I have received a copy of this document for my records.

Signature	Print Name	Date
Agency Name	Patient Name	Room Number

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**KNEE IMMOBILIZER APPLICATION AND RANGE OF MOTION (ROM) BRACE**
Purpose:	To outline the nursing responsibilities in the application of knee immobilizer.
Supportive Data:	Knee immobilizers provide support to prevent knee flexion. Requires a physician order.
Equipment:	Knee immobilizer/universal knee splint; ROM brace.

A. **KNEE IMMOBLIZER:**

1. Assess neurovascular status and skin integrity of patient pre and post application of splint and ongoing. (**ie. ~~M~~minimum every 4 hours or per physician orders.)
2. Place leg inside immobilizer with posterior fossa resting in posterior panel so that when the immobilizer is secured, the patella is visible. **It is not necessary for the patella strap to ~~may not~~ fasten.**
3. ~~Close anterior panel over medial panel.~~
4. **3.** ~~Run~~ **Apply** Velcro straps through metal loops ~~and then secure~~**snugly,** ~~Velcro straps should not be so tight as to~~ **but not** restrict**ing** venous flow.
5. **4.** Record neurovascular assessment, application of immobilizer/splint, and patient's tolerance in the medical record.

B. **RANGE OF MOTION (ROM) BRACE:**

1. Assess neurovascular status and skin integrity of patient pre and post application of brace. (**ie.** ~~Minimum~~ **minimum** every 4 hours or per physician orders.)
2. Set dial for extension and flexion per physician order.
3. Open brace and place under leg. Line padding up for lower and upper sections of leg and making sure that circular padding lines up with knee joint, using popliteal fossa as a point of reference.
4. Close ~~up~~ padding with Velcro.
5. Apply Velcro straps snugly, but not restricting venous flow.
6. Record neurovascular assessment, application of brace, and patient's tolerance in the medical record.

C. **REFERENCES:**

1. ~~W.B. Saunders Co. (2004). Orthopedic nursing, 4th ed.~~**National Association of Orthopaedic Nurses (NAON): Core Curriculum for Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.**
2. **NAON: Scope and Standards of Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.**

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Division of Orthopedics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
11/93, 01/11	02/11, **11/15**	03/11, **12/15**	**05/16**	04/11, **10/16**	05/11	12/93, 5/00, 6/00, 7/03, 1/06, 6/08, 05/11

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**SWALLOW SCREENING IN THE ADULT PATIENT**
Purpose:	To screen for appropriateness of oral intake.
Supportive Data:	The swallow screen is performed on any **medically stable** patient who is at risk for aspiration secondary to the inability to swallow safely. This includes the nursing assessment of patient alertness, respiratory status, secretion management, voice quality and an effective cough. Oral intake is contraindicated if any of the above are compromised. This would constitute failure of the swallow screen.

A. **PROCEDURE:**

1. **Prior to 3 Ounce Water Protocol check patient's ability to swallow by giving the patient a teaspoon of water and assess for laryngeal movement, clear vocal quality, coughing, choking, or throat clearing during swallowing up to one minute. If able to swallow without difficulty proceed to 3 Ounce Water Protocol.**

~~A.~~**2. 3 Ounce Water Protocol:**

- **a. Observe patient.**
  - **i. If patient is not alert then make patient NPO until alert and then screen the patient.**
  - **~~i.~~ii. If patient is alert, face is symmetrical, and tolerating their own secretions, proceed with swallow screen.**
    - **1) Sit patient upright.**
    - **2) Ask patient to drink entire 3 ounces (90 mL) of water from a cup or through a straw in sequential swallows without stopping.**
    - **3) Assess patient for coughing, choking, or throat clearing during swallowing and up to one minute after drinking.**
- b. **Results**
  - **i. Pass: Able to drink 3-ounces of water sequentially without overt signs or symptoms of aspiration.**
  - **ii. Fail: Inability to drink the entire amount sequentially or demonstration of coughing or choking during trial.**

3. **If patient passes protocol, diet per physician/Allied Health Professional's order**
4. **If patient fails protocol:**
   - **i. Keep NPO, notify the physician as needed**
   - **ii. Obtain order for Swallow Evaluation by Speech Pathologist as needed**

~~2.~~**5. Document results in electronic health record under Swallow Screen**

B. **REFERENCES:**

1. **Suiter DM, Leder SB, Karas DE. The 3 ounce (90 cc) water swallow challenge: A screening test for children with suspected oropharyngeal dysphagia. Otolarygology Head & Neck Surgery 2009;140:187-190.**

~~3.~~**2. Suiter DB, Leder SB. Clinical utility of the 3 ounce water swallow test. Dysphagia 2008; 23:244-250**

3. **Suitor, D. S., Sloggy, J., & Leder, S.B. (2014). Validation of the Yale Swallow Protocol: A Prospective Double-Blinded Videofluoroscopic Study. *Dysphagia*, 199-203.**

~~**LOOK** Observe patient. If patient is not alert then make patient NPO until alert and then screen patient. If patient is alert, face is symmetrical, and tolerating their own secretions, proceed to **LISTEN**. If patient fails **STOP** assessment and proceed to At Risk Section of the Swallowing Screening Results Table.~~

~~**LISTEN** Have the patient say "ahhh" and hold the sound for a count of three. If patient's voice sounds clear, proceed to **FEEL**. If patient coughs, sounds wet or gurgly **STOP** assessment and proceed to At Risk Section of the Swallowing Screening Results Table.~~

Revision Dates	Clinical Policies & Procedures	Nurse Executive Council	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/06, 7/09, 1/12, 10/16	09/11, 4/15, 11/16	10/11; 4/15, **01/17**	n/a	n/a	11/11; 05/15, **01/17**	1/12; 06/15	6/15

~~FEEL~~ ~~Feel for movement of the larynx by placing the tips of the fingers vertically on the front of the throat. If you feel a strong and timely vertical movement of the larynx, then proceed to Safe Section of the Swallowing Screening Results Table. If patient fails, **STOP** assessment and proceed to Swallowing Screening Results Table.~~

~~SWALLOWING SCREENING RESULTS TABLE~~	
~~AT RISK – Screening Failed~~	**~~SAFE – Screening Passed~~**
~~If the patient is unable to pass any of the above steps:~~	~~If the patient is able to perform **all** of the above steps:~~
~~• **DO NOT** give any oral intake, including oral medication. Make patient NPO for 24 hours or until Swallow Evaluation is ordered and performed by Speech Pathologist.~~ ~~• Document **FAIL** in Cerner under Swallow Screen.~~	~~• Give patient sips of water without a straw.~~ ~~• Look, Listen and Feel as above.~~ ~~• If patient coughs, sounds gurgly or wet in response to water then document as **FAIL** in Cerner under Swallow Screen.~~ ~~• If patient passes, document **PASS** in Cerner under Swallow Screen, then resume diet per physician's orders.~~ ~~• Proceed with oral medications.~~ ~~• Supervise the patient's initial attempts of eating and drinking.~~

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 12/01 **SUBJECT: ADMINISTRATOR ON CALL**

REVISION DATE: 11/02, 8/03, 3/06; 02/09; 03/11; 11/13 **POLICY NUMBER:** 8610-281

Department Approval:	**01/17**
Administrative Policies & Procedures Committee Approval:	**~~11/13~~01/17**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**04/14**
Board of Directors Approval:	**04/14**

A. **PURPOSE:**

1. To provide a process of administrative oversight and direction to ensure effectiveness of service continues during off hours (after business hours, weekends and holidays).

B. **DEFINITIONS:**

1. Administrator on Call: The Chief Operating Officer (COO), Chief Nurse Executive (CNE) and Chief Financial Officer (CFO) and Senior **Leaders**~~Directors of Clinical Areas~~ are assigned on a rotational basis to provide administrative oversight and direction.
2. Administrative Supervisor: The Administrative Supervisor on duty is responsible to the Directors **and Managers** for the management of patient care activities and hospital operations on their assigned shift. They have authority to act in the absence of the Chief Nurse Executive, Directors, and Nurse Managers.

C. **POLICY:**

1. The Administrator on Call (AOC) rotates weekly amongst the Senior Team.
2. The Administrative Supervisor will report any Level IV (Sentinel) occurrence/incident or significant patient care, risk management or operational issues to the Administrator on Call. Types of occurrences/incidents that are reportable to the Administrator on Call are:
   a. Any occurrence requiring reporting to the California Department of Public Health per Administrative Policy **Mandatory Reporting Requirements** #236
   b. Significant risk management issues
   c. Significant physician, staff or operational issues
   d. Implementation of Hospital Incident Command System (HICS)
   e. Media contacts or potential media reportable events
   f. Non-availability of inpatient beds
3. All reported occurrences will include the following information in the Administrative Supervisor report:
   a. Brief description of event
   b. Individuals involved
   c. Action Plan (current and proposed)
   d. Impact on Organization or Outcome (current and potential)
   e. Communication Status
   f. Requested Assistance
      i. None Necessary
      ii. Approval
      iii. Plan Modification

D. **RELATED DOCUMENTS:**

1. **Administrative Policy: Policy Mandatory Reporting Requirements #236**

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 7/76 **SUBJECT: Lost and Found Articles**

REVISION DATE: 4/89; 6/94; 10/99; 9/00; 9/02; 6/03; 2/06; 01/09; 02/11 **POLICY NUMBER:** 8610-202

Department Approval:	**01/17**
Administrative Policies & Procedures Committee Approval:	**~~01/14~~01/17**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**02/14**
Board of Directors Approval:	**02/14**

A. **PURPOSE:**

1. The Lost and Found service provided by Security and the Patient Representative Office provides a method for returning lost or misplaced articles to their proper owners and/or reimbursement, if applicable.

B. **DEFINITIONS:**

1. Items of Value: Money, Credit Cards (to be destroyed after 90 days), jewelry, and watches.

C. **POLICY:**

1. Lost or misplaced items shall be promptly returned to their rightful owners.

D. **PROCESS:**

1. When an article is found, a reasonable effort is made to determine its ownership immediately, and, whenever possible, to return the article to its rightful owner. If this is not possible, the person who found the article must attach a Tri-City Healthcare District (TCHD) "Found Property Slip" and take directly to the Lost and Found or Security. Call Security and someone will meet you to receive the item. "Found Property Slips" may be obtained from Security. NOTE: The loss of hearing aids, dentures and glasses will be reported directly to the Patients' Representative.
2. If the owner is a patient who has been discharged, a representative from the Nursing Unit where the article was found will contact the patient or his/her family and ask him/her to claim the article in the Lost and Found section of Security. The time and date of the contact, the name of the person contacted, and the person making the call, is to be recorded and provided to Security. The article may not be held on the unit, but forwarded immediately to Security.
3. The article is to be forwarded by placing it in a container labeled with the name of the person who found the article, the patient's name, address, room number, contents of container, and recorded notes of contact with patient or family on the TCHD "Found Property Slip." A notation should also be made on the patient's medical record in Clinical Notes.
4. Items found in areas other than patient rooms, which cannot be returned to the owners (or ownership cannot be determined), are to be placed in a container and labeled with a TCHD "Found Property Slip", indicating where the item was found, the time and date of discovery, the name of the person who found the article, and the contents of the container and sent to Lost and Found.
5. Upon receipt of lost items Security will:
   a. Place all items deemed to be of value in the ~~Patient Business Services~~ **Security** Office safe until claimed. If unclaimed after 90 days, the item is to be donated to an approved charitable organization.
   b. Give all other items an identification number and properly log into the Lost and Found Control Binder.
   c. Attempt to identify ownership, then contact owner.

~~d.~~**6.** **The Patient Representative will** ~~M~~mail identified articles to owners who are unable to come to the hospital. Mail certified, return receipt. ~~When receipt is returned to TCHD, it is to be scanned to patient's electronic record.~~

~~e.~~**a.** After a period of 90 days all unclaimed items will be donated to a charity as determined by Administration and allowed by law.

~~6.~~**7.** Anyone who has lost articles may contact Security **through**~~by calling~~ **the** PBX operator.~~ and have operator connect you to Lost and Found~~.

~~7.~~**8.** Reports of lost articles that cannot be found are to be referred to the Patient Representative's Office via phone, with follow-up in writing for investigational purposes and information with description and contact information placed in the Lost and Found Inquiry book.

~~8.~~**9.** If an investigation concludes a hospital representative is responsible for a lost/damaged article, and reimbursement by the Organization is appropriate, a check request and a copy of the investigation **General Release of All Claims Form (from the patient)** will be submitted by the Patient Representative Office to the Director of Risk Management.

~~9.~~**10.** The Director of Risk Management will obtain the signature of the proper administrator.~~ if needed; otherwise, he/she will sign the check request.~~ The Patient Representative will obtain the cost center location for charging purposes. **The check request will be forwarded to AP in Accounting.**

~~10.~~**11.** ~~The Director of Risk Management will forward the check request to the Patient Representative, who will send it to the Accounting Department.~~**When the check is issued Accounting emails the Patient Representative the date, the check number and the amount. Accounting sends out the check to the patient/family member or the professional who is preparing the replacement articles (for example: new dentures or hearing aid).**

~~11.~~**12.** ~~Accounting will approve and return to Patient Representative for distribution.~~**The original forms will be filed along with the check information to the Patient Relations Specialist and into the Complaint Resolution file.**

13. ~~The original forms will be filed in the Patient Representative office.~~

E. RELATED DOCUMENT(S):

~~12.~~**1. General Release of All Claims Form Sample**

General Release of All Claims Form Sample

The undersigned, being over the age of eighteen, for the sole consideration for waiving events that occurred on or about date:_____ with a value in the amount of _____($00.00) by TRI-CITY HEALTHCARE DISTRICT (hereinafter referred to as the "RELEASEE") do/does hereby and for my/our/its heirs, executors, administrators, successors and assigns release, acquit and forever discharge the RELEASEE, their agents, servants, successors, heirs, executors, administrators and all other persons, firms, corporations, associations or partnerships of and from any and all claims, actions, causes of action, demands, rights, damages, costs, loss of service, expenses and compensation whatsoever, which the undersigned now has or which may hereafter accrue on account of or in any way growing out of any and all known and unknown, foreseen and unforeseen bodily and personal injuries and/or property damage or loss and the consequences thereof resulting.

It is understood and agreed that this settlement is the compromise of doubtful and disputed claims, and that the payment made is not to be construed as an admission of liability on the part of the RELEASEE. The RELEASEE specifically denies liability therefor and intends merely to avoid litigation and buy its peace. It is further understood and agreed that this Release in Full of All Claims and the write off herein acknowledged shall be held in confidence and that the undersigned and his/her attorneys will not publicize, publish, disclose, talk about, or promote the publication or disclosure of the facts or terms of this Release in Full of All Claims or the payment/write off here acknowledged to any person not a party to this Release of All Claims.

It is further understood and agreed that all rights under Section 1542 of the *Civil Code of California* and any similar law of any state or territory of the United States are hereby expressly waived. Section 1542 reads as follows:

> **"Section 1542. [Certain claims not affected by general RELEASE.]** ***A general release does not extend to a claim which the creditor does not know or suspect to exist in its favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor."***

The Undersigned hereby declares and agrees that they rely only upon their own judgment, belief and knowledge of the nature, extent, effect and duration of said damages and liability. This RELEASE is made without reliance upon any statement or representation of the RELEASEE or its/their representatives or by any party or person employed by it/them.

The Undersigned further declares and represents that no promise, inducement or agreement not herein expressed has been made to the Undersigned, and that this RELEASE contains the entire agreement between the parties hereto and that the terms of this RELEASE are contractual and not a mere recital.

The Undersigned has been advised by the RELEASEE of the right to have this RELEASE reviewed by counsel and has either voluntarily chosen not to seek counsel or the Undersigned have been represented by counsel of their own choosing and have relied only upon the advice and counsel of their attorney.

The Undersigned has read the foregoing RELEASE and fully understands it.

CAUTION: READ BEFORE SIGNING BELOW

I declare under penalty of perjury according to the laws of the state of California that the forgoing is true and correct.

Signed this _____date. Print or Type Name: _____:

Signature:_____

FOR YOUR PROTECTION CALIFORNIA LAW
REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM:

ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

SUBJECT: **Prion Diseases: Transmissible Spongiform Encephalopathies (TSE) such as: Creutzfeldt-Jakob disease (CJD) and Variant (vCJD), Gerstmann-Sträussler-Scheinker Syndrome (GSS), Kuru, Fatal Insomnia, or Bovine Spongiform Encephalopathy (BSE or Mad Cow disease)**

ISSUE DATE: **01/03**
REVISION DATE: **01/09** ~~**POLICY NUMBER: IC.6.5**~~

Department Approval:	**03/16**
Infection Control Committee Approval:	~~**1/12**~~**03/16**
Medical Executive Committee Approval:	~~**2/12**~~**01/17**
Professional Affairs Committee Approval:	
Board of Directors Approval:	~~**2/12**~~

A. **INTRODUCTION:**

1. **Prion diseases, or transmissible spongiform encephalopathies (TSE's) are a family of rare progressive neurodegenerative disorders that affect both humans and animals. They are distinguished by long incubation periods, characteristic spongiform changes associated with neuronal loss, and a failure to induce inflammatory response. The causative agents of TSE's are believed to be prions. The term "prions" refers to abnormal, pathogenic agents that are transmissible and are able to induce abnormal folding of specific normal cellular proteins called prion proteins that are found most abundantly in the brain. This abnormal folding of the prion proteins leads to progressive degenerative brain and nervous system damage. Prion diseases are usually rapid progressive and always fatal. Examples of Human Prion Diseases: Creutzfeldt-Jacob Disease (CJD), Variant Creutzfeldt-Jakob Disease (vCJD), Gerstmann-Straussler-Scheinher Syndrome, Fatal Familial Insomnia, and Kuru. Examples of Animal Prion Diseases: Bovine Spongiform Encephalopathy (BSE or Mad Cow Disease), Chronic Wasting Disease, and Scrapie.** ~~Transmissible spongiform encephalopathies (TSEs), also known as prion diseases, are degenerative brain diseases. They are invariably fatal and there is no proven treatment or prophylaxis. TSEs are characterized by microscopic vacuoles and the deposition of amyloid (prion) protein in the grey matter of the brain. Examples include: Kuru, Gerstemenn-Straussler-Scheinder (GSS), Fatal familial insomnia, and Creutzfeldt-Jakob (CJD, the most common prion disease).~~
2. **Prion diseases** ~~TSEs~~ are not known to spread **by contact from** ~~by contact from~~ person to person. **In the healthcare setting, risk of transmission to patients has been associated with direct contact with infectious tissues (See B.76. Tissue Infectivity). Contaminated surgical equipment or implantation of electrodes deep in the brain can also transmit infectious prions from one patient to another.** ~~I~~Transmission has occurred during invasive medical interventions (two confirmed and four unconfirmed cases) after contaminated medical equipment was not properly cleaned before use on another person.
3. **The prions that cause TSE's exhibit an unusual resistance to conventional chemical and physical decontamination methods. The infectious agents that transmit prion diseases are resistant to inactivation by heat and chemicals, and therefore require special biosafety precautions. Incineration is the preferred method for all instruments exposed to high infectivity tissues.** ~~The disease has been transmitted by depth electrodes (inserted in the brain) used for another patient; injected pooled pituitary hormones (growth hormone and gonadotropin); and transplanted infected corneal, dura mater, and pericardium tissues.~~

4. **Prion diseases are transmissible by inoculation or ingestion of infected tissues.** A new variant CJD has been linked to eating contaminated beef, elk or deer meat.
5. Symptoms include an insidious onset of confusion, progressive dementia, variable ataxia, **seizures, visual or sensory deficits, and rapid mental deterioration**- in patients' aged 16+, most frequently between 40 and 70 years old. Incubation period ranges from 15 months to more than 30 years, **usually fatal within 1 year after diagnosis.**~~.~~
6. The most common form, sporadic Creutzfeldt-Jakob disease (CJD), has a worldwide death rate of about 1 case per million people each year.

B. **PATIENT CARE:**

1. Normal social and patient contact, and non-invasive procedures with TSE patients do not present a risk to healthcare workers, relatives, other patients or visitors.
2. **Standard precautions should be used for all known or suspected cases.**~~Apply Standard Precautions.~~
~~2.~~**3.** **It is very important that patients who are known or suspected to have prion disease be identified before any surgical procedure involving tissues that may be infectious.**
~~3.~~**4.** Patients with TSEs must not donate organs, **tissues, or blood components.**~~.~~
~~4.~~**5.** TSE is not known to be transmitted from mother to child during pregnancy or childbirth.
~~5.~~**6.** To prevent the transmission, it is important to consider: (1) the probability that an individual has or will develop TSE, (2) the level of infectivity in tissues or fluids, and (3) the nature or route of the exposure. **Risk assessment and prevention of exposure through the use of personal protective equipment and disposable equipment are the best means to reduce any risk of transmission in the healthcare setting** [Assignment of different organs and tissues to categories of high and low infectivity is chiefly based upon the frequency with which infectivity has been detectable, rather than upon quantitative assays of the level of infectivity, for which data are incomplete.]
~~6.~~**7.** Tissue infectivity.

a.	Highly infective tissues	~~Highest concentration in~~ **B**~~b~~rain, spinal cord & eye
b.	Low infective tissues	**Cerebral spinal fluid, l**~~L~~ung, liver, kidney, spleen/lymph nodes, and placenta
c.	Not infective	Heart, skeletal muscle, peripheral nerve, adipose tissue, gingival tissue, intestine, adrenal gland, thyroid, prostate, testis) or in blood, bodily secretions or excretions (urine, feces, saliva, mucous, semen, milk, tears, sweat, serous exudates).

~~7.~~**8.** Route of exposure

a.	Very serious risk	CNS exposures (i.e. inoculation of the eye or CNS)
b.	Greater potential risk	Transcutaneous exposures: cut or puncture by a contaminated sharp instrument or contact with the mucus membrane of the eye
c.	Negligible risk	Cutaneous exposure of intact skin or mucous membranes, except those of the eye

C. **DIAGNOSTIC AND SURGICAL PROCEDURES**

1. All non-emergent brain biopsy procedures and neurosurgical and neuroophthalmology procedures are screened by the schedulers in Surgery Services or Interventional Radiology (See Appendix A). If **the brain biopsy is for any reason OTHER than tumor, or if** TSE is suspected, notify the departments listed on the screening tool so that planning can be made for instrument handling, storage, cleaning and decontamination or disposal.
   a. See Appendix B for Instrument Handling algorithm and Controlling TSE Agent Transmission Table on pages 6,7,~~ and~~ 8**, and 9** for details. Clinical Laboratory stores 1 Molar sodium hydroxide.
   b. All known cases and cases that meet the case definition of suspect Transmissible Spongiform Encephalopathies will be performed with disposable instruments whenever

possible.

c. Procedures that are normally carried out at the bedside (e.g. lumbar puncture) may be performed at the bedside. Use a chux at the site to contain a potential spill of infective material.

d. Alert the laboratory and clearly label all specimens. Place specimens in formalin as usual.

2. Dental Procedures: general infection control practices recommended by national dental associations are sufficient when treating TSE patients during procedures not involving neurovascular tissue. The following are precautions for major dental work:
   a. Use single-use items and equipment e.g. needles and anesthetic cartridges.
   b. Re-usable dental broaches and burrs that may have become contaminated with neurovascular tissue should be destroyed after use by incineration or decontaminated by a method listed on Controlling TSE Agent Transmission Table on pages 6, 7, ~~and~~ 8, **and 9** for details.
   c. Schedule procedures involving neurovascular tissue at end of day to permit more extensive cleaning and decontamination.
3. If reusable instrumentation must be used keep instruments and other devices moist between the time of exposure to infectious materials and subsequent decontamination and cleaning. See Appendix B for Instrument Handling algorithm and Controlling TSE Agent Transmission Table on pages 6,7, ~~and~~ 8, **and 9** for details.
   a. Remove bio-burden from reusable instruments while wearing a face shield or goggles and surgical mask and double glove. Instruments are then placed in a flash pan for processing as close as possible to the room where the procedure was performed. Autoclave for 18 minutes at 134° C.
   b. If the procedure was performed in another department (for example a brain biopsy in the CT Scan) call **Sterile Processing Department** ~~the OR charge nurse~~ for assistance with autoclaving.
   c. After autoclaving place instruments in a robust, leak-proof container labeled "Incinerate Only". This box will be placed and remain in ~~the SPD Manager's Office~~**a designated locked area**.
      i. If the laboratory result is negative, all items can be returned to the decontamination area and reprocesses as normal.
      ii. If the laboratory result confirms a Transmissible Spongiform Encephalopathy, the instruments ~~are incinerated~~**will be sent out for incineration**.
4. See unit specific policies for safety in the Clinical Laboratory.
5. Occupational exposure
   a. There have been no confirmed cases of occupational transmission of TSE to humans. Report any occupational exposure to blood, body fluids, or other potentially infectious materials to your supervisor and go to Emergency Room for assistance.

~~6.~~**b.**

D. RELATED DOCUMENTS:

1. **Infection Control Manual: Bloodborne Exposure Control Plan**
2. **Infection Control Manual Standard and Transmission Based Precautions**
3. **Employee Health Services Policies: AP&P #401 Injury Prevention Program**
4. **Tri-City Medical Center Laboratory Procedure: The Handling of Tissues of Patients with Transmissble Spongiform Encephalopathies (TSE) including Creutzfeld-Jakob Disease**

~~D.~~E. REFERENCES:

1. www.who.int/emc WHO Infection Control Guidelines for Transmissible Spongiform Encephalopathies. (1999)

2. ~~Macmillan, S~~**Kavanagh, B.** (**2014**~~2000~~) Creutzfeldt-Jakob disease and other **Prion Diseases**~~prions~~. **In P. Grota (Ed.),** *APIC Text of Infection Control and Epidemiology* ***4th Ed.***, ~~10~~**873**:1-1~~40~~**.**

~~3. Olmsted, R, ed. (1996) APIC Infection Control and Applied Epidemiology: principles and practice. St. Louis: Mosby.~~

3. Karasin, M. (2014, October). Special Needs Populations: Perioperative Care of the Patient with Creutzfeldt-Jakob Disease. Vol 100, No 4.

4. Steelman, V.M. (1994) Creutzfeld-Jakob Disease: recommendations for infection control. American Journal of Infection Control, 22(5): 312-318.

5. Brown, P., Wolff, A., Gajdusek, D.C. (1990) A simple and effective method for inactivating virus infectivity in formalin-fixed tissue samples from patients with CJD. Neurology, 40: 887-890

~~5.~~**6. Rutula, W., and Weber, D. (2010, February). SHEA Guideline: Guideline for Disinfection and Sterilization of Prion-Contaminated Medical Instruments.** ***Infection Control and Hospital Epidemiology*****, Vol 31, No.2, 107-117.**

~~6. Bloodborne Exposure Control Plan IC. 11~~

~~7. Standard and Transmission Based Precautions IC.5~~

~~8. Employee Health Services Policies~~

~~9. AP&P #401 Injury Prevention Program~~

Neurosurgery Transmissible Spongiform Encephalopathies Screening Tool

This information is required when scheduling any patient for non-emergent craniotomy or brain biopsy to identify potential Creutzfeldt-Jakob Disease (CJD), Bovine Spongiform Encephalopathy (BSE), Gerstemenn-Straussler-Scheinder Syndrome (GSS), Kuru, or Fatal Insomnia

	Circle One	
1. Does the patient present with symptoms of TSE (rapidly progressive dementia, cerebella symptoms, spasticity or hyper-reflexia, EEG with periodic sharp-wave complexes, rapid cerebral atrophy on CT scan)?	Yes	No
2. Does the patient have a family history of CJD or CJD-like fatal illness?	Yes	No
3. Is the patient being scheduled for craniotomy or brain biopsy when diagnosis is unknown or uncertain (no specific lesion identified by imaging procedures)?	Yes	No
4. Is the biopsy for the diagnosis of dementia or encephalitis?	**Yes**	**No**

Patient Name_____ Today's Date_____

Surgeon providing the screening information_____

Office personnel providing the screening information_____

Print name of scheduler taking the Information_____

A "No" answer may be scheduled as usual. ~~File this form in the scheduling department for at least 7 years.~~

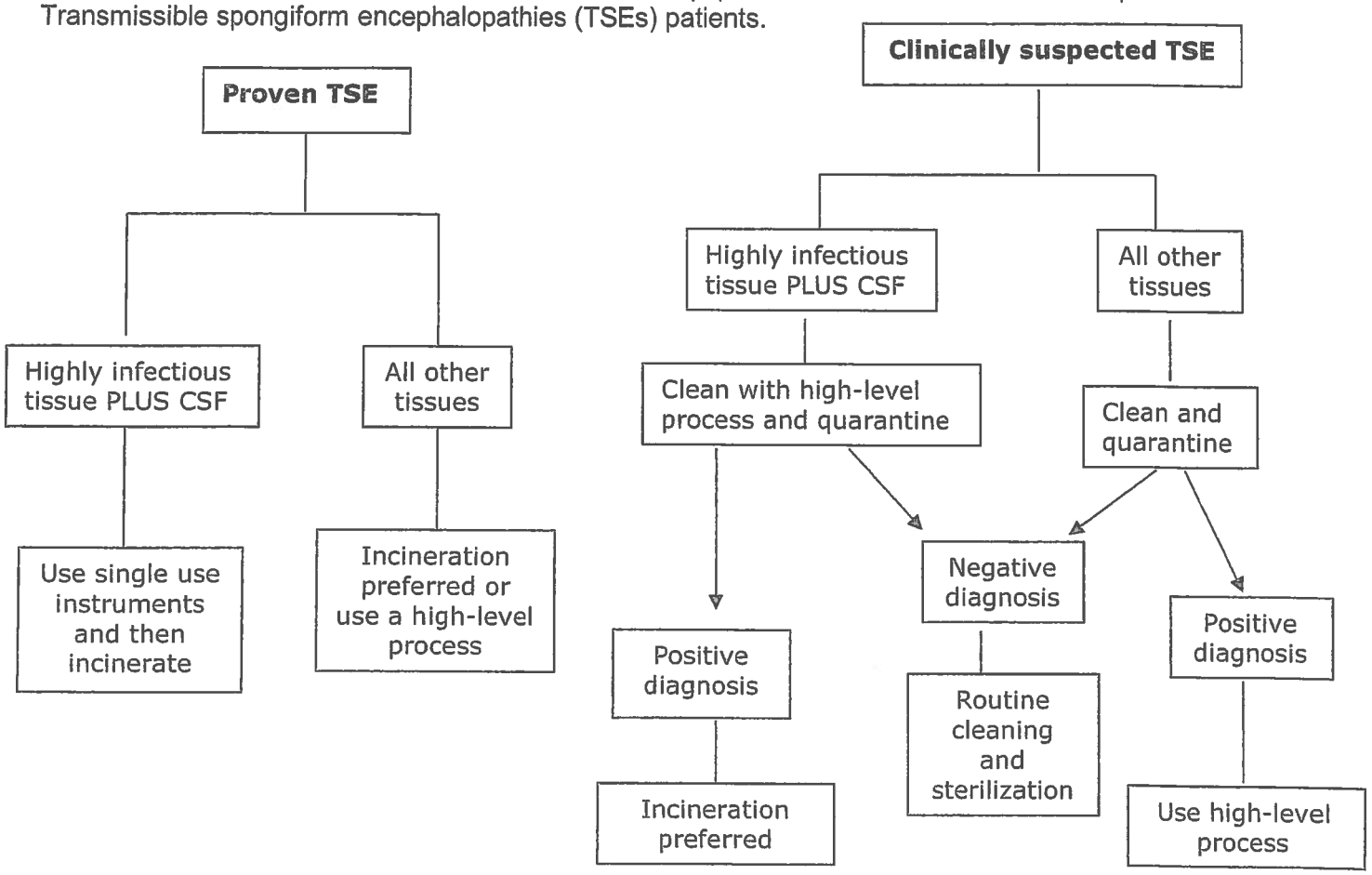
A "Yes" answer to one of these questions means the patient meets the case definition of suspect Transmissible Spongiform Encephalopathies. Call the following services below to report and reference the policy in the Infection Control Manual, ~~IC 6.4~~ Transmissible Spongiform Encephalopathies. ~~When complete, file this form in the scheduling department for at least 7 years.~~

Service	Phone Number	Message left	Spoke with (name of person) and Comments
Neuro-Speciality Coordinator	5400		
Environmental Services	7295		
SPD Ops Manager	7338		
Histology Supervisor	7914		
Infection Control	~~3007~~**7410 or 5696**		
Pharmacy	3012		

Instrument Handling Algorithm

Appendix B

Decontamination and disposition of instruments and equipment used with confirmed or suspected Transmissible spongiform encephalopathies (TSEs) patients.



Diagnosis	Procedures	Method and product/devices	Comments
Sporadic CJD; suspected TSE; at risk for CJD asymptomatic; (hormone recipient, dura mater transplant, familial CJD in a first degree relative).	1. Noninvasive procedures 2. Care after death, no postmortem performed 3. Employee sharps injury	1. Use standard cleaning, regular laundering, and routine waste handling. 2. Embalming is acceptable. 3. Gently encourage site to bleed, wash with warm soapy water, rinse, and cover with a waterproof bandage.	1. There is no epidemiological evidence that normal contact presents a risk to health care providers. Procedures involving high-risk tissue or fluid, e.g., brain, spinal cord, pituitary, dura mater, retina, and cornea, require use of disposal aprons/gowns, gloves and single-use instruments/equipment. See next section. 2. Refer to special handling of tissue and special handling of the body after pathology procedures and postmortem. 3. Document all incidents. Maintain all files in the Employee Health dept.

Controlling TSE Agent Transmission in the Hospital

Diagnosis	Equipment used for neurosurgery (brain, spinal cord, dura, pituitary, neuroophthalmology)	Other nondisposable equipment		
Known TSE	• Where possible, avoid performing OR procedure. • If procedure must take place, book case at the end of the day. • The surgeon is to alert Surgery or Interventional Radiology when scheduling procedures. Schedulers are to notify the departments listed on the Neurosurgery Transmissible Spongiform Encephalopathies Screening Tool. • Use dedicated sterile equipment or equipment nearing "end-of-life use" where possible. • Use disposable OR packs, gowns, drapes. • Use nonelectrical (mechanical) hand saws/drills. • Incinerate disposable supplies when procedure is complete. Suction wastewater and treat container with Premicide prior to placing in "Incinerate Only" box. 1. During procedure, use a damp cloth OR sponge-superficial wiping method to keep items clear of debris. Avoid excess handling of instruments. 2. At the end of the procedure, place all disposables in an "Incinerate Only" box and call the waste management vendor for disposal. Do not put any instruments from this case in contact with reusable containers.	• Cover nondisposable power equipment that must be used with plastic drapes. • Avoid touching surfaces with gloves, which have been in contact with brain, spinal cord and adjacent tissue. If in doubt, change gloves. • Keep the least amount of equipment in the room. • Completely isolate/drape anesthetic/respiratory equipment near the patient's head to prevent accidental splatter or contamination of the equipment.	Steps, OR Room: 1. Use damp cloth/sponge, superficial cleaning method ~~(1 molar sodium hydroxide (NaOH) per gal. water)~~**2 N NaOH undiluted** for surfaces in the OR. 2. At end of case, place cleaning cloths in an "Incinerate Only" box. 3. Chemical disinfection - **2 N NaOH undiluted**~~1 Molar NaOH per gal. water~~, disassembled equipment, completely submerged, or continuously wet for 60 min. Rinse in water and wipe dry. 4. Confine and contain all effluent for incineration. Treat with Premicide to solidify waste for ease of handling 5. Manual clean instruments in OR area while wearing full face shield or mask and goggles. 6. Steam autoclave reusable items for 18 min. at 134 C; use an open container in a prevaccum sterilizer. 6. Place in an "Incinerate Only" box and transport to SPD for quarantine in the ~~Manager's Office~~**in a designated locked area.**	• Consult with Sterile Processing Department (SPD) for supply and use of equipment nearing end-of-life use. (NaOH is highly corrosive). • Cases booked at the end of the day allow for surface decontamination of "touch surfaces" at end of the case with noxious agents (~~1 Molar NaOH for 60 min continuous wetting~~ **2 N NaOH undiluted for one hour and rinsed with water, non-critical patient care items and surfaces).** • 2.5% sodium hypochlorite has been inconsistent in killing the scrapie agent. • Tissue dried on instruments, which have not been inactivated first by NaOH, may have a protective effect on the TSE agent and render the autoclave process ineffective. Keep instruments moist until decontamination occurs.

Controlling TSE Agent Transmission in the Hospital

Diagnosis	Equipment used for neurosurgery (brain, spinal cord, dura, pituitary, neuroophthalmology)	Other procedures, equipment, potential risk	Comments
Suspected TSE	Follow steps as above. SPD 1. Quarantine autoclaved reusable equipment until the diagnosis is finalized. • If confirmed positive, incinerate equipment. • If negative, follow regular cleaning in a washer disinfector, then routine sterilization.	Follow steps as above.	See comments above.
At risk for TSE asymptomatic (hormone recipient, dura mater, corneal transplant, familial CJD in a first-degree relative.	• Where possible, avoid performing the OR procedure. • If diagnosis is delayed (long incubation period). Use disposable instruments wherever possible and follow steps as above.	Follow standard cleaning and sterilization.	• Regular cleaning and disinfection procedures with a hospital grade disinfectant in a basin (contact time according to label recommendation). • the incubation period for TSE is long. • Asmptomatic patients have very low infectivity. • Upgraded neurosurgical procedure equipment sterilization cycles will provide a margin of safety in the very rare event a TSE diagnosed case is found.

Diagnosis	Lumbar puncture/biopsies	Specimen handling	Comments
Known TSE	• Notify Infection Control • Only trained staff aware of TSE hazards should perform these procedures. • Perform procedures in an OR environment whenever possible. • Use disposable, single-use equipment where possible. • Incinerate packs, gowns, barrier drapes after use. • Where possible, avoid performing the OR procedure.	• It is prudent to refer to a specialist neuropathology lab center for brain and tissue biopsy material. • Containment is level 3 for central nervous system (CNS) samples. See department specific P&P. • Other clinical specimens are handled as per standard routine infection control precautions. • Tissue may still be infective if fixed in formaldehyde and then c steam sterilized. • Other clinical specimens are handled as per standard routine infection control precautions.	• Routine disinfection for all non-contaminated surfaces. • Cases booked at the end of the day allow for decontamination of brain tissue contaminated surfaces with a solution of ~~1 Molar NaOH for 60 min of continuous wetting~~**2 N NaOH undiluted for one hour and rinsed with water, non critical patient care items and surfaces.** Pay close attention to technique to avoid contamination and decrease the need for additional use of NaOH. • 2.5% sodium hypochlorite has been inconsistent in killing the scrapie agent.
Suspected TSE **At risk for TSE asymptomatic**	• If diagnosis is delayed (long incubation period) use disposable instruments wherever possible or use the NaOH decontamination process (see above procedure for suspected TSE). • Regular cleaning and sterilization	Other clinical specimens are handled as per standard routine infection control precautions.	

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

SUBJECT: BLOCK TIME

ISSUE DATE: 3/08
REVISION DATE(S): 6/09, 11/09, 4/15, 11/15

Department Approval Date(s):	**10/16**
Operating Room Committee Approval Date(s):	**10/16**
Pharmacy & Therapeutics Committee Approval Dates(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/17**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

A. **PURPOSE:**

1. To outline the granting, review, use~~,~~ and revocation ~~use~~ of block time. Block time scheduling will be provided in the operating room to regulate and ensure continuity of scheduling and to optimize the utilization of the operating room.

B. **DEFINITIONS:**

1. **Block Time:** Surgical time consistently reserved for a surgeon, surgeon group or specialty.
2. **Full Block:** Eight (8) hours of time.
3. **Half Block:** Four (4) hours of time.
4. **Release Time:** Specified lead time prior to the day of **the** block which is a cutoff date or time.
   a. If the block is not booked by this time, the time will become available for open booking.
   b. If the surgeon voluntarily releases the block prior to the specified release date, the time will not be included when the adjusted utilization is calculated.
   c. If the block is not released prior to the specified lead time, the unused time is included in the adjusted utilization.
5. **Utilization:** The amount of time used for surgical cases.
~~5.~~**6.** **Utilization calculation: The amount of time used for surgical cases** divided by the amount of time allocated to the block.
~~6.~~**7.** **Adjusted Utilization:** Utilization calculated with released time subtracted from the allocated time.
~~7.~~**8.** **Unadjusted Utilization: Utilization calculated with all released and unused time included in the allocated time.**

C. **POLICY:**

1. Requested/Approval of Block Time:
   a. Surgeon, service~~,~~ or group may request time.
   b. Hospital administration may request time on behalf of a new surgeon or service.
   c. Block time will be granted based on actual/anticipated case volume.
   ~~c.~~**d.** **Requests will be approved by the OR Committee.**
2. Release Time: Release time may vary among individual block and percentage released, depending upon utilization and type of service.
   ~~a. Release time may vary among individual block and percentage released, depending upon utilization and type of service.~~
   ~~b.~~**a.** For utilization of 85% or greater for a three-month period: 24 hour release (except in cases where 25% of the block time is released).
   ~~c.~~**b.** For utilization of 70-84%: 72 hour release.

~~d. For utilization of 85% or greater for a three-month period: 24 hour release (except in cases where 25% of the block time is released).~~

~~e.~~**c.** For utilization ~~of 70-84%~~**at or below 69%**: ~~72 hour~~**7 day** release.

~~f.~~**d.** Release block time cannot be reclaimed once released and other cases are scheduled.

~~g.~~**e.** Released block time can be reclaimed if no cases are scheduled in the time.

~~h.~~**f.** If the block time is voluntarily released before the assigned release time, the released time does not count in the adjusted utilization ~~and~~ calculation.

~~i.~~**g.** If the block time is not voluntarily released before the automatic release time, then unused time will be included in the adjusted utilization.

~~j.~~**h.** Adjustments to release times will be made quarterly (January, April, July, October) based on the prior quarter's utilization.

3. Maintenance of Block Time:
   a. Monthly block time utilization reports will be distributed to individual surgeons.
   b. Monthly block time utilization reports will be reviewed at OR Committee.
   c. Quarterly (January, April, July, October) block utilization will be reviewed **and the block time may be increased, reduced or revoked** based on the prior six-month average.
   d. Block utilization must be at ~~65~~**60%** adjusted or 50% unadjusted to ~~be~~ retain~~ed~~ block time.
   e. If utilization for the previous quarter falls below requirements, the surgeon~~/~~/surgeon group~~/~~/service will be notified of the deficiency. ~~They will then be given the next quarter to improve the average utilization to minimum requirements.~~

~~f. Inability to utilize block time at 65% adjusted will result in loss of time.~~

~~g.~~**f.** Periodic reviews of block time and surgeon on time arrival by the OR Committee may result in further adjustments to or reinstatement of block time.

~~h.~~**g.** Generally, action is taken based on a rolling six-month average, NOT by per month average.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

SUBJECT: BUMPING SURGERY PROCEDURES

ISSUE DATE: 6/09
REVISION DATE(S): 11/10, 09/12, 4/15

Department Approval Date(s):	**10/16**
Operating Room Committee Approval Date(s):	**10/16**
Pharmacy & Therapeutics Committee Approval Dates(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/17**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

A. **PURPOSE:**
1. To provide guidelines for "bumping" of a surgical procedure

B. **DEFINITIONS:**
1. **Bumping:** The process of superceding a scheduled case with an emergency/emergent/urgent procedure
2. **Emergency Surgical Procedure:** Any procedure requiring surgical intervention immediately upon presentation to preserve life or limb. Emergency procedures are performed in the first available operating room, or may require staffing an additional operating room (OR) immediately to care for the patient (i.e., trauma).
3. **Emergent Surgical Procedure:** Any procedure requiring surgical intervention within approximately one hour of presentation. Emergent procedures are performed in the first available time in the OR schedule.
4. **Urgent Surgical Procedure:** Any procedure which requires surgical intervention within approximately 4-6 hours of presentation. Urgent procedures are placed in an available time on the OR schedule.

C. **POLICY:**
~~D.~~**1.** ~~Any ee~~**E**mergency~~-/-~~emergent~~-/ urgent surgical procedures will~~ **procedures will** take priority and will be performed before a scheduled procedure that is not in progress. The OR charge nurse~~-/-~~Anesthesiologist running the schedule will advise the bumping surgeon of the affected surgeon to be contacted, based on the criteria listed below.

~~1.~~**2.** **When a surgeon deems to bump another surgical procedure, the bumping surgeon must inform the affected surgeon of their intent.**

~~2.~~**3.** The surgical case to be bumped will be determined ~~by the bumping surgeon~~**by the OR Charge Nurse and Anesthesiologist** -based on the following criteria:
   a. Time of case
   b. Length of case
   c. Condition of patient
   d. Availability of equipment
   e. Least disruptive to entire schedule
   f. Date/time the case was scheduled (last scheduled may be bumped first)
   g. Choosing of surgeons within the same group will not be a determining factor

~~3.~~**4.** Urgent procedures may require surgical intervention within a specific time period and may require a scheduled procedure to be bumped.

~~4.~~**5.** Every effort will be made to accommodate the bumped procedure in a timely manner, and the bumped procedure will take first priority for any open time.

~~6. When a surgeon deems to bump another surgical procedure, the bumping surgeon must inform the affected surgeon of their intent.~~

~~5.~~**6.** When a surgeon elects to bump his/**her** own elective scheduled case, the bumped case will be placed in the order to be rescheduled based on availability of rooms and staff to accommodate the case.

7. Disagreement between surgeons in the above process will be arbitrated by the **OR Medical Director,** Chief of Surgery **or Chief of Staff.**

~~6.~~**8.** **Requests for bumping may be referred to the** ~~and the~~ **appropriate surgical Division for review** ~~Surgery Supervisory Committee~~.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

SUBJECT: DISASTER AND EMERGENCY PREPAREDNESS

ISSUE DATE: 4/94
REVISION DATE(S): 2/05, 6/09, 11/10, 9/12, 5/15

Department Approval Date(s):	**10/16**
Operating Room Committee Approval Date(s):	**10/16**
Pharmacy & Therapeutics Committee Approval Dates(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/17**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

A. **POLICY:**

1. To provide guidelines for Perioperative Services **(Pre-op Education, Pre-op Hold/SPRA, OR and PACU)** personnel in the event of a disaster.
2. **To maintain adequate availability of personnel and supplies during a disaster.**
1. ~~Patients coming to this service will be triaged as immediate life saving emergency surgery or delayed emergency surgery.~~

~~B. PERSONNEL:~~

~~1. Director of Surgical Services~~
~~2. Clinical Managers~~
~~3. Registered Nurses~~
~~4. Operating Room Technicians~~
~~5. Anesthesia Technicians~~
~~6. Perioperative Aides~~
~~7. Scheduling Secretaries~~
~~8. Clinical Educator~~
~~9. Anesthesiologists/Surgeons~~
~~10. Instrument Aide~~
~~11. SPD Manager~~
~~12. SPD Technicians~~

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

~~1. LEVEL I – Internal Disaster~~

1. **Due to the varying types and magnitudes of emergency events, Tri-City Healthcare District (TCHD) has adopted the command structure of Hospital Incident Command System (HICS). Once the decision has been made to activate the disaster plan, the HICS becomes the standard operating procedure. The complete plan is located in the TCHD Disaster Plan Manual located in each department.**
2. **French Rooms 1 and 2 are designated as the Incident Command Center (ICC).**

C. **NOTIFICATION:**

1. **In the event of a disaster (Code Orange or Code Yellow), departments will be notified via the overhead paging system.**
2. **Management staff is to be notified by their respective area lead staff via pager/phone 24 hours per day, 7 days per week.**

3. Manager/Supervisor/designee responsibilities following the activation plan for a disaster or drill:
   a. The Surgical Services Clinical Manager(s)/designee from their respective areas will:
      i. Review the HICS form, located in the disaster manual
      ii. Assess number of patients currently in department(s)
      iii. Assess anticipated time of discharge from departments
      iv. Assess number of available staff
      v. Complete HICS form and submit to the Incident Command Center.
   b. Dependent upon the type and severity of the disaster, the Incident Command Center may direct the departments to:
      i. Delay or cancel elective surgeries/procedures
      ii. Discharge patients
      iii. Call in on-call staff
      iv. Initiate the disaster recall list
      v. Post Anesthesia Care Unit may be directed to discharge all patients capable of returning to the nursing units, and clearing this department for holding area of disaster victims if necessary.
      vi. OR staff will obtain emergency case carts and pick extra supplies for emergency procedures:
         1) Extra Lap, Chest, and Extremity custom packs
         2) Six (6) extra cases of Laps and 4x4 sponges
         3) IV solutions and tubing
         4) Blood administration sets
         5) Irrigation: water and saline
         6) Antibiotics
         7) Morgue packs

4. Employee's Responsibilities:
   a. Employees at work but away from the department are to return immediately to their home department.
   b. In the event that the department is in the location of the disaster, employees will report to the Labor Pool.
   c. Personnel will take direction from the OR/PACU Clinical Managers/designee in each area.
      i. Operating Room:
         1) Registered Nurses will circulate/scrub with surgical procedures, picking of supplies and instruments of following cases.
         2) Anesthesia technician will assist anesthesiologist with line placement and intubations as directed.
         3) OR Technicians will scrub surgical cases or assist with instrument processing and running errands.
         4) Endoscopy Suite personnel will assist with minor surgical care and in Pre-Op holding area.
         5) Perioperative Aides will assist with transporting patients from the ER and discharging cancelled elective surgical patients, as well as routine duties of cleaning.
         6) OR Secretaries will answer the telephones, take messages, and run errands as needed.
      ii. Post Anesthesia Care Unit:
         1) Registered Nurses will assist with the delayed surgery patients. Some of these patients may require resuscitation or monitoring. They will also assist in ICU nursing units if patients are sent directly back, bypassing PACU if staffing allows.

2) **Acute Care Technicians (ACTs) will assist with transporting patients and patient care as directed.**

D. EVACUATION OF THE OPERATING ROOM:

1. In the event the Surgical Services is directed to evacuate:

a. Evacuation routes are posted in each specific department

b. Hallways are to be cleared, moving any carts/equipment to the closest storage areas.

i. Storage Room 1 and 2
ii. Dirty Utility Room
iii. Case Cart Room
iv. Back hallway by the windows
v. Any open Operating Room
vi. Forensic Pre-Op Hold
vii. PACU cubicles

~~2. On duty Monday through Friday 0700 to 2300 hours:~~

~~i. The OR Clinical Managers (OCM) / designee will assess the OR rooms in progress and bump scheduled cases for immediate life saving emergencies.~~

~~ii. It may be necessary to cancel some elective cases.~~

~~b. 2300 to 0700 hours shift, Saturdays, Sundays, and Holidays:~~

~~i. The OR Clinical Manager/designee on Saturday or Sunday 0700 to 1700 hours will call in all call crews (including open heart team).~~

~~ii. Staff on duty after 1700 hours on Saturday or Sunday will call in call crews as necessary.~~

~~iii. Extra staff may be called in as necessary.~~

~~3. LEVEL II – External Minor~~

~~a. On duty Monday through Friday 0700 to 2300 hours:~~

~~i. The OR Manager/designee will assess elective surgeries in progress for possible cancellations.~~

~~ii. The OR Manager/designee will assess surgical caseload for possibility of calling in off-duty nurses.~~

~~b. 2300 to 0700 hours shift, Saturdays, Sundays, and Holidays:~~

~~i. Saturday, Sunday 0700 to 1700 hours OR Clinical Manager/designee will assess number of patients needing life saving emergency surgeries and call in all three call crews (OR and PACU).~~

~~ii. PACU Nurse on duty will call in extra nurses as necessary. ACCU patients may go directly back to unit when beds are available.~~

~~iii. 2300 to 0700 hours and Holidays, the personnel on duty will call in all nurses, techs, OR aides, and anesthesia technicians on call. Extra nurses will be called in if necessary.~~

~~4. LEVELS III & IV – External Major~~

~~a. On duty 0700 to 2300 hours:~~

~~i. **The Director of Surgical Services, in conjunction with the OR/PACU Clinical Manager/designee, will review the disaster plan.**~~

~~ii. Employees away from the department will return immediately to the department.~~

~~iii. In the event that the department is in the location of the disaster, employees will report to the Personnel Pool.~~

~~iv. The Chief of the Department of Surgery/designee will be notified and will assume medical command of the Surgery, in conjunction with the Chief of the Department of Anesthesia.~~

~~v. The Director of Surgical Services/OR/PACU Clinical Manager/designee will be notified as to which level disaster is underway. The direction of the entire area will be under her/his supervision, in conjunction with the Anesthesiologist in~~

charge that day. He/she will assist with communication between the OR and the triage area of the Emergency Department.

vi. All elective surgeries will be cancelled and patients discharged.

vii. The OR will immediately be assessed for availability of open rooms and length of surgeries in progress.

viii. The OR Secretary will call in any available personnel who may be off-duty that day, from the OR or PACU, in addition to all available Anesthesiologists.

ix. Post Anesthesia Care Unit will discharge all patients capable of returning to the nursing units, clearing this department for holding area of disaster victims. Unstable surgery patients needing resuscitation or monitoring may go to this area (maximum of 10 patients).

x. OP-PACU will dress all patients. Those patients who are recovered will be discharged. All others will be placed in the OP-PACU, clearing the main recovery area for holding disaster victims.

xi. The Operating Room will take those patients triaged as urgent (maximum of eleven patients at one time).

xii. Post Anesthesia Care Unit and Pre-Op Holding areas will take those patients needing surgery but have been triaged as delayed surgeries.

xiii. OP-PACU will hold patients needing surgery but triaged as delayed surgery (maximum of six patients), holding one area for post anesthesia patients.

b. Patients coming out of surgery will go directly to ACCU post-op, bypassing PACU if agreed upon by the anesthesiologist and surgeon.

c. Endoscopy Suite personnel will assist with minor surgical care and in holding area.

d. Personnel will take direction from the OR/PACU Clinical Managers/designee in each area.

i. Operating Room:

1) Registered Nurses will circulate/scrub with surgical procedures, picking of supplies and instruments of following cases.

2) OR Technicians will scrub surgical cases or assist with instrument processing and running errands.

3) Perioperative Aides will assist in transporting patients from the ER and discharging cancelled elective surgical patients, as well as routine duties of cleaning.

4) OR Secretaries will man the telephones, take messages, and run errands as needed.

ii. Post Anesthesia Care Unit:

1) Registered Nurses will assist with the delayed surgery patients. Some of these patients may require resuscitation or monitoring. They will also assist in ACCU nursing units if patients are sent directly back, bypassing PACU if staffing allows.

2) Perioperative Aides will assist in transporting patients from the ER, and discharging cancelled elective surgical patients.

e. Weekends, Holidays, and 1700 to 0700 hours, Monday through Friday:

i. The OR/PACU Clinical Manager /designee or Call Nurse will activate the Emergency / Disaster Recall list. In the event of a disaster, all employees contacted will be expected to report to duty. In the event of a major disaster, and telephone services are out, personnel will report automatically to their departments for direction.

ii. The OR is always staffed with at least one RN or Technician. Personnel on duty will immediately pick and set-up each Operating Room. The room will be opened as directed by the Physician (i.e., abdominal, chest, or head case) in charge of the disaster triage.

iii. Each area will be staffed and used in the same way outlined in regularly staffed hours.

~~f. LEVELS III & IV: SUPPLIES~~
- ~~i. Extra Lap, Chest, and Extremity custom packs~~
- ~~ii. Six (6) extra cases of Laps and 4 x 4 sponges~~
- ~~iii. IV solutions and tubing~~
- ~~iv. Blood administration sets~~
- ~~v. Irrigation: water and saline~~
- ~~vi. Narcotics and Antibiotics~~
- ~~vii. Glutaraldehyde to sterilize instruments if water supply is lost~~
- viii. ~~Morgue packs~~

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

SUBJECT: OPERATING ROOM (OR) COMMITTEE

ISSUE DATE: 4/94
REVISION DATE(S): 1/05, 6/09, 10/12, 5/15; 11/15

Department Approval Date(s):	**10/16**
Operating Room Committee Approval Date(s):	**10/16**
Pharmacy & Therapeutics Committee Approval Dates(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/17**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

A. **OPERATING ROOM COMMITTEE:**

1. Existence
   a. The chairperson of the Operating Room Committee will be either the chief of surgery or chief of anesthesia, alternating each fiscal year.
   b. Members shall consist of ~~P~~**physicians representation from**~~-~~ ~~A~~**anesthesia, S**~~s~~**urgical S**~~s~~**ub-specialities, P**~~p~~**erioperative N**~~n~~**ursing L**~~l~~**eadership and A**~~a~~**dministration.** ~~a general surgeon, orthopedic surgeon, gynecologist, other sub-specialty surgeons, one anesthesiologist, the Director of Surgical Services, PACU Manager and OR Manager.~~
   c. The committee shall function as a liaison between ~~operating room~~**Perioperative Services** and **the M**~~m~~**edical Staff**~~staff~~ and shall:
      i. Conduct periodic review of operation**al** policies (i.e., scheduling of elective and emergency cases)
      ii. Review incidents and adverse events
      iii. Review problems with the daily management of the Operating Room schedule
      iv. Review~~s~~ block time utilization
      v. Review late surgeons for appropriate sanctions
   d. The committee shall meet monthly in addition to any meetings called by the committee chair.
   e. The chair of the committee with input from the Director of Surgical Services**/designee and OR Medical Director** ~~, OR , surgeons, and anesthesia department~~ develop**s the meeting** agenda ~~formation.~~
   f. Documentation of the minutes is ~~done by the~~**forwarded to the** ~~m~~**M**edical ~~s~~**S**taff ~~o~~**O**ffice and ~~must be~~ approved by the Medical Executive Committee and Board of Directors.
2. Responsibility
   a. All surgical and anesthesia services are coordinated by the Operating Room Committee through the development of policies and protocols relating to the functioning of the Operating Room, **Post-Anesthesia Care Unit** (PACU), and Anesthesia Department. These are coordinated in conjunction with administration and are reviewed ~~annually~~**at least every three years**.
   b. The Committee ~~has~~**determines** ~~input into the~~ **OR** ~~room~~ availability requirements to meet the needs of the community.

~~The quality assurance summary report is done on a monthly basis and reported to Patient Care Review monthly with a quarterly summary to the Committee.~~

B. **EXTERNAL COMMITTEES:**

1. ~~The Operating Room~~**Perioperative Services**~~-~~ is represented on select hospital level committees in order to link surgical/anesthesia activities with other hospital-wide critical

situations. The following lists these external committees and addresses the Operating Room/external group interactions.

~~a. ENVIRONMENT OF CARE~~

~~The Perioperative Services Educator is an active member of the Environment of Care Committee and report to the Director of Surgical Services.~~

~~b.~~**a.** Clinical Value Analysis Team (CVAT)

i. The OR Materials Manager, **OR Manager** ~~-~~and the **Sterile Processing Department** (SPD) Operations Manager are members of this committee, which reviews products for the entire facility for compatibility, cost effectiveness, etc.

~~i. The SPD Operations Manager reports to the Director of Surgical Services.~~

~~c.~~**b.** Infection Control

i. The Director for Surgical Services **and SPD Manager are** ~~is a~~ members of the Infection Control committee, which reviews hospital-wide infection control issues.

~~.IPC~~

~~i.The Director of Surgical Services is a member of this committee, which reviews ancillary licensed and unlicensed assistive personnel applying for privileges.~~

c. Quality Assurance (QA)/Performance Improvement (PI) Committee

i. The Director of Surgical Services attends this committee, which reviews Quality Initiatives and Outcomes.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

DELETE - Content added to "Admission/Discharge Criteria" or covered in other policies

SUBJECT: PRE-OPERATIVE REQUIREMENTS

ISSUE DATE: 6/09
REVISION DATE(S): 10/12; 4/15

Department Approval Date(s):	**10/16**
Operating Room Committee Approval Date(s):	**10/16**
Pharmacy & Therapeutics Committee Approval Dates(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/17**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

~~A. PURPOSE:~~
~~To provide guidelines for the pre-operative patient.~~

~~B. POLICY:~~
~~1. Except in cases of emergency, all patients scheduled for surgery should be admitted no later **less** than 1.5 hours prior to the scheduled surgery start time.~~
~~2. Except in the cases of emergency, Physical Examination and Medical History (H&P) shall be **available** in the **in the** medical record prior to the patient being taken into the Operating Room.~~
~~a. The H&P shall be shall be dictated or electronically generated within the first twenty-four (24) hours of admission and before surgery or anesthesia.~~
~~If the history & physical has been completed within thirty (30) days prior to the patient's admission or readmission, an update to the patient's condition shall be dictated or written upon admission.~~
~~b. **If the history and physical was completed more than 30 days prior to the patient's admission, the H&P must be redone; anupdate alone is not sufficient**~~
~~c. In cases of emergency, the physician shall document in the medical record the medical determination that an emergency exists.~~
~~3. Except in cases of emergency, all patients scheduled for surgery shall have an "Authorization For and Consent To Surgery or Special Diagnostic or Therapeutic Procedures" completed (**and** or other consent forms as required) and contained in the medical record prior to the patient being taken into the surgical suite.~~
~~a. The procedure listed on the consent must match the physicians order.~~
~~b. In cases of emergency, the physician shall document in the medical record the medical determination that an emergency exists.~~
~~c. The Consent form is valid only through the patient's specific admission.~~
~~d. If it is necessary to repeat the same surgery/procedure during this admission, a new consent must be obtained. This does not include follow-up studies that are an expected part of the original procedure.~~
~~e. A Consent for Sterilization is required ONLY when sterilization is the primary reason for the surgical procedure.~~
~~4. NPO Requirements:~~
~~a. Adult patients:~~
~~i. Adult p**P**atients must be NPO for at least 2 hours for clear liquids (examples of clear liquids include, but are not limited to, water, fruit~~

juices without pulp, carbonated beverages, clear tea and black coffee; these liquids do not include alcohol).

ii. Allow 2 hours NPO for hard candy (i.e., life savers, mints), chewing gum and communion wafers.

iii. Allow 8 hours NPO for all other solid foods and non-clear liquids prior to surgery.

b. Pediatric patients:

i. Infants 0-1 year of age:

1) No solids the day of procedure
2) Formula or breast milk until 4 hours before procedure
3) Clear liquids until 2 hours prior to procedure
4) NPO thereafter until the procedure

ii. Ages 1 to 2 years:

1) No solids the day of procedure
2) Full liquids until 6 hours prior to procedure
3) Clear liquids until 3 hours prior to procedure
4) NPO thereafter until the procedure

iii. Ages 3 to 10 years:

1) No solids the day of procedure
2) Clear liquids until 4 hours prior to procedure
3) NPO thereafter until the procedure

c. Note: The volume of liquid ingested is less important that the type of liquid ingested.

5. Appropriate laboratory screening tests based on the needs of the patient, as determined by the surgeon and anesthesiologist, must be accomplished and recorded within 72 hours prior to surgery [22 CCR §70223(d)(2)].

6. A Blood Type, RH, and appropriate antibody titer(s) should be determined or available in the patient's record for all patients undergoing therapeutic abortion or D&C for incomplete abortion. Pregnancy termination for dead fetus, which is either hydropic or ≥ 20 weeks gestational age and ≥ 30 days duration, shall include a fibrinogen.

7. Patients undergoing voluntary sterilization:

a. Medi-Cal patients must wait 30 days from the date the consent form is signed.

b. Private patients may voluntarily waive the 30-day waiting period to no less than 72 hours. This waiver must be in writing. (22 CCR §70707.1 through §70707.6

c. EXCEPTION: Sterilization may be performed at the time of premature delivery if the physician certifies that:

i. The written informed consent was signed at least 30 days before the expected date of delivery. The physician shall state the expected date of delivery on the MediCal/Medicare Consent Form.

ii. At least 72 hours have passed after written informed consent to be sterilized was given and the sterilization consent form was signed.

8. Sterilization may be performed at the time of emergency abdominal surgery if the following requirements are met:

a. The written informed consent was signed at least 30 days before the expected date of delivery. The physician shall state the expected date of delivery on the Medi-Cal/Medicare Consent Form.

b. At least 72 hours have passed after written informed consent to be sterilized was given and the sterilization consent form was signed.

c. Describe the emergency on the Medi-Cal/Medicare Consent Form.

9. Documentation of any other preoperative studies or procedures ordered by the attending physician, consultant, or Anesthesiologist.

10. **ALL** patients must have an interval History and Physical examination on the chart performed within the previous 24 hours [22 CCR §70223(d)(1)].

a. Excluding emergencies, a completed "Physician Procedural Verification" form must be on the chart before the patient is brought to the operating room.

11. The requirements above do not preclude rendering emergency medical or surgical care to a patient in dire circumstances [22 CCR §70223(e)].

12. Documentation by a nurse that preoperative medications (including antibiotics) were given as ordered, and that the Pre-Operative Check List was completed.

13. Check chart for any Advance Directives.

C. REFERENCES:

1. California Code of Regulations Title XXII, §70223 & §70707.1 through §70707.6
2. California Physicians Legal Handbook, Chapter 6
3. Jones, D., Weintraub, P. (2000). Surgical patients benefit from less strict `nothing after midnight' rule. http://www.asahq.org/Media/NPOrelease.html.
4.1. American Society of Anesthesiologists. (1998, October). Practice guidelines for preoperative fasting and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: Application to healthy patients.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

DELETE - Content covered in Patient Care Services Policy: Safe Medical Device Act Tracking and Reporting

SUBJECT: SAFE MEDICAL DEVICE ACT: TRACKING & REPORTING

ISSUE DATE: 4/94
REVISION DATE(S): 2/05; 6/09

Department Approval Date(s):	**10/16**
Operating Room Committee Approval Date(s):	**10/16**
Pharmacy & Therapeutics Committee Approval Dates(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/17**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

A. **POLICY:**
1. In compliance with the "Safe Medical Devices Act" of 1990 (effective 8/29/93), all implants and explants will be recorded into the patient's surgical record.

B. **DEFINITIONS:**
1. **Permanently implantable device**: A device that is intended to be placed into a surgically or naturally formed cavity to continuously assist, restore, or replace the function of an organ system or structure throughout the useful life of the device. (Does not include devices intended and used for temporary purposes or that are intended for explanation.)
2. **Life-supporting or life-sustaining device used outside a device user facility**: A device that is essential, or yields information that is essential, to the restoration or continuation of a bodily function important to the continuation of human life that is intended for use outside a hospital, nursing home, ambulatory surgical facility, or diagnostic or outpatient treatment facility.

C. **PROCEDURE:**
1. Examples of devices subject to tracking, including but not limited to:
   a. Permanently implantable devices:
      i. Vascular graft prosthesis
      ii. Ventricular graft prosthesis
      iii. Implantable pacemaker generator
      iv. Cardiovascular permanent pacemaker electrode
      v. Annuloplasty ring
      vi. Replacement heart valve
      vii. Automatic implantable cardioverter/defibrillator
      viii. Tracheal prosthesis
      ix. Implanted cerebellar stimulator
      x. Implanted diaphragmatic/phrenic nerve stimulator
      xi. Implantable infusion pumps
      xii. TMJ prosthesis
      xiii. Glenoid fossa prosthesis
      xiv. Mandibular condyle prosthesis
      xv. Interarticular disk prosthesis
   b. Life-sustaining or life-supporting devices used outside device user facilities:
      i. Apnea monitor
      ii. Continuous ventilator
      iii. DC defibrillator and paddles
   c. FDA designated devices:
      i. Silicone inflatable breast prosthesis
      ii. Silicone gel filled breast prosthesis
      iii. Silicone gel filled testicular prosthesis
      iv. Silicone gel filled chin prosthesis
      v. Silicone gel filled Angelchik reflux valve
      vi. Inflatable penile implant

~~vii. Infusion pumps (electromechanical only)~~
~~viii. Urinary sphincter prosthesis~~

~~2. Documentation of Implants (on Implant Record) must include:~~
~~a. Name/type of implant, size if applicable~~
~~b. Site of implantation~~
~~c. Manufacturer of implant~~
~~d. Catalog number of implant if available~~
~~e. Serial or lot number of implant~~
~~f. Expiration date if noted on packaging~~
~~g. Date of implantation~~
~~h. Name of surgeon implanting the device~~

~~3. If an implantable device has patient user information included in the packaging, this must be labeled with the patient's name and sent with the patient.~~

~~4. If the packaging includes a manufacturer tracking device form this must be completed and mailed back to the company for their records.~~

~~5. EXPLANTS:~~
~~a. Documentation of Explanted items must include:~~
~~i. The date the device was explanted~~
~~ii. Name, mailing address, and telephone number of the explanting physician~~
~~iii. The date of the patient's death (if applicable)~~
~~iv.~~**i.** ~~The date the device was returned to the manufacturer or distributor, permanently retired from use, or otherwise permanently disposed of.~~

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

SUBJECT: SCHEDULING SURGICAL PROCEDURES ~~**POLICY NUMBER: 7420-109**~~

ISSUE DATE: 04/94
REVISION DATE(S): 09/99; 04/01; 01/02; 06/03; 02/05; 02/08; 06/09; 11/10; 10/12; 12/12; 04/13; 08/13; 5/15
REVIEW DATE (S): 12/05; 12/07

Department Approval Date(s):	**08/16**
Department of Anesthesiology Approval Date(s):	**n/a**
Operating Room Committee Approval Date(s):	**08/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/17**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	**01/13**

A. **PURPOSE:**
1. To provide scheduling guidelines for surgery, ~~and~~ endoscopy**, and elective cesarean sections (in OB-OR).**

B. **DEFINITIONS:**
1. **Add-On Cases:** Additions to the surgery schedule after the "final schedule" has been published. The "final schedule" is published by 4 PM for the next day.
2. **Elective Case:** Surgery can be scheduled at the time best suited for the surgeon and the patient.
3. **Urgent Case**: Surgical intervention is needed within 4-6 hours of presentation. Urgent procedures are placed in an available time on the OR schedule.
4. **Emergent Case:** Surgical intervention is needed within one hour of presentation and may require that another scheduled or add-on case is bumped.
5. **Emergency**: Surgical intervention is needed immediately upon presentation to preserve life or limb. Emergency procedures are performed in the first available operating room and may require that another scheduled or add-on case is bumped.

C. **SCHEDULING ~~WEEKDAY~~ ELECTIVE CASES:**
1. All **elective** surgical and endoscopic procedures **and elective cesarean sections in OB-OR** will be scheduled through the ~~OR~~**Surgery** ~~-~~scheduling office ~~or OR main desk~~.
2. There are 12 rooms in the TCMC OR suite which are utilized as follows:
   a. Ten (10) operating rooms (OR 1-10) can accommodate any type **of** case.
   b. OR 5 and 6 are set up and primarily are used for cardiac cases.
      i. OR 5 is released for non-cardiac cases at 24 hours
      ii. OR 6 is held for cardiac cases
   c. OR 11 is the Cystoscopy Room and is considered a wound class II room. Only certain procedures may be performed in this room due to the open drain:
      i. Circumcision
      ~~i.~~**ii.** Endourology procedures
      ~~ii.~~**iii.** Percutaneous Sub~~b~~prapubic Cystotomy
      iv. Vasectomy
      ~~iii.~~**v.** Orchiectomy
   d. OR 12 is the GI/~~Pulmonary~~ Endoscopy Room

3. **Expected** ~~A~~available surgery rooms Monday-~~Friday~~**Thursday (may fluctuate based on staffing, surgical volume and surgical acuity)**:
   a. 0730-1500 hours: 8 rooms
   b. 1500-1900 hours: 5 rooms
   c. 1900-2100 hours: 3 rooms
   d. 2100-2300 hours: 2 rooms

4. **Expected available surgery rooms on Friday (may fluctuate based on staffing, surgical volume and surgical acuity):**
   a. 0730-1500 hours: 7 rooms
   b. 1500-1900 hours: 4 rooms
   c. 1900-2100 hours: 3 rooms
   d. 2100-2300 hours: 2 rooms

~~4.~~**5.** **Elective** ~~C~~cases shall be scheduled by the surgery scheduling office between the hours of ~~8:35AM~~**0835** and ~~4:30PM~~**1630**, Monday through Friday, at 760-940-7382.
   a. Elective cases are performed Monday through Friday from 07**15**~~30~~ (08**15**~~30~~ on Thursday) to 2300 hours. Elective cases should not extend beyond 2300.

6. **Start Times:**
   a. The Start time of a procedure (time on the OR schedule) is the time the patient is expected to be in the OR. Start time of first cases are tracked and report to the OR committee monthly.
   b. The start time of elective or add-on case requested for 1600 or later cannot be guaranteed. In those instances, the surgeon's preferred start time will be noted, and the surgeon will be given one hour's notice of expected start time. If the surgeon cannot start at the expected time, the next surgeon to start will be offered the time.

7. **Delays:**
   a. Surgeons who notify the OR they will be late for their scheduled start time must provide an expected time of arrival. Delays of more than 30 minutes, or delays that will impact another surgeon's schedule will cause the first surgeon to be bumped back to the next available start time.
   b. Surgeons who are not in house 30 minutes past the scheduled time of surgery and are unable to be contacted will be bumped back to the next available start time once they either arrive at the hospital or contact the OR.

~~6. Urgent, Emergent, and Emergency cases may be performed at any time.~~

~~5.~~**8.** Cases are scheduled on a consecutive, first-come first-served basis, or in a surgeon's block time.

~~6.~~**9.** Procedures may be scheduled by the surgeon or the surgeon's office staff only.

~~7.~~**10.** The **process for scheduling an elective case**~~information required at the time of scheduling~~ is as follows:
   a. The surgeon's office ~~shalls~~ calls the TCMC Surgery Scheduling department to reserve a case time.
   b. The surgeon's office ~~shall~~ completes a written "TCMC Surgery Scheduling Patient Information" booking form and faxes to the TCMC Surgery department fax server (Fax # 760-940-7138) within 48 hours of the telephone reservation.
      i. Upon receiving the written booking form, the TCMC Surgery Scheduler will schedule the case, obtain a FIN# and book a Pre-Operative Education appointment.
      ii. The TCMC Surgery Scheduler will write the FIN# and the date and time of the Pre-Operative Education appointment on the "TCMC Surgery Scheduling Patient Information" booking form, and will fax the form back to the surgeon's office as confirmation.
   c. The surgeon's office enters electronic orders or ~~shall~~ faxes written orders to the TCMC Surgery Scheduling department fax server *at least one week prior to surgery date*. Electronic orders will also be accepted.

i. If the case is scheduled less than one week prior to the date of surgery, written or electronic orders are required by the next business day.

~~Patient name and second approved identifier~~
~~b. Surgeon and Assistant, if required~~
~~c. Name of monitor, if required~~
~~d. Procedure~~
~~e. Approximate amount of time including preparation time~~
~~f. Pre-op diagnosis~~
~~g. Patient's phone number, date of birth, Social Security number, insurance company, address~~
~~h. Patient status (i.e., inpatient, outpatient, AM admit, admit day before, etc.)~~
~~i. Permission to contact patient by hospital personnel~~
~~j. Special equipment, supplies, any special instructions~~
~~k. Special requests (i.e., Anesthesiologist)~~
~~7. Infants & Children:~~
~~8. The order of cases will be revised so that the youngest is first and then up to the oldest.~~
~~a. Pre-Op Teaching will notify the parents when to arrive with the child at the hospital.~~
~~b. Pediatric Cases:~~
~~i. Outpatient surgery may be performed on patients of any age~~
~~ii. Inpatient pediatric surgery patients should be:~~
~~1) At least 80 lbs~~
~~2) At least 124 years of age~~
~~3) ASA class I or II~~

11. Age/Weight/ASA Requirements:

a. Surgery patients must be at least 14 years of age at the time of surgery
b. Adolescent patients (ages 14-18) must be:
i. At least 80 lbs
ii. ASA class I or II
c. Adult Patients (over age 18) must be at least 80 lbs.
d. Any requested Adolescent or Adult patient who does not meet criteria must be reviewed/approved prior to scheduling by the Chief of Anesthesia or designee.

~~8. d. Any requested pediatric inpatients who do not meet these criteria must be approved by the chief of anesthesia/designee.~~

12. The surgeon must have the appropriate privileges granted to be allowed to schedule a procedure.

a. Current privilege lists are maintained through the E-PRIV system, accessible through TCMC Intranet.
~~c.~~**b.** If the physician's privilege status is still not clear, the Medical Staff Office is contacted for clarification.

~~9. After the patient has been scheduled for surgery, during the same phone contact, the OR Scheduler will schedule the patient with the office staff for a pre-operative education visit.~~
~~a. Patients may be scheduled for a telephone vs. in-person pre-operative education appointment.~~
~~b. Those patients who do not need to be scheduled for regular teaching include:~~
~~i. Debilitated patients~~
~~ii. Nursing home patients~~
~~iii. Requests from physician's office if HMO is doing blood work and the patient has a transportation problem~~
~~iv. Patients who are rescheduled for surgery and have already attended a Pre-operative Education appointment~~

D. PRE-OPERATIVE EDUCATION APPOINTMENT SCHEDULING GUIDELINES:

1. Patients may be scheduled for a telephone vs. in-person Pre-Operative Education appointment.

2. **Those patients who do not need to be scheduled for regular teaching include:**
   a. **Debilitated patients**
   b. **Nursing home patients**
   c. **Requests from physician's office if HMO is doing blood work and the patient has a transportation problem**
   d. **Patients who are rescheduled for surgery and have already attended a Pre-Operative Education appointment**

E. **SCHEDULING ADD-ON URGENT, EMERGENT, OR EMERGENCY PROCEDURES:**
1. **Urgent, Emergent, and Emergency cases may be performed at any time.**
2. **Urgent, Emergent, and Emergency cases shall be scheduled through the Main OR desk in person or via telephone (760-940-5400).**
3. **Required information when scheduling an add-on case includes:**
   a. **Patient name, date of birth, age, and medical record number**
   b. **Patient phone number, Social Security number, and insurance information (excludes in-house patients)**
   c. **Patient current location in the hospital**
   d. **NPO status**
   e. **Pre-Op diagnosis and Procedure to be performed**
   f. **Surgeon and assistant (if applicable)**
   g. **Equipment/X-ray needed**
   h. **Relevant cardiac/medical history**
   i. **Time of surgeon availability**

F. **WEEKEND/HOLIDAY CASES:**
1. Saturday, Sunday and three recognized Monday Holidays (President's Day, Memorial Day and Labor Day) have two rooms available for Add-on and Urgent cases **0730-1530. After 4 PM only one room is available.** ~~A third room is available for emergency cases only.~~**In addition, one room is available for emergency cases only.**
   ~~b.~~**a. The heart room counts as one of the available rooms.**
~~9.~~**2.** The remaining holidays (July 4, Thanksgiving, Christmas, New Year's Day) have one urgent room and one emergent room only. **No elective surgeries are scheduled on these holidays.**
~~10.~~**3.** Weekend/holiday cases are scheduled no more than 24 hours prior to the day of surgery.
~~11.~~**4.** Add-on cases are started in order of scheduling, providing the surgeon is available and the patient is ready for surgery.
5. If the first scheduled add-on case cannot be performed in the first available time, the next case's surgeon will be contacted and offered to start at the available time. Upon availability of the next time to start an add-on case, the surgeon for the first case will again be contacted and offered the time.
   a. **The first available time is 071530. If a physician requests a specific time, eg, 0900 to start a case, then another physician is available to start at 071530, the physician requesting the 0900 start time will be contacted to move up to 071530, or will start after the preceding case is finished.**
~~12.~~**6. For 0715 cases, the patient must be ready for transfer to the Operating Suite by 0645, otherwise, the next scheduled case may replace the delayed case**
7. When the first Saturday/Sunday room is booked for three hours or more, the second room is opened. The surgeon following the 071530 slot in the first room will be offered the **0715**~~0730~~ slot in the newly available room.
8. **Surgeons are allowed to schedule no more than ONE elective procedure, no greater than three hours, per weekend.**
   a. **Scheduling questions for weekend electives are decided by the 1st call Anesthesiologist.**
   b. **Robotic Cases (Mazor or daVinci) are not scheduled for weekends or holidays**

~~D.~~**G. ENDOSCOPY:**

1. Endoscopy services are available 24/7.
2. Endoscopy procedures are scheduled in the same manner as surgical procedures.
~~2.~~**3. Endoscopic procedures requiring general anesthesia are scheduled in an open time on the OR schedule.**

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

SUBJECT: SCOPE OF SERVICE FOR SURGICAL SERVICES

ISSUE DATE: 10/11
REVISION DATE(S): 12/11; 10/12; 5/15

Department Approval Date(s):	**10/16**
Operating Room Committee Approval Date(s):	**10/16**
Pharmacy & Therapeutics Committee Approval Dates(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/17**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

A. **PURPOSE:**
1. To describe the Scope of Service for the department of Surgical Services at Tri-City Medical Center, including Pre-operative Education, Pre-operative Hold (POH), Surgery and Endoscopy.

B. **POLICY:**
1. Goals
   a. To improve the general health and well-being of patients who require surgical care.
   b. To improve patients' health knowledge related to pre-operative preparation, the scheduled surgical procedure, and post-operative plan for patients requiring surgical care.
   c. To reduce and manage complications and unexpected outcomes.
   d. To continuously evaluate and improve the services provided.
2. Description of Service & Assessing Department Services
   a. The department of surgical services provides diagnostic, therapeutic and operative interventions for patients requiring a variety of surgical procedures 24 hours a day, 7 days a week.
   b. Assessment activities include pre-operative, intra-operative and post-operative patient care for persons requiring elective, urgent or emergent surgery.
   c. The Pre-operative Education department provides instructions to patients **electively scheduled for procedures** ~~s~~regarding preparation for surgery, surgical procedures and post-operative care, facilitates ordered laboratory and diagnostic procedures as part of the pre-operative patient preparation, and gathers patient health history information. Pre-operative Education appointments are conducted in-person or via telephone, Monday-Friday 8:00am-5:00pm.
   d. The Pre-operative Hold department is responsible for assessing patients prior to surgery and carrying out pre-operative orders. POH is staffed with RN's Monday-Friday 5:30am-5:00pm. After hours, the surgical RN is responsible for assessing patients pre-operatively and completing pre-operative orders.
3. Methods Used To Assess Patient Needs
   a. Patient health history and educational needs related to the surgical procedure and post-operative care are assessed by a Pre-operative Education Registered Nurse (RN) during the Pre-operative Education appointment **(as applicable)**~~-~~.
   b. Patients are assessed and prepared for surgery by a ~~POH~~ **perioperative** RN **on** ~~in the pre-operative area on~~ the day of surgery. ~~Pre-operative orders are carried out in this area prior to going to the Operating Room.~~

c. Patient assessment is performed by a surgical Registered Nurse (RN) and anesthesia care provider (if applicable) ~~in the Pre-operative area~~ prior to going to surgery/Endoscopy suite.

d. Ongoing patient assessment and care is performed by the circulating RN and anesthesia care provider in the surgical suite throughout the procedure. RN's may monitor patients and administer moderate sedation for appropriate procedures (including Endoscopy procedures).

4. Scope of Services

a. Service specialties include orthopedic, thoracic, vascular, neurosurgical, urologic, gynecological, anesthesia, plastics, otolaryngolic, ophthalmologic, oral surgery, endoscopic, cardiac, robotic and general surgery.

b. There are 12 rooms in the OR suite, including 10 operating rooms (1-10) that can accommodate any type of case, **a cystoscopy** ~~a cystoscopy~~ suite (OR #11) and an Endoscopy suite (OR #12).

c. Patients are discharged from the Operating Room by the surgeon and/or anesthesiologist upon completion of the surgical procedure, and admitted to the appropriate postoperative level of care.

d. The Pre-operative Hold department, located in the surgical pavilion, contains **patient** ~~86~~ bays, with additional access to two private cubicles located in the Post-Anesthesia Care Unit (PACU). **A Preoperative Hold area with six bays is available for elective admission of Forensic patients.** POH services inpatients, outpatients and AM admissions for all surgical specialties and Endoscopy.

e. The Pre-operative Education department services **electively scheduled** outpatients and AM admissions for all surgical specialties~~, including patients undergoing Cesarean sections.~~

5. Staffing and Availability of Staff

a. Sufficient staffing is maintained at all times in terms of number of personnel, skill mix, and competency to meet the needs of the patients in the OR. Standby and call-back will be utilized to additionally staff those shifts that have minimal staffing in-house.

b. Each patient is assigned at least two surgical team members, one of which is the RN circulator.

c. The Assistant Nurse Manager (ANM) or charge nurse will make staff assignments according to individual staff competencies and patient needs.

d. Procedures requiring additional resources, due to severity of illness of the patient or complexity of the procedure, shall be staffed with additional personnel as appropriate.

e. For complete staffing and on-call guidelines see Surgical Services Polic**iesy** ~~#7420-203:~~ Staffing, ~~#7420-101:~~ Admission/Discharge Criteria and ~~#7420-201:~~ On-call.

f. Pre-operative Education appointments are conducted by RN's. Appointments are scheduled in advance by the surgery schedulers. ~~Pre-operative Education also has a Unit Secretary and Pre-operative Education Liaison staffed during normal business hours.~~

g. Pre-operative Hold department**s** ~~is~~**are** staffed with RN's during normal business hours. After hours, the surgical RN conducts the pre-operative patient assessment and preparation.

6. Patient Population

a. ~~Pediatric~~**Adolescent**, adult, and geriatric patients requiring surgical management. ~~Outpatient surgery may be performed on patients of any age~~**Patients between the ages of 14-18 must meet defined criteria set forth in Surgical Services Policy ~~#7420-109:~~ Scheduling Surgical Procedures.**

~~b. Limitations apply to inpatient pediatric patient selection. For complete pediatric patient guidelines see Surgical Services Policy #7420-109: Scheduling Surgical Procedures.~~

7. Extent to Which The Department's Level of Care/Service Meet Patient Needs

a. The services provided by surgical services meet the needs of both inpatients and outpatients through availability of staff who are competent to provide service for the current patient population.

8. Performance Improvement (PI)
   a. In order to improve patient care, several indicators are monitored ~~to reported quarterly to Quality Control Council.~~**and reported to the OR Committee, Infection Control Committee, Quality Committee or other committees as requested.**
   b. PI data is posted in the department.
   c. ~~Surgical Services PI Committee meet every other month, with minutes maintained in the binder in the staff lounge. See Surgical Services Policy #7420-202: Staff Based Committees/Meetings for complete details of PI committee composition and function.~~
9. Standards of Practice
   a. Surgical Services follows practice recommendations as outlined in the Association of PeriOperative Registered Nurses (AORN) ~~Perioperative Standards and Recommended Practices.~~**Guidelines for Perioperative Practice**
   b. The nursing service abides by regulations of California Title XXII, Joint Commission guidelines, CMS and the Board of Registered Nursing.
   c. See Surgical Services Policy ~~#7420-506: Perioperative~~ Standards of Practice.
10. Medication Administration Standards Related to Care of The Patient
   a. Medications, general and narcotics, are dispensed via the Pyxis system. Emergency cardiac medications are stored in Cardiac OR Suites in locked cabinets and refrigerator. Medications requiring refrigeration are stored at the appropriate temperature.
   b. Anesthesia Pyxis machines are maintained in each OR suite.
   c. Preoperative antibiotics and medications **dispensed to and/or** administered on the surgical field during the surgical procedure are documented in the surgical **nursing** record.
   d. Anesthesia providers are responsible for documenting all meds they administer on the Anesthesia record.
   e. Medications administered in POH are documented in the electronic Medication. Administration Record (MAR~~) for inpatients and AM admissions, and on the paper chart for outpatients.~~
   f. See Surgical Services Policy ~~#7420-408:~~ Medications in Surgery.

C. **RELATED DOCUMENTS:**

1. Surgical Services Policy: Admission/Discharge Criteria
~~1.~~2. Surgical Services Policy: On-call
3. Surgical Services Policy: Scheduling Surgical Procedures
4. Surgical Services Policy: Staffing

Tri-City Medical Center
Oceanside, California

TELEMETRY ~~UNIT SPECIFIC POLICY MANUAL~~

SUBJECT: Assignments for~~:~~ Telemetry Core Staff & Acute Care Services (ACS) ~~and Resource Staff~~ Floating to Telemetry

~~POLICY NUMBER: 6150-102~~

ISSUE DATE: 10/96
REVISION DATE(S): 10-12, 4-13.4/15

Department Approval Date(s):	
Division of Cardiology Approval Date(s):	**n/a**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval:	**02/11**

A. **PURPOSE:**
1. To outline the Registered Nurse (RN) and Advanced Care Technician (ACT) patient assignments and responsibilities on the Telemetry Unit.
2. To outline the patient assignments and responsibilities of TCMC staff floating to the Telemetry Unit.

B. **DEFINITIONS:**
1. Core Telemetry Staff: RNs or ACTs hired as staff for the Telemetry Unit and/or resource staff identified by the Telemetry Assistant Nurse Manager (ANM).
2. **Acute Care Staff (ACS):** ~~CS staff: One North, 2P, 3P, 4P, Forensics, and Rehab services RNs and ACTs~~**: staff hired on an ACS unit.**

C. **POLICY**
1. Assignments
   a. Each unit will be assigned the appropriate RN staff based on TCMC's staffing guidelines.
   b. An ACTs shall be assigned based on unit staffing guidelines.
      i. ACTs duties shall be assigned by the RN. Refer to the ACT Shift Routines
   c. Each nurse shall be assigned a maximum of 4 (four) patients.
   d. Each unit shall have an assigned Resource Nurse. The Resource Nurse shall be a core Telemetry RN or RN assigned by the ANM/Relief Charge Nurse ~~(RCN).~~
   e. The Resource Nurse shall ensure appropriate assignments are made based on the Synergy Model.
      i. Assignments may be changed throughout the shift based upon the Synergy Model and patient acuity.
      ii. The Telemetry Admission and Discharge Criteria shall serve as a reference.
   f. The ANM/**Relief Charge Nurse**~~CN~~ may make changes to the assignment as necessary to ensure the assigned nurse competencies meet the patient's characteristics and needs.
   g. The following patients shall be assigned to Telemetry core RNs and core Intensive Care Unit (ICU) RN floating to Telemetry:
      i. Pre and post cardiovascular surgery
      ii. Immediate post Percutaneous Coronary Intervention (PCI) patients with femoral arterial and/or venous sheaths post coronary cardiac catheterization 12 hours or less
      iii. Immediate post PCI without femoral and/or venous sheaths 12 hours or less

iv. Patient requiring invasive line monitoring; femoral or radial arterial sheath monitoring, and/or central venous pressure (CVP) monitoring
v. Patients requiring application of a FemoStop after losing hemostasis
vi. Patients requiring removal of a FemoStop
vii. Patients requiring transcutaneous pacing
viii. Patients with dysrhythmias requiring the initiation, loading, or maintenance of IV antiarrhythmic drugs, IV calcium channel blockers and/or IV beta-blockers to decrease a tachycardia, or patients requiring vasoactive drips.
ix. Immediate post conscious sedation for bedside procedures
x. Carotid Endarterectomy
xi. Ventilated endotracheal tube or tracheostomy patients
xii. Ventilator dependent
xiii. Patients requiring Bi-PAP

~~2. Resource Staff~~
~~a. TCMC resource nurses successfully completing one or all of the following may be assigned patients listed in number 7 per the ANM/relief charge nurse.~~
~~i. Telemetry or ICU RN Skills Checklist~~
~~i. Telemetry or ICU RN Advanced Nursing Skills Checklist~~
~~ii. Demonstration of skill during an annual skills lab~~
~~b. 2. TCMC resource ACTs successfully completing one of all of the following may be assigned care responsibilities and task for all telemetry patient populations:~~
~~i. Telemetry Advanced Care Technician Skills Checklist~~
~~ii. Telemetry Advanced Care Technician Skills Checklist Addendum~~

~~3.~~**2.** Acute Care Services (ACS)
a. RNs floating to Telemetry from Acute Care Services (ACS) ~~and resource nurses~~ who have not completed the Telemetry or ICU Skills Checklist and/or the Telemetry or ICU skills lab cannot be assigned total responsibility for patient care including duties and responsibilities for planning and implementing patient care, and ~~providing clinical supervision and coordination of care given by LVNs and~~ unlicensed nursing personnel" (Board of Registered Nursing (BRN), 1998).
b. RNs floating to Telemetry from ACS~~, resources RNs~~ whose primary floating pod is not Telemetry and registry medical surgical nurses patient assignments and responsibilities may include but are not limited to the following:
i. RNs shall receive patient assignments based on their clinical competency on ACS.
ii. Assignments will be modified throughout a shift based on patient acuity and Telemetry unit specific criteria for assigning patients to ACS and registry nurses.
iii. ~~RNs "~~**RNs** "may accept a limited assignment of nursing care duties, which utilizes his/her currently existing clinical competence" (BRN, 1998).
c. RNs shall perform "duties and responsibilities for which their competency has been validated" (BRN, 1998) by the following:
i. ACS per their unit specific skills checklist
ii. Registry per their agency skills checklist
d. RNs shall implement interventions within their scope of practice on ACS
e. RNs may not institute care, administer IV medications, or accept orders from physician that are not within their ACS scope of practice and/or orders that may not be received or implemented on ACS.
f. RNs may not implement Standardized Procedures, policies or procedures, which are specific to the Telemetry unit.
g. RNs shall consult with a core Telemetry RN~~, Resource RN~~, **or** ANM/RCN when the following occurs:
i. Receive report on a new admission or transfer to unit
ii. Changes in patient status from initial assessment or information obtained during hand-off.
iii. Cardiac rhythm, rate, or vital sign changes

iv. New orders to initiate procedures i.e., BiPAP, cardioversions, bronchoscopy, insertion of chest tube, pre-operative teaching for cardiovascular surgery, cardiac catheterization, insertion of pacemaker or implanted cardioverter defibrillator.

~~4.~~**3.** Orders to implement, initiate, or maintain IV a RNs floating to Telemetry from Acute Care Services (ACS) ~~and resource nurses~~ who have not completed the Telemetry or ICU Skills Checklist and/or the Telemetry or ICU skills lab "cannot be assigned total responsibility for patient care including duties and responsibilities for planning and implementing patient care, ~~and providing clinical supervision and coordination of care given by LVNs~~ and unlicensed nursing personnel" (Board of Registered Nursing (BRN), 1998).

~~5.~~**4.** RNs floating to Telemetry from ACS~~, resources RNs~~ whose primary floating pod is not telemetry and registry medical surgical nurses patient assignments and responsibilities may include but are not limited to the following:

a. RNs shall receive patient assignments based on their clinical competency on ACS.
b. Assignments will be modified throughout a shift based on patient acuity and Telemetry unit specific criteria for assigning patients to ACS and registry nurses.
c. RNs "may accept a limited assignment of nursing care duties, which utilizes his/her currently existing clinical competence" (BRN, 1998).
d. RNs shall perform "duties and responsibilities for which their competency has been validated" (BRN, 1998) by the following:
   i. ACS per their unit specific skills checklist
   ii. Registry per their agency skills checklist
e. RNs shall implement interventions within their scope of practice on ACS
f. RNs may not institute care, administer IV medications, or accept orders from physician that are not within their ACS scope of practice and/or orders that may not be received or implemented on ACS.
g. RNs may not implement Standardized Procedures, policies or procedures, which are specific to the Telemetry unit.
h. RNs shall consult with a core Telemetry RN~~, Resource RN,~~**or** ANM/relief charge nurse when the following occurs:
   i. Receive report on a new admission or transfer to unit
   ii. Changes in patient status from initial assessment or information obtained during hand-off.
   iii. Cardiac rhythm, rate, or vital sign changes
   iv. New orders to initiate procedures i.e., BiPAP, cardioversions, bronchosocpy, insertion of chest tube, pre-operative teaching for cardiovascular surgery, cardiac catheterization, insertion of pacemaker or implanted cardioverter defibrillator.
   v. Orders to implement, initiate, or maintain IV antidysrhythmics or IV vasoactive medications, or any medications that cannot be administered on ACS.
   vi. Discharge of patient's with the following admitting diagnoses without consulting a core Telemetry nurse or ANM/RCN:
      1) Heart failure
      2) Acute Myocardial Infarction (MI)
      3) Post PCI
      4) Post CVS
   vii. Antidysrhythmics or IV vasoactive medications or any medications that cannot be administered on ACS.
   viii. Discharge of patient's with the following admitting diagnoses without consulting a core Telemetry nurse or ANM/Charge Nurse:
      1) Heart failure
      2) Acute MI
      3) Post PCI
      4) Post CVS

~~6.~~**5.** Registry Nurses

a. It is the responsibility of the registry RN to notify the **Telemetry**~~resource~~ RN, ANM and/or the relief charge nurse of their skills prior to accepting an assignment or implementing interventions.
b. Registry staff shall receive patient assignments as outlined for ACS.
c. Registry staff may not be assigned the following patients post cardiovascular surgery, post cardiac catheterization, ventilator assisted, or patients as identified by an ANM.
d. Registry staff may not be assigned total responsibility to provide interventions outside of their agency's skills checklist.
e. Registry Certified Nursing Assistant will be assigned task within their skill set for all Telemetry patients.

D. **EXTERNAL LINKS:**

1. **California** Board of Registered Nursing **(BRN). Retrieved from http://www.rn.ca.gov/regulations/rn.shtml**
   a. California Nursing Practice Act: Scope of Regulation. Business and Professional Code Division 2, Chapter 6. Article 2
   b. RN Responsibility when Floating to New Patient Care Unit or Assigned to New Population
   c. Standards of Competent Performance
   d. Unlicensed Assistive Personnel
   e. Abandonment of Patients

DELETE – no longer required

Tri-City Medical Center

Distribution: Women and Newborn Services

PROCEDURE: HYDRALAZINE HYDROCHLORIDE ADMINISTRATION

Purpose: To outline the nursing management of the obstetric patient receiving hydralazine hydrochloride.

Supportive Data: Hydralazine is a direct vasodilator; reducing vascular resistance via direct relaxation of arteriolar smooth muscle. Initially, pulse rate, cardiac output and renal blood flow will increase. Vasodilatation with Hydralazine results in a reflex increase in cardiac output (increased uterine blood flow); this increase in cardiac output blunts the hypotensive effect and makes it difficult to overdose the patient (Roberts.J.M.; Creasy et Resnick, 2004). The rennin-angiotensin-aldosterone system influences expansion of plasma and extra cellular fluid volumes, sodium and water retention and edema formation. Clinically, diastolic **Blood Pressure (BP)** is usually decreased more than systolic BP. **Administration** Intervention is usually recommended when the BP is consistently > **or equal to** 160/110 mm/Hg. (BP point at which hypertensive end organ failure can occur). A satisfactory antepartum , and intrapartum **and/or** (or postpartum) response has been defined as a decrease in diastolic blood pressure to 90-100 mm/Hg. without decreasing utero-placental perfusion. Apresoline is used to prevent cerebral vascular accidents (CVA) and to reduce diastolic BP to levels of 90-100 mm/Hg or 15-20% (ACOG Perinatal guidelines, 2007).

Half Life	2 to 4 hours
Maximum Effect	10 to 80 minutes
Duration	2 to 6 hours

Equipment:
1. Syringe
2. Hydralazine (20 mg per mL)

A. **PROCEDURE:**

1. Position **blood pressure cuff on a superior arm.**
2. Obtain two BPs ten minutes apart with the patient in the lateral recumbent position.
3. Obtain order for hydralazine (Apresoline) **administration from OB provider for persistent BP greater than or equal to 160/110.(List**, route, dose, and frequency)for persistent B/P > 160/110.
4. Identify the patient and check for medication allergies.

Maintain continuous electronic fetal monitoring (antepartum and intrapartum)

5. **Notify the provider for non-reassuring fetal heart rate tracing.**
6. Assess patient's level of understanding regarding the need for the medication and her conditionion. Obtain the medication, syringe, and automatic blood pressure equipment.Apply blood pressure cuff on a superior arm.
7. Initially give hydralazine 5 mg **via iIntravenous push (IVP)** over 1-2 minutes for severe **BP findings per provider order.** e pregnancy induced hypertension.
   a. **A**May give additional doses of hydralazine 5-10 mg IVP **can be given** every 20 minutes **per provider order until a**for desired diastolic BP range of not lower that 90-100 mmHg **is obtained**.
   b. Decreasing the diastolic blood pressure suddenly from ≥ 110 mm Hg to ranges below 90 to 100 mm Hg, can cause decreasing utero-placental perfusion resulting in fetal compromise
   c. **If no effect after 20 mg, provider shall consider switching to another agent**
   d. **Do NOT** Recommendation of total bolus amount not to exceed 40 mg per hypertensive episodeConfirm order if different from recommended guidelines for administration with

Review/Revision Date	Clinical Policies & Procedures	Patient Care Quality Committee	Department of OB/GYN	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
8/96; 2/99; 4/00; 3/03; 8/09, 05/16	n/a	n/a	8/09, 08/16	11/16	01/17		7/03, 9/09

attending obstetrician If no effect after 20 mg, physician will consider switching to another ag

- Assess BP after each IVP dose.Q2 minutes x 10 minutes, then Q5 minutes x 15 minutes, thenQ15 minutes x 1 hour, thenQ1 hour if stable.
- Monitor the fetus via electronic fetal monitoring while the mother is receiving IV Hydralazine.Notify obstetrician immediately for non-reassuring FHR tracing. Maintain strict Intake & Output, assess every 1 to 2 hours or as ordered by the **provider.**hysician.
  - Notify **provider** hysician for urine output of ≤ 30 mL per hour or ≤120 mL per 4 hour**s.**
- rs Notify **provider** hysician if diastolic blood pressure is not decreased to ≤100 mm/Hg within 20 minutes after last IV push administration**n.** Refer to AGoal is to reduce maternal diastolic blood pressure to levels not lower than a range of 90-100 mm Hg For continued physician evaluation for patient's blood pressure not responding to Hydralazine treatment

e. **Make sure** Assure that the pre-eclamptic emergency supplies and the crash cart are immediately available.

B. DOCUMENTATION:

1. Record abnormal BP findings in OB TraceVue/Cerner, as well as other abnormal findings in the clinical notes.
2. Document maternal-fetal response in the patient **'s electronic medical record.** care record.

C. CONTRAINDICATIONS:

1. Relative contraindications to the use of hydralazine **includes**are:
   a. Drug sensitivity
   b. Severe dehydration
   c. Coronary artery disease
   d. Pre-existing angina
   e. Mitral vascular rheumatic heart disease

D. ADVERSE EFFECTS MAY INCLUDE:

1. Maternal
   a. Tachycardia
   b. Palpitations
   c. Flushing
   d. Headache* -may be confused with worsening preeclampsia
   e. Epigastric discomfort* -may be confused with worsening preeclampsia
      i. Nausea
      ii. Diarrhea
   f. Hypotension
   g. Sodium retention
   h. Angina
   i. Dizziness
   j. Dyspnea
   k. Hydralazine induced SLE syndrome
2. Fetal
   a. Tachycardia
   b. Late decelerations (a sharp decrease in the maternal diastolic BP will decrease utero-placental blood flow and O_2 delivery to the fetus)
   c. Thrombocytopenia, leukopenia in newborns

E. REFERENCES:

- **American Academy of Pediatrics (AAP)** & **American College of Obstetrics and Gynecology (ACOG).** (2012)07). Guidelines for Perinatal Care, 76th Edition
- **Druzin, M., Shields, L., Peterson, N., & Cape, Valerie. (2013) Preeclampsia Toolkit: Improving Health Care Response to Preeclampsia (California Maternal Quality Care**

~~**Collaborative Toolkit to Transform Maternity Care). Developed under contract #11-10006 with the California Department of Public Health; Maternal Child and Adolescent Health Division; Published by the California Maternal Quality Care Collaborative, November 2013.**~~

~~**ACOG. Hypertension in Pregnancy: Report of the American College of Obstetricians and Gynecologists' Task Force on Hypertension in Pregnancy. Obstet Gynecol. 2013:122(5): 1122-1131.**~~

1. ~~**ACOG. Diagnosis and Management of Preeclampsia and Eclampsia #33. ACOG Practice Bulletin Number 33, 2002 (Reaffirmed 2012).**~~
2. ~~Creasy, R.K., & Resnik, R., Iams, J. (2004). *Maternal-fetal medicine (5th Ed.).* Philadelphia: Saunders.~~
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Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES POLICY MANUAL

ISSUE DATE: 10/94 **SUBJECT:** NEONATAL TEAM ATTENDANCE AT DELIVERIES

REVISION DATE: 1/00, 6/03, 3/06, 9/09, 4/10

Department Approval Date(s):	**01/16**
Division of Neonatology Approval Date(s):	**08/16**
Department of Pediatrics Approval Date(s):	**11/16**
Department of OB/GYN Approval Date(s):	**12/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval:	**~~05/13~~01/17**
Professional Affairs Committee Approval:	**06/13**
Board of Directors Approval:	**06/13**

A. **POLICY:**

1. The goals of neonatal resuscitation include rapid assessment and stabilization of the newborn's airway, breathing and circulation (~~the~~ ABC's) as well as the stabilization of the thermal environment.
2. To the degree that all resuscitations can be anticipated, the guidelines for neonatal resuscitation as put forth by the **Neonatal Resuscitation Program** (NRP) ~~program~~ developed by the American Academy of Pediatrics and the American Heart Association will apply to all impending deliveries in the Women **and Newborn Services (WNS)** ~~'s and Children's Center~~ of Tri-City Medical Center.
3. Compliance with this policy is the responsibility of all health care providers in **WNS** ~~Women's and Children's Services~~ and the **Neonatal Intensive Care Unit (NICU)**.
4. ~~Refer to California Children's Services Manual of Procedures/ Community NICU /Provider Standards Chapter 3.25.2; Community NICU General Policies and Procedures #2 f page 27,1999.~~

B. **PURPOSE :**

1. To provide guidelines for NICU team attendance at deliveries **for the resuscitation and stabilization of the high risk newborn.**
2. ~~For the resuscitation and stabilization of the high-risk neonate.~~

C. **EQUIPMENT**:

1. Infant warmer
2. Resuscitation equipment
1. ~~Neonatal medications~~
3. Warmed Blankets **and towels**
~~3.~~**4. Warming Mattress if 35 weeks gestation and less**~~,~~
2. ~~Towels~~
~~4.~~**5.** Neowrap (if ~~less than 28~~ **32** weeks **gestation and less**)
~~5.~~**6.** Stethoscope
~~6.~~**7.** Thermometer
~~7.~~**8.** Neonatal Crash Cart
~~8.~~**9.** Neonatal Transport Warmer

D. **~~NEONATAL INTENSIVE CARE UNIT (NICU)~~ RESUSCITATION TEAM ATTENDANCE AT DELIVERIES:**

1. The NICU resuscitation team will be present at the delivery of **newborns**~~infants~~ with the following **risk factors**~~problems~~:

a. Anticipated delivery of 35 completed weeks (35 weeks 6 days) or less or more than 42 completed weeks gestation
b. Known or suspected congenital defects or chromosomal anomalies
c. Multiple gestations
d. Cesarean sections – ~~**Unscheduled,**~~ **Emergent, and/or with high risk indications not limited to:**
i. Fetal Heart Rate Category III strip tracing
ii. Prolapsed Cord suspicion
iii. Placental Abruption
~~a.~~**iv. Uterine Rupture** ~~high risk as defined in D.1.~~
~~d.~~**e.** Signs of fetal distress at the discretion of the **Obstetrical (OB) provider**~~obstetrician~~
f. Macrosomic fetus and**/ or** potential for shoulder dystocia
~~e.~~**g.** At the request of the labor and delivery (L&~~/~~D) Assistant Nurse Manger (ANM)/or designee~~*~~ in collaboration with the **OB provider**~~obstetrician~~.

2. The NICU resuscitation team shall consist of:
   a. Neonatal Attending Physician (MD) **or Neonatal Nurse Practitioner/ Allied Healthcare Provider (AHP)**
   b. NICU nurse
   c. Respiratory Care Practitioner
3. The composition of the NICU resuscitation team may vary according to special circumstances.
4. One member of the team must be skilled in neonatal intubation.
5. All team members must be currently trained in NRP ~~(Neonatal Resuscitation Program).~~

E. **RESPONSIBILITIES OF L&~~/~~D AND NICU TEAM MEMBERS:**

1. The NICU resuscitation team shall be identified at the start of each shift.
2. The L&~~/~~D ANM **or designee**~~*~~ shall provide the NICU ANM **or designee**~~*~~ with updated information regarding the status of high-risk patients that will require the presence of the NICU resuscitation team at a delivery **as indicated**.
3. The **OB provider** ~~Obstetrician (OB) and~~ or the L&~~/~~D nurse (in collaboration with the OB **provider**) may request the presence of the NICU resuscitation team at birth.
4. When the request for the NICU resuscitation team is made the following information shall be communicated**, as available**:
   a. Whether the infant is yet delivered
   b. The type of problem and estimated gestational age (if known)
   c. The location
5. The L&~~/~~D or Nursery nurse shall be responsible for having the resuscitation supplies available in the room.
6. The L&~~/~~D or Nursery nurse shall provide sufficient time for the NICU team to arrive and check equipment **as possible**.
7. Management of the NICU resuscitation team shall belong to the neonatologist**/AHP**, and includes coordination, performance, and delegation of activities.
8. For delivery of multiple gestations, the neonatologist shall determine the staffing and supplies needed to ensure adequate neonatal care.
9. Upon arrival for the delivery the NICU resuscitation team shall identify themselves to the patient/family and to the L&~~/~~D team.
10. The neonatologist**/AHP** will ensure that there is communication with the parents and the L&~~/~~D team about the infant's condition after delivery.
~~10.~~**11.** The assessment, care and evaluation of the infant shall be provided by the NICU resuscitation team following the guidelines put forth in the NRP program.
~~11.~~**12.** The NICU nurse shall receive the ID bands from the L&~~/~~D or Nursery nurse and place them on the baby.
~~12.~~**13.** The NICU nurse will report off to the L&~~/~~D or Nursery nurse prior to leaving the birthing area.
14. At no time will a newborn be left without the presence of a nurse designated to provide care for him/her.

F. **DOCUMENTATION:**

1. Documentation of all assessments and interventions shall be completed by the NICU nurse and/or licensed professional performing the interventions/~~ and~~ assessments prior to leaving the birthing area **on the newborn admission record and in the patient's electronic medical record, as appropriate**.
2. The documentation shall include:
   a. The time the NICU team arrived **and** ~~The timed interventions and~~ who on the team performed the interventions
   b. The condition of the infant and response to interventions
   ~~a.~~**c. Use of the Neonatal Resuscitation Record, if indicated**
   ~~b. The name and discipline of each member of the NICU resuscitation team~~

G. **REFERENCES**:

1. American Heart Association **and American Academy of Pediatrics.** (201~~6011)5~~). ~~Part 7:~~ Neonatal **R**~~r~~esuscitation **~~6~~7th Ed. Washington, D.C., Library of Congress**

2. American Academy of Pediatrics (2010). Special Report- Neonatal resuscitation: 2010 American Heart Association guidelines for cardiopulmonary resuscitation and emergency cardiovascular care. Pediatrics, 126 (5), 1400-1411.

~~1. From the 2005 international census conference on cardiopulmonary resuscitation and emergency cardiovascular care science with treatment recommendations. *Circulation, 112,* III-91–III-99.~~

~~2. Kattwinkel, J. (ed): Textbook of neonatal resuscitation (5th ed) Elk Grove Village, Il, 2006, American academy of Pediatrics and American Heart Association.~~

~~3. Kenner, C. (2003). Resuscitation and stabilization of the newborn. In C. Kenner & J. W. Lott (Eds.), *Comprehensive neonatal nursing: A physiologic perspective* (pp. 210–227). Philadelphia: Saunders.~~

~~4. Knobel, R. B. Wimmer, J. E., & Holbert, D. (2005). Heat loss prevention for preterm infants in the delivery room. *Journal of Perinatology, 25*(5), 304–308.~~

~~4.~~**3.** ~~Merrill, J. D., & Ballard, R. A. (2005). Resuscitation in the delivery room. In H. W. Taeusch, R. A. Ballard, & C. A. Gleason (Eds.), *Avery's Diseases of the Newborn* (8th ed., pp. 349–363). Philadelphia: Elsevier.~~

Tri-City Medical Center
Oceanside, California

WOMEN'S AND NEWBORN SERVICES (WNS)

SUBJECT: STANDARDS OF CARE – NEWBORN'S

ISSUE DATE: 06/14
REVISION DATE(S):

Department Approval Date(s):	**07/16**
Department of OB/GYN Approval Date(s):	**n/a**
Division of Neonatology Approval Dates(s)	**08/16**
Department of Pediatrics Approval Date(s):	**~~08/13~~11/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/17**
Professional Affairs Committee Approval Date(s):	**06/14**
Board of Directors Approval Date(s):	**06/14**

A. PREAMBLE:

1. Nursing practice in the care of Women**'s** and Newborn's **Services (WNS)** is delivered in an environment that respects the goals, preferences, and patient rights of the unique dyad of the maternal-fetal unit and/or mother-baby couplet and the family from admission, through the episode of care, to discharge. The Women and Newborn nursing staff shall use established TCMC and unit specific policies and procedures, and shall adhere to the standards and guidelines set forth by the California Nurse Practice Act, American Nurses Association (ANA), Association of Women's Health, Obstetrics and Neonatal Nurses (AWHONN), and National Association of Neonatal Nurses (NANN). Couplet care is based on a philosophy that embraces the family-s spiritual and cultural values, is ethically relevant and is grounded on evidence-based practices.

~~A.~~B. DEFINITIONS:

1. **Standards of Professional Nursing Practice ~~Care~~:** "Authoritative statements **of the duties that all registered nurses, regardless of role, population or specialty are expected to perform competently (American Nurses Association (ANA), 2010, p.2).** ~~by which the nursing profession describes the responsibilities for which its practitioners are accountable (ANA, p. 77)." "Standards of care describe a competent level of nursing care as demonstrated by the nursing process (ANA, p.78) and are examples of the nursing professional expected roles and responsibilities for providing patient care.~~
1. **Scope of Nursing Practice: "describes the who, what, where, when, why and how of nursing practice. Each of these questions must be answered to provide a complete picture of the dynamic and complex practice of nursing and its evolving boundaries and membership (ANA, 2010)".**
2. **Standards: "Authoritative statements defined and promoted by the profession by which the quality of practice, service or education can be evaluated" (ANA, 2010, p. 67).**
   a. **"Standards of care are Standards of Professional Nursing Practice."**
~~2.~~3. **Nursing Process: "The essential core of practice for the Registered Nurse (RN) to deliver holistic, patient-focused care. The nursing process as outlined by the ANA 2016 includes the following:** ~~Encompasses all significant actions taken by nurses in providing care to all clients, and forms the foundation of clinical decision making. The nursing process also defines additional nursing responsibilities for providing cultural and ethnic relevant care, education to the woman and for her fetus or newborn, caregivers, maintaining a patient safe environment, and~~

~~patient health care promotion and the planning for continuity of care. The nursing process includes the following:~~

a. **Assessment:** A systematic, dynamic **way to collect and analyze data about a client i.e., patient. Assessment includes not only physiological data, but also psychological, sociocultural, spiritual, economic and life-style factors". An assessment includes subjective and objective data.** ~~process by which the registered nurse through interaction with the patient, significant others, and health care providers collect comprehensive data with the priority of data collection determined by the immediate condition of the woman, the fetus or newborn and their needs for health promotion, maintenance, and restoration.~~

~~i. Registered Nurses (RN) performs assessments.~~

~~ii. Obstetrical Technician (OB Techs), OB Advanced Care Technicians (ACTs) collect patient data.~~

~~iii. Only RNs perform admission, transfer, and/or discharge assessments.~~

i. Subjective-what the patient says

ii. Objective-observation based on assessment findings

iii. Focused Assessment/Reassessment: A more specific generalized assessment that focuses on the main items needed reassessed. This may be documented as no change since last assessment. The items that may be assessed are not all inclusive, but not limited to : sleep/alert status, cry reflexes, tone, movement, respiratory symptoms, respirations, respiratory pattern, room air/oxygen, abdominal description, skin color, skin temperature and neonatal skin integrity.

b. **Diagnosis:** A **nurses'** clinical judgment about the client's response to actual or potential health conditions or needs.

c. **Outcomes/Planning: "Based on the assessment and diagnosis. Outcomes are measurable and achievable short and long-range goals".** ~~Measurable, expected, client-focused goals.~~

~~d.~~**i. Planning: (Care Plan i.e.,** Plan of Care): A comprehensive outline of care to be delivered to attain expected outcomes.

~~e.~~**d. Implementation: "Nursing care is implemented to the care plan. This is "continuity of care" from the patient during hospitalization and in preparation for discharge needs".** ~~Includes any or all of these activities: intervening, delegating, and/or coordinating the plan of care.~~

i. ~~TCMC's Mosby's, and Unit Specific Procedures shall be used to implement nursing interventions when appropriate.~~

~~f.~~**e. Evaluation:** The process of determining both **"The patient's status and the** ~~the client's progress toward the attainment of expected outcomes~~ and the effectiveness of nursing care. **It is a process that involves continuously evaluation of the patient and the modifications to the Plan of Care".**

~~3.~~**4. Patient:** Recipient of nursing care.

~~4.~~**5. Health Care Providers:** Individuals with special expertise who provide healthcare services or assistance to clients.

~~5.~~**6. Significant Others:** Family members and/or those significant to the client.

~~6.~~**7. Reasonable and a Timely Manner:** Defined as within 4 hours after completion of assessments or care provided.

B. **REGISTERED NURSES:**

1. Use the nursing process to plan and provide individualized care to their patients. Nurses use the theoretical and evidence-based knowledge of human experiences and responses to collaborate with patient and her fetus or newborn to assess, diagnose, identify outcomes, plan, implement, and evaluate care. Nursing interventions are intended to produce beneficial effects, contribute to quality outcomes, and above all, do no harm. Nurses evaluate the effectiveness of their care in relation to identified outcomes and use evidence-based practice to improve care (ANA, 2010)."

C. **WNS NEWBORN STANDARDS OF PRACTICE:**

1. The results of care provided to the patient shall be continuously evaluated by the health care team, while looking for opportunities to improve delivery and quality of care given.
2. A comprehensive and dynamic database shall be maintained on all patients admitted to the hospital.
3. The patient can expect to have appropriate confidentiality maintained at all times.
4. The patient can expect that the RN shall ensure the optimal desired level of privacy.
5. The patient can expect that the RN shall collect initial objective data within established time frames that reflect the gravity of his/her condition.
6. The patient can expect that the RN shall facilitate the availability of pertinent data and collaborate with other members of the healthcare team to establish an integrated plan of care.
7. The identification and prioritization of the patient's problems/needs shall be based on collected data obtained from assessments, patient/parent interview, patient medical records, and from other members of the healthcare team.
8. The patient can expect that the RN shall utilize collected data to individualize the plan of care.
9. The patient can expect that the RN shall establish the priority of problems/needs on an ongoing basis according to the gravity of the patient's condition.
10. An appropriate plan of care shall be formulated for each patient.
11. The plan of care will be implemented according to the priority of identified problems or needs.
12. The plan of care shall be developed with an understanding of the psychosocial needs of the patient.
13. The patient can expect that there will be documentation of interventions related to the plan of care and that this documentation will be part of the patient's permanent medical record.

D. **GENERAL NEWBORN NURSING ASSESSMENT:**

1. **Standards of Care: Vital Signs**
   a. Vital sings with the first 30 minutes of birth, at one hour, then every 30 minutes until 2 hours of age, upon transfer of care, then every 4 hours until 12 hours post-birth, then if stable, every 6 hours until discharge with vital signs, prior to discharge per Patient Care Services (PCS) procedure, Discharge of Patients, or per provider's orders.
2. Vitals shall include:
   a. Axillary temperature documented in Celsius.
   b. Apical Heart Rate (AHR).Respiratory Rate (RR).
   c. SpO_2, prn spot check when clinically indicated.
   d. Pain level.
3. ~~**If mother and infant are stable v**Vital signs **while the mother has time for skin to skin and breastfeeding** will be assessed within the first 30 minutes of birth, at one hour, then every 30 minutes until 2 hours of age.~~
4. ~~3.~~ If mother and infant stable, vital signs will be assessed while infant is skin-to-skin **or breastfeeding** within the first 30 minutes of birth, at one hour, then every 30 minutes until 2 hours of age.
   a. After two hours of age, the vitals will be taken every 4 hours until 12 hours post birth, then if stable after the 12 hours, every 6 hours until discharge (unless condition warrants more frequent vital signs or per provider order) and prior to discharge per Patient Care Services (PCS) procedure, Discharge of Patients.
   b. Any deviation of temperature, pulse**, respirations** and/or normal limits should warrant reassessment within 30-60 minutes.
   c. Notify provider if reassessment outside of normal limits.
   d. Any deviation from normal limits warrants further assessments, documentation, appropriate intervention and provider notification as needed.
   e. Oximetry spot checks may be considered based on vital signs and clinical assessments.
   f. Normal ranges for newborns after transition (a few hours after birth).
   g. Temperature range: 97.5°F – 99.5°F (36.5°C - 37°5C).
   h. Pulse range: 110-160 bpm **(may be lower due to sleep status).**
   i. Respirations: 30-60 per minute **(may be lower due to sleep status).**

E. STANDARDS OF CARE: NEWBORN PAIN ASSESSMENT:

1. **Assessment: Pain per Pain Management Policy**
   a. The Neonatal Infant Pain Scale (NIPS) is used for pain assessment of the neonate. The infant shall be assess on a scoring system based on 5 parameters, (Behavioral and one physiologic parameter):
      i. Facial expression
      ii. Cry
      iii. Breathing patterns
      iv. Arms
      v. Legs
      vi. State of arousal

2. Pain assessment will be done on admission at the initial shift assessment with vital signs, and as needed.

~~2.~~**3.** **Patient may have fussiness due to delivery or handling versus pain. Reassessment does not need to occur in these instances.**

~~3.~~**4.** Pain will be assessed and assigned a score as follows:

a.

Assessment of Pain	Intervention
No pain	NIPS 0
Mild pain	NIPS less than 2~~, may be managed with non-pharmacologic measures~~
Mild to moderate pain	NIPS 2-4~~, may be managed with non-pharmacologic measures~~
Moderate to severe pain	NIPS greater than 4-7 ~~may need pharmacologic intervention in addition to comfort measures~~

~~4. Pain assessment will be performed before and after procedures that may induce pain.~~
~~5. Pain assessment will be performed after an intervention as follows:~~
~~a. Within one hour of the intervention or as soon as the nurse deems it to be necessary.~~
~~i. Reassess within minutes if infant experiencing acute pain.~~
~~ii. Within two hours or at the next overall nursing assessment, whichever is first.~~

F. STANDARDS OF CARE: INTAKE AND OUTPUT:

1. Intake and output shall be monitored as ordered and as follows:
   a. Intake:
      i. Encourage breastfeeding of the baby at least 8 to 12 times in a 24-hour period.
         1) In the first 24-hours, infant may be sleepy and requirements and demands may be less than the 8-12 feedings.
         2) Evaluate and document LATCH assessment every shift until discharge.
         3) A lactation consult is a separate evaluation and shall be assessed and documented as needed and/or for infants in the NICU.
      ii. ~~If formula is requested for any infant: feeding every 3-4 hours ad lib per Lactation Services Policy.~~ **Formula should only be given per mother request or~~f~~ physician recommendation.** Refer to Infant Feeding policy.
   b. Output:
      i. Urine – the baby should have:
         1) 1 wet diaper in the first 24 hours.
         2) 2 wet diapers on the second day of life.
         3) 3-5 wet~~d~~ diapers on the third-fifth day of life.
         ~~4) 4-6 wet diapers per day by 5-7 days of life.~~
      ii. Stooling:
         ~~1)~~ Ensure the infant is passing meconium a minimum of 1 stool per day ~~(3-4) during the first 1-3 days of life.~~
         ~~2) The baby should have 3-4 stool eliminations by 3-5 days of life.~~
         ~~3)~~**1)** ~~The baby should have 3-6 stool eliminations by 5-7 days of life.~~

iii. Stools will change color, consistency, and texture after meconium passed on day 1-3 (green to yellow).
1) Breastfed infants may appear to have stool that is runny and seedy once milk supply is in.
iv. Document number of wet and/or stooled diapers per shift.
v. Document color and consistency of stooled diapers per shift.

c. Notify provider:
i. Infant has not urinated in the first 24 hours.
ii. Infant has not stooled or passed meconium plug in first 24 hours.
1) Terminal meconium may have occurred after delivery. Ensure that this was reported and documented.

G. STANDARDS OF CARE: HEIGHT AND WEIGHT/OTHER MEASUREMENTS:

1. Weight and length will be measured and documented after birth. Daily weight will be measured and documented until discharge.
   a. Weights shall be documented in grams and length in cm.
2. Occipital frontal circumference (OFC) will be measured at birth and/or when ordered by a provider.
3. Abdominal (ABD) and chest circumference will be measured at birth.
   a. ABD, chest, and OFC measurements shall be documented in centimeters (cm).
   b. Medications shall be calculated using the patient's admission weight unless ordered otherwise by a provider.
   c. Ballard assessment for gestational age shall be performed on all newborns within 12 hours post-delivery.

H. STANDARDS OF CARE: ASPIRATION ASSESSMENT:

1. Maintain aspiration precautions for newborns in transition.
   a. Keep bulb syringe in clean dry area close to newborn's head for use PRN.
      i. Do not use bulb suctioning for oropharyngeal and nasal malformations
   b. Some newborn infants may have increased or thick secretions and may require deep suctioning.
   c. Chest physiotherapy requires a provider order and is contraindicated for newborns with history of meconium fluids.
      i. Chest physiotherapy when ordered shall be performed by a respiratory clinical practitioner (RCP).

I. STANDARDS OF CARE: PATIENT SAFETY:

1. The healthcare team shall provide measures to ensure patient safety for the unique maternal-fetal dyad and/or mother baby couplet.
2. Patient safety shall be assessed per the following:
   a. The RN shall observe the patient's physical condition on admission at transfer to their unit, prior to and after procedures and as needed.
   b. All newborns shall have identification bands placed at birth and be identified per WCS procedure: "Identification/Banding of Newborns."
      i. Newborns admitted to TCMC following delivery outside the labor and delivery unit shall be banded with mother present prior to separation for evaluation of current condition per procedure as referenced above.
   c. **Newborn a**Allergies will be monitored and documented upon admission **as No Known Allergies (NKA)**.
      i. Any known medication or fool allergy shall be documented as follows:
         1) The patient allergy band.
         2) Allergy sticker placed on the front of the chart.
         3) Medication Administration Record.
   d. Orders shall be obtained, reviewed, and implemented per PCS: Provider Orders policy.

e. Critical test values shall be reported per PCS Procedure: Critical Results and Critical Test/Diagnostic Procedures.
f. Patient's specimens shall be handled per PCS: Specimen Handling Procedure or by selecting the appropriate Mosby's Online Specimen Collection Procedure.
g. Electronic or medical equipment brought to TCMC shall be evaluated, used, and store per PCS: Medical Equipment brought into the Facility, policy.
h. Hand-off communication shall be provided per PCS: Hand-off Communication policy and unit specific hand-off policies.
i. Medication shall be reconciled per PCS: Medication Reconciliation policy.
j. All alarms shall be reviewed for appropriateness based on patient's status and maintained in the ON position with the volume at an audible level.

J. **SYSTEM REVIEW:**

1. All newborn patients will have a general system review in all systems completed and documented. Detailed system assessments shall be completed and documented as indicated by the patient's condition.

K. **STANDARD OF CARE NEWBORN: ASSESSMENT:**

1. All patients admitted to WNS nursing units shall be assessed by a registered nurse per the following:
   a. Admission and/or Transfer: Assessment.
      ~~i. All patients admitted or transferred to a higher level of care shall have a biophysical assessment initiated within the following time frames:~~
      ~~ii.~~**i. Infant should first have skin to skin contact with mother and time to breastfeed for as long as possible according to infant stability.** Complete physical exam by 2 hours of age.
      ~~iii.~~**ii.** Upon admission to couplet care
      ~~iv. The biophysical assessment shall be completed in a timely manner.~~
2. Admission Assessment – Patient History (post-delivery):
   a. All inpatients shall have the Admission Assessment – Patient History completed ~~and documented~~ within 2 hours of delivery.
   b. After delivery: Vitals will be done q30 minutes times four with one assessment being a complete head to toe.
3. Initial Shift Assessment
   a. An RN shall perform an ongoing head to toe assessment as follows:
      i. **Transition RN**~~Nursery~~: within 2 hours of the start of the shift.
      ii. Newborn couplet: within 3 hours of the start of the shift.
   b. Reassessment (Focused assessment)
      i. After completion of an admission or an initial shift assessment, all patients shall have ~~a head to toe~~ focused reassessment performed and documented ~~on the ongoing assessment during the shift~~ **as assessment completed and no changes since last assessment. See definition section.**
      ii. Guidelines for reassessment are as follows:
         1) **Transition RN**~~Nursery~~: every 6~~-4~~ hours until stable newborn returned to couplet care (if applicable) or more frequently if treatment or condition warrants.
         2) Newborn couplet: after transitional assessments are complete, every 4 hours until 12 hours post birth, then if stable, every 6 hours until discharge or more frequent if treatment or condition warrants.
      iii. If the patient's guardian refuses a reassessment, document their refusal in the medical record.

L. **STANDARDS OF CARE 1.1: ADMISSION ASSESSMENT NEUROLOGICAL SYSTEM REVIEW:**

1. Neurological: System Review.
2. Assess for the following:

a. Periods of alertness.
b. Symmetric features and movements
c. Posture
d. Tone
e. Tremors or jitteriness

3. Seizure activity.
   a. Facial nerve paralysis.
   b. Newborn reflexes (Moro/startle, reflex, rooting, grasp, plantar, and Babinski reflexes).
   c. Assess if reflexes are symmetrical.
      i. Birth trauma of the head, assess for risk factors.
      ii. Operative assist during delivery process.
   d. Molding or bruising of head, presence of.
      i. Abrasions.
      ii. Caput succedaneum.
      iii. Cephalohematoma.
   e. Eyes:
      i. Sclera – clear, redness, hemorrhage.
      ii. Drainage.
4. Abstinence scoring needs continuous monitoring by RN to assess for signs and symptoms of withdrawal. See Neonatal Abstinence Scoring policy.

M. **STANDARDS OF CARE 1.2: ADMISSION ASSESSMENT CARDIOVASCULAR SYSTEM REVIEW:**

1. Cardiovascular System Review.
   a. Assess heart sounds in all auscultatory areas; note regular or irregular apex or point of maximal impulse (PMI) at left third or four intercostal space.
      i. Murmurs should be reported to MD with notification of birth.
      ii. Murmurs that are present after 12 hours of life should be reported and evaluated to rule out underlying structural abnormalities.
         1) Notify provider immediately if infant is symptomatic.
         2) Notification of the stable infant during provider rounds the next morning is appropriate **or notification via the well baby line**.
   b. Check capillary refill.
   c. Check edema location and grade.
   d. Palpate bilateral brachial and femoral pulses of the newborn.
   e. Assess peripheral perfusion; skin warm and dry.
   f. Assess newborn's fontanels – anterior and posterior.
      i. Flat, depressed, bulging.
      ii. Soft, tense.

N. **STANDARDS OF CARE 1.3: ADMISSION ASSESSMENT PULMONARY SYSTEM REVIEW:**

1. Pulmonary: System Review.
   a. Check oxygen delivery devices if applicable.
   b. Check amount oxygen flow/FiO_2 if applicable.
   c. Assess respiratory effort.
   d. Auscultate breath sounds all lobes.
   e. Assess sputum amount, color, and consistency.
   f. Assess for presence of cough.
   g. Assess for presence of artificial airway, tubes, and drains.
   h. Assess chest expansion for symmetry.
2. In addition to above:
   a. Expected findings for chest/lungs:
      i. Patency of airway.
      ii. Patency of nares.
         1) Presence of congestion or drainage.
         2) Symmetric, barrel shaped, with equal anteroposterior and lateral diameters.

3) Slight subcostal and intercostals retractions are common **during transition.**
4) Bilateral bronchial breath sounds. Fine crackles and transient hoarseness are normal **during transition.**
5) Respiratory rate and effort.

b. Document all findings, notify provider for abnormals. Assess for:
i. Tachypnea – persistent respiratory rate greater than 60 per minute.
ii. Grunting.
iii. Significant retraction.
iv. Questionable color.
v. Lack of breath sounds in one or more lobes.
vi. Oximetry spot checks based on vital signs and clinical assessments.

O. **STANDARDS OF CARE 1.4: ADMISSION ASSESSMENT GASTROINTESTINAL (GI) SYSTEM REVIEW:**

1. GI: System Review
a. Assess contour/tone of abdomen.
~~i. Round, concave, scaphoid, distention.~~
~~ii. Soft, firm.~~
b. Assess for ~~nausea and/or~~ vomiting.
c. Auscultate for presence of bowel sounds in all four quadrants.
d. Assess bowel function including ~~passing flatus~~ or last stool.
~~e. Assess for the presence of tubes and drains, if present assess type and location.~~
~~i. Confirmation of placement, and drainage description.~~
~~ii. Check tube placement for drainage and insertion site integrity.~~
~~iii. Assess type of formula, rate, and residual amounts.~~

2. In addition to above assess for:
a. Maternal risk factors:
i. Polyhydraminios.
ii. Cesarean delivery.
iii. Maternal intrapartum bleeding.
iv. Meconium stained fluid.
b. Warning signs:
i. Green bilious emesis.
ii. Presence of blood in emesis or stools.
iii. Tense or tender abdomen.
iv. Abnormal distention.
v. Notify provider immediately for presence of warning signs.

P. **STANDARDS OF CARE 1.5: ADMISSION ASSESSMENT GENITOUTINARY SYSTEM REVIEW**

1. Genitourinary (GU) System Review
a. Assess urine color and frequency.
b. Assess for bladder distension if no urination in 24 hours.
c. Assess external anatomy as applicable.

2. In addition to above, assess for:
a. Females:
i. Presence of labial skin tags and/or edema.
ii. Presence of discharge.
iii. Presence of ambiguous genitalia.
b. Males:
i. Location of meatus (hypospadias, epispadias).
ii. Condition of foreskin.
iii. Presence of descended testes.
iv. Condition of scrotum (hydrocele, hernia, etc.).
v. Presence of ambiguous genitalia.

vi. Assess circumcision site when applicable.

Q. **STANDARDS OF CARE 1.6: ADMISSION ASSESSMENT MUSCULOSKELETAL SYSTEM REVIEW:**

1. Musculoskeletal System Review.
   a. Presence of joint or musculoskeletal abnormalities.
   b. Full range of motion against gravity, some to full resistance of all extremities.
   c. ~~Mobility~~ Movement appropriate for age.
2. In addition to above, assess for presence of:
   a. Symmetry of extremities.
   b. Head/neck:
      i. Full range of motion of neck without torticollis.
         ~~1) Tonic neck reflex present.~~
      ii. Sutures.
         ~~1) Overriding, widened, fused.~~
      iii. Mouth, lips, and palate (patent, fused, cleft, intact, precocious teeth).
      iv. Nares
   c. Muscle tone.
   d. Intact clavicles with no tenderness, swelling, or crepitation.
   e. All ten fingers and toes present without webbing, extra digits.
   f. Spine intact without openings, masses, curves, dimples, or hairy tufts.
   g. Gluteal folds/creases, palmar creases, or hip click.

R. **STANDARDS OF CARE 1.7: ADMISSION ASSESSMENT INTEGUMENTARY SYSTEM REVIEW:**

1. Skin Assessment.
   a. Admission ~~and/or shift assessment~~ exams.
      i. Temperature.
      ii. Color ~~– pink, cyanosis, acrocyanosis, pallor, jaundice, plethoric.~~
      iii. Warmth.
      iv. Turgor.
      v. Moisture.
      vi. Edema.
      vii. Transient mottling.
      viii. Vernix
      ix. Lanugo.
      x. Milia.
      xi. Port wine stain.
      xii. Capillary hemangiomas: "stork bite," "angel kiss."
      xiii. Mongolian spots.
      xiv. Skin tags.
   ~~b. Ongoing assessments shall also include presence of:~~
      ~~i.~~**xv. Newborn Rash(e**~~E~~rythema toxicum**)**: pink popular rash with vesicles on chest, arms, **back**, or abdomen.
      xvi. Petechiae.
      ~~ii.~~**xvii. Ecchymosis**
2. The infant should be dried per Neonatal Resuscitation Guidelines without wiping all the vernix from the skin. Visible blood should be cleaned from the infant. After 24 hours of life, the stable infant may receive an initial bath upon parent's request. ~~For term infants (greater than or equal to 37 weeks and 0 days), recommended only after newborn's temperature and vital signs have been stabilized. Postpone bath until thermal stability is ensured, unless indicated by maternal infection risk factors (i.e., HIV, Hep B, etc.).~~
   a. If the infant is bathed during the hospital stay, familial participation should be encouraged.
   b. A sponge bath may be given to the infant in the crib and then the infant should be placed skin to skin with mother.

c. Earlier bathing may be considered per specific parental request, meconium stained infant, or malodorous fluid.

d. The infant whose mother is infected with a blood borne pathogen or current STD should receive a bath as soon as possible after delivery.

3. Cord Care/Assessment.
   a. Assessment to include:
      i. Number of vessels.
      ii. Condition – moist, drying.
      iii. Drainage.
      iv. Clamp.
   b. Initial: clean the cord and surrounding skin surface during the initial bath with cleansing solution, rinse thoroughly and then allow to air dry folding the diaper away from the umbilical cord.
   c. Ongoing: every shift and as needed, inspect cord for degree of moisture or dryness, drainage and odor. Keep the cord dry and clean if cord becomes soiled with urine or stool, cleanse with water.

S. **STANDARDS OF CARE 1.8: ASSESSMENT PSYCHOLOSOCIAL SYSTEM REVIEW:**

1. Psychosocial assessment will be done with the mother and social service consultation ordered as needed.

T. **OTHER PROCEDURES:**

1. Newborn will have blood glucose performed per **Blood Glucose Newborn Monitoring**~~Newborn Hypoglycemia during Transition to Extrauterine Life~~ Standardized Procedure.
2. Toxicology urine specimen will be obtained if the mother has a positive toxicology screen, a positive history of substance abuse, is suspected of substance abuse or with diagnosis, has had less than or equal to three prenatal visits or suspicion of placental abruption and on all babies assigned to Neonatology.
3. Prophylactic eye ointment and Vitamin K will be given per PCS Standardized Procedure: Administration of Aquamephyton Injection and Erythromycin Ophthalmic Ointment to the Newborn.
4. Hepatitis B vaccination or Hep B vaccine and HBIG immunuglobin injection will be given per PCS Standardized Procedure: Administration of Pediatric Hepatitis B Vaccine and Hepatitis B Immunoglobulin (HBIG) to Newborns.
5. Newborn Hearing Screen prior to discharge, but at least 12 hours post-delivery per hospital procedure: Hearing Screening Newborn and Infant.
6. **Serum** ~~Transcutaneous~~ bilirubin screening for assessment of jaundice will be done around 24 hours, prior to discharge or if baby visually jaundiced.
7. Newborn metabolic screen will be done prior to discharge per PCS Procedure: Newborn Screen, Collection of Specimen.
8. Universal Screening for Critical Congenital Heart Disease will be done after 24 hours of life or prior to discharge per Standardized Procedure: Universal Blood Saturation Screening for Critical Congenital Heart Disease (CCHD).
9. Car seat challenge will be performed on infants meeting criteria per WNS/NICU Procedure: Care Seat Challenge Test.
10. Neonatal Abstinence Scoring will be performed on all infants meeting criteria per WNS/NICU Procedure: Neonatal Abstinence Scoring.

U. **NURSING PROCESS:**

1. Standards of Care: Assessment.
   a. An RN shall ensure all maternal and infant patients have a general system review in all systems completed. Detailed system assessments shall be completed as indicated by the patient's condition.
2. Standards of Care: Diagnosis.

a. An RN shall review the data obtained from each patient's assessment, history, and information documented by the interdisciplinary team to identify outcomes to develop the patient's plan of care (POC) every shift, and PRN.

3. Standards of Care: Outcome Identification.
   a. An RN shall use the information obtained from Standards of Care: Assessment and Standards of Care: Diagnosis to identify appropriate patient outcomes every shift and PRN.
4. Standards of Care: Planning.
   a. An RN shall use the outcomes identified in Standards of Care: Outcome Identification and the provider orders to develop an individualized patient POC. The POC shall prescribe interventions which may be implemented to attain expected outcomes.
5. Standards of Care: Implementation.
   a. An RN shall implement the interventions identified in the POC and/or ensure unlicensed assistant personnel are assigned task appropriately.
6. Standards of Care: Evaluation.
   a. An RN shall evaluate the patient's progress forward obtaining their outcomes in the POC per TCMC policy.
   b. Emergent and urgent changes in the patient's assessment shall be communicated to providers as soon as possible per TCMC policy.
   c. Non-emergent and/or not urgent changes in patient's assessment shall be communicated during provider rounds or as soon as possible within the shift the changes were identified.
7. Standards of Care: Documentation.
   a. It is recommended that all shift assessments, reassessments, PRN assessments and/or care provided be documented after completion of the care in a timely manner.
   b. When it is not possible to document shift assessments, reassessments, PRN assessments and/or care provided due to unforeseen circumstances such as urgent or emergent situations, changes in assignment or increased patient acuity, document the nursing care and assessment as soon as reasonably able to do so.

   c. Reasonable and a timely manner may be defined as within 4 hours after completion of assessments or care provided.

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STANDARDS OF CARE – POSTPARTUM
WOMEN'S AND ~~CHILDREN'S~~NEWBORN'S SERVICES

SUBJECT: STANDARDS OF CARE - POSTPARTUM

ISSUE DATE: 06/14
REVISION DATE(S):

Department Approval Date(s):	**07/16**
Department of OB/GYN Approval Date(s):	**~~04/13~~12/16**
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Medical Executive Committee Approval Date(s):	**11/17**
Professional Affairs Committee Approval Date(s):	**06/14**
Board of Directors Approval Date(s):	**06/14**

A. **PREAMBLE:**

1. Nursing practice in the care of Women and Newborns is delivered in an environment that respects the goals, preferences, and patient rights of the unique dyad of the maternal-fetal unit and/or mother-baby couplet and the family from admission, through the episode of care, to discharge. The Women's and ~~Children's~~**Newborn's Services (WNS)** nursing staff shall use established TCMC and unit specific policies and procedures, and shall adhere to the standards and guidelines set forth by the California Nurse Practice Act, American Nurses Association (ANA), Association of Women's Health, Obstetrics and Neonatal Nurses (AWHONN), and National Association of Neonatal Nurses (NANN).Couplet-care is based on a philosophy that embraces the family's spiritual and cultural values, is ethically relevant and is grounded on evidence-based practices

B. **DEFINITIONS:**

1. **Standards of ~~Care~~Professional Nursing Practice: "**Authoritative statements **of the duties that all registered nurses, regardless of role, population or specialty are expected to perform competently (American Nurses Association (ANA), 2010, p. 2.**~~by which the nursing profession describes the responsibilities for which its practitioners are accountable (ANA, p.77)". "Standards of care describe a competent level of nursing care as demonstrated by the nursing process (ANA, p.78) and are examples of the nursing professional expected roles and responsibilities for providing patient care.~~
2. **Scope of Nursing Practice: "describes the who, what, where, when, why and how of nursing practice. Each of these questions must be answered to provide a complete picture of the dynamic and complex practice of nursing and its evolving boundaries and membership (ANA, 2010 p. 67).**
   a. **"Standards of care are Standards of Professional Nursing Practice."**
~~2.~~3. **Nursing Process: The essential core of practice for the Registered Nurse (RN) to deliver holistic, patient-focused care. The nursing process as outlined by the ANA (2016) includes the following** ~~Encompasses all significant actions taken by nurses in providing care to all clients, and forms the foundation of clinical decision-making. The nursing process also defines additional nursing responsibilities for providing cultural and ethnic relevant care, education to the woman and for her fetus or newborn, caregivers, maintaining a patient safe environment, and patient health care promotion and the planning for continuity of care. The nursing process includes the following:~~
   a. **Assessment:** A systematic, dynamic **way to collect and analyze data about a ~~client~~patient i.e., patient. Assessment includes not only physiological data, but also psychological, sociocultural, spiritual, economic and life-style factors". An assessment includes subjective and objective data.** ~~process by which the registered~~

~~nurse, through interaction with the patient, significant others, and health care providers, collects comprehensive data with the priority of data collection determined by the immediate condition of the woman, the fetus or newborn and their needs for health promotion, maintenance and restoration.~~

~~a. Registered Nurses (RN) performs assessments.~~

~~b. Obstetrical Care Technicians (OB Techs) and OB Advanced Care Technicians (ACTs) collect patient data.~~

~~c. Only RNs perform admission, transfer, and and/ or discharge assessments.~~

i. Subjective-what the patient says

ii. Objective-observation based on assessment findings

b. Focused Assessment/Reassessment: A more specific generalized assessment that focuses on the main items needed reassessed. This may be documented as no change since last assessment. The items that may be assessed are not all inclusive, but not limited to: orientation, assessment, level of consciousness, affect/behavior, respiratory symptoms, respirations, respiratory pattern, skin color, skin temperature, fundal/lochia/cesarean section/tubal ligation assessment.

~~b.~~**c. Diagnosis:** A **nurses'** clinical judgment about the ~~client's~~ **patient's** response to actual or potential health conditions or needs.

~~c.~~**d. Outcomes/Planning: "Based on the assessment and diagnosis. Outcomes are measureable and achieved short and long-range goals".** ~~Measurable, expected, client-focused goals~~

~~2.~~**i. Planning**: ~~(~~**Care Plan i.e.** Plan of Care~~)~~: A comprehensive outline of care to be delivered to attain expected outcomes.

~~d.~~**e. Implementation: "Nursing care is implemented to the care plan. This is "continuity of care from the patient during hospitalization and in preparation for discharge needs".** ~~Includes any or all of these activities: intervening, delegating, and/or coordinating the plan of care.~~

i. ~~TCMC's, Mosby's, and Unit Specific Procedures shall be used to implement nursing interventions when appropriate.~~

~~e.~~**f. Evaluation:** The process of determining both the **"Patient;s status** ~~client's progress toward the attainment of expected outcomes~~ and the effectiveness of nursing care. **It is a process that involves continuously~~ evaluation of the patient and the modifications to the Plan of Care."**

~~3.~~**4. Patient:** Recipient of nursing care.

~~4.~~**5. Health Care Providers:** Individuals with special expertise who provide health care services or assistance to ~~client~~**patients**.

~~5.~~**6. Significant Others:** Family members and/or those significant to the ~~client~~**patient**.

~~6.~~**7. Reasonable and a timely manner:** Defined as within 4 hours after completion of assessments or care provided.

~~7.~~**8. Registered nurses** use the nursing process to plan and provide individualized care to their patients. Nurses use the theoretical and evidence-based knowledge of human experiences and responses to collaborate with patient and her fetus or newborn to assess, diagnose, identify outcomes, plan, implement and evaluate care. Nursing interventions are intended to produce beneficial effects, contribute to quality outcomes, and above all, do no harm. Nurses evaluate the effectiveness of their care in relation to.identified outcomes and use evidence-based practice to improve care (ANA, 2010)".

C. ~~WCS~~WNS STANDARDS OF PRACTICE:

1. The results of care provided to the patient shall be continuously evaluated by the health care team, while looking for opportunities to improve delivery and quality of care given.
2. A comprehensive and dynamic data-base shall be maintained on all patients admitted to the hospital.
3. The patient can expect to have appropriate confidentiality maintained at all times.

4. The patient can expect that the RN shall ensure the optimal desired level of privacy.
5. The patient can expect that the RN shall collect initial objective data within established time frames that reflect the gravity of his/her condition.
6. The patient can expect that the RN shall facilitate the availability of pertinent data and collaborate with other members of the health care team to establish an integrated plan of care.
7. The identification and prioritization of the patient's problems/needs shall be based on collected data obtained from assessments, patient/parent interviews, patient medical records, and from other members of the health care team.
8. The patient can expect that the RN shall utilize collected data to individualize the plan of care.
9. The patient can expect that the RN shall establish the priority of problems/needs on an ongoing basis according to the gravity of the patient's condition.
10. An appropriate plan of care shall be formulated for each patient.
11. The plan of care will be implemented according **to** the priority of identified problems or needs.
12. The plan of care shall be developed with an understanding of the psychosocial needs of the patient.
13. The patient can expect that there will be documentation of interventions related to the plan of care and that this documentation will be part of the patient's permanent medical record.

D. **NURSING PROCESS:**

1. **STANDARDS OF CARE: ASSESSMENT**
   a. RN shall ensure all maternal and infant patients have a general system review in all systems completed. Detailed system assessments shall be completed as indicated by the patient's condition.
2. **STANDARDS OF CARE: DIAGNOSIS**
   a. RN shall review the data obtained from each patient's assessment, history, and information documented by the interdisciplinary team to identify outcomes to develop the patient's plan of care (POC) every shift and PRN.
3. **STANDARDS OF CARE: OUTCOME IDENTIFICATION**
   a. RN shall use the information obtained from Standards of Care: Assessment and Standards of Care: Diagnosis to identify appropriate patient outcomes every shift and PRN.
4. **STANDARDS OF CARE: PLANNING**
   a. RN shall use the outcomes identified in Standards of Care: Outcome Identification and the provider orders to develop an individualized patient POC. The POC shall prescribe interventions, which may be implemented to attain expected outcomes.
5. **STANDARDS OF CARE: IMPLEMENTATION**
   a. RN shall implement the interventions identified in the POC and/or ensure unlicensed assistant personnel are assigned task**s** appropriately.
6. **STANDARDS OF CARE: EVALUATION**
   a. RN shall evaluate the patient's progress toward obtaining their outcomes in the POC per TCMC policy.
   b. Emergent and urgent changes in the patient's assessment shall be communicated to providers as soon as possible per TCMC policy.
   c. Non-emergent and/or not urgent changes in patient's assessment shall be communicated during provider rounds or as soon as possible within the shift the changes were identified.

E. **STANDARDS OF CARE: DOCUMENTATION:**

1. It is recommended that all shift assessments, reassessments, PRN assessments and/or care provided be documented after completion of the care in a timely manner.
2. When it is not possible to document shift assessments, reassessments, PRN assessments and/or care provided due to unforeseen circumstances such as urgent or emergent situations, changes in assignment or increased patient acuity, document the nursing care and assessment as soon as reasonably able to do so.

3. Reasonable and a timely manner may be defined as within 4 hours after completion of assessments or care provided.

GENERAL OB NURSING ASSESSMENT

A. **STANDARDS OF CARE: VITAL SIGNS:**

1. Maternal vital signs shall include:
   a. Temperature, documented in Celsius (preferred)
   b. Blood Pressure (BP)
   c. Heart Rate (HR)
   d. Respiratory Rate (RR)
   e. SpO2
   f. Pain Level
2. Vitals signs shall be obtained on admission, transfer to a unit, at discharge per Patient Care Services (PCS) procedure Discharge of Patients, per provider's orders and as follows:
   a. **Postpartum, Vaginal Delivery**:
      i. **In Labor and delivery v**~~V~~ital signs **are obtained** every 15 minutes x4, at 2 hours, upon admission to couplet care, then every 6 hours for the first 24 hours post-delivery, then every shift until discharge, prior to discharge per Patient Care Services (PCS) procedure Discharge of Patients and prn as clinically indicated or ordered by provider. Patient's temperature is taken x 1 following delivery.
      ii. Notify provider if:
         1) Temperature greater than or equal to 100.4° F or 38° C
         2) Blood pressure greater than or equal to systolic 140 and/or diastolic 90; greater than or equal to systolic 160 and/or 110 diastolic if known preeclamptic
         3) Pulse greater than or equal to 120 bpm
         4) Respirations greater than 28 or less than 12
   b. **Post-Operative, Cesarean Delivery**:
      i. PACU vital signs as ordered by anesthesiologist/provider
      ii. Vital signs, including temperature, upon admission to couplet care, then every 6 hours for first 48 hours post-delivery, then every shift and prn as clinically indicated or ordered by provider and prior to discharge per Patient Care Services (PCS) procedure Discharge of Patients
         1) See anesthesia Power Plan for vital signs in the first 24 hours after cesarean section (generally includes respiratory rate every 1 hour times 12 hours then every 2 hours times 12 hours).
      iii. Notify provider if:
         1) Temperature greater than or equal to 100.4° F or 38° C
         2) Blood pressure greater than or equal to systolic 140 and/or diastolic 90; greater than or equal to systolic 160 and/or 110 diastolic if known preeclamptic
         3) Pulse greater than or equal to 120 bpm
         4) Respirations greater than 28 or less than 12

B. **STANDARDS OF CARE: PAIN ASSESSMENT:**

1. Assessment: Pain per Pain Management Policy
   a. A general pain assessment shall consist of the following:
   b. Acceptable pain
   c. Pain scale
   d. Current pain intensity
   e. If patient complains of pain, assess the following:
      i. Location, intensity, and duration/onset
      ii. Quality/type

iii. Aggravating factors
iv. Alleviating factors

f. Assess for presence of pain/discomfort with vital signs and PRN
g. Perform a pain assessment with each patient report of new or different pain.
h. Perform a pain reassessment as follows:
i. Thirty (30) minutes after intravenous medications, intramuscular, or subcutaneous intervention
ii. One (1) hour after PO intervention

C. **STANDARDS OF CARE: INTAKE AND OUTPUT:**

1. Intake and output shall be monitored as ordered and as follows:
a. Postpartum, Vaginal Delivery:
i. Check if patient voiding without difficulty x 2 post-delivery.RN or designee to offer assistance as needed.
ii. After delivery or after catheter removal goal is for patient to void spontaneously within 6 hours
1) If patient on I/O or has an IV ordered, notify provider if measured output is less than or equal to 30 mL per hour or less than or equal to 120 mL in 4 hours
iii. Maintain IV access for 24 hrs. post epidural anesthesia unless ordered by provider.
iv. Post-partum hemorrhage
1) Assess and review risk factors for obstetrical hemorrhage, and monitor patient's blood loss for baseline blood loss output
2) Monitor lochia color, odor, amount, consistency, clots, steady stream or trickle
a) Assess pads and saturation
b) Weigh all blood saturated pads, chux, other soft/cloth materials for accurate assessment of blood loss
c) Document blood loss in medical record, including provider notification, interventions, blood replacement products, and medications given.
d) Refer to ~~WCS~~**WNS** Obstetrical Hemorrhage procedure.

b. Postoperative, Cesarean Delivery:
i. OB PACU: upon arrival from the OR and prior to transfer to couplet care:
1) Assess and document the number of the IV fluid bag
2) Assess and document patency of the Foley catheter with urine collection bag for amount, color and clarity of urine
ii. I&O totals every shift with 24 hour totals for day of delivery, and post-op day.
1) Notify provider if measured output is less than or equal to 30 mL per hour or less than or equal to 120 mL in 4 hours
2) IV converted to saline lock or discontinued on post-op day 1, or as ordered by provider
3) Foley catheter discontinued on post-op day 1 or as ordered by provider
a) Assess bladder/voiding difficulties prn
b) Check voiding x2 post-removal of catheter. RN or designee to offer assistance as needed. After catheter removal goal is for patient to void spontaneously within 6 hours.
iii. Post-operative cesarean hemorrhage:
1) Assess and review risk factors for obstetrical hemorrhage, and monitor patient's blood loss for baseline blood loss output
2) Monitor lochia color, odor, amount, consistency, clots, steady stream or trickle
a) Assess pads and saturation

b) Weigh all blood saturated pads, chux, other soft/cloth materials for accurate assessment of blood loss
c) Document blood loss in medical record, including provider notification, interventions, blood replacement products, and medications given.
d) Refer to ~~WCS~~**WNS** Obstetrical Hemorrhage procedure.

iv. Assess for the presence of tubes and drains, if present, assess type and location
1) Confirmation of placement, and drainage description
2) Check tube placement for drainage and insertion site integrity

D. **STANDARDS OF CARE: HEIGHT AND WEIGHT/OTHER MEASUREMENT:**

1. Height and weight will be self-reported and/or transcribed from prenatal record with information from last office visit prior to admission. If the situation permits, it is preferred that the patient be weighed upon admission to Labor and Delivery.
   a. Weights shall be documented in kilograms (kg) and height in centimeters (cm)
   b. Medications shall be calculated using the patient's admission weight unless ordered otherwise by a provider.

E. **STANDARDS OF CARE: ASPIRATION ASSESSMENT:**

1. Maintain aspiration precautions for maternal patients identified at risk.
   a. Maintain head of bead (HOB) at 30 degrees at all times
      i. If eclamptic seizure, lower head of bed, open airway, roll patient to side and suction secretions as necessary
      ii. Avoid attempts to insert suctioning device when patient's teeth are clenched
   b. Maintain suction equipment at bedside at all times.

F. **STANDARDS OF CARE: PATIENT SAFETY:**

1. The health care team shall provide measures to ensure patient safety for the unique maternal-fetal dyad and/or mother baby couplet. This includes the bed in the lowest position, wheels locked, and room free of clutter.
2. Patient safety shall be assessed per the following:
   a. The RN shall observe the patient's physical condition on admission and/or transfer to their unit, prior to and after epidural placement and/or other procedures and as needed.
   b. Patients shall be identified per Patient Care Services (PCS): Identification, Patient Policy.
   c. Allergies will be monitored and documented upon admission
      i. Any known medication or food allergy shall be documented as follows:
         1) The patient allergy band
         2) Allergy sticker placed on the front of the chart
         3) Medication Administration Record
      ii. Orders shall be obtained, reviewed, and implemented per PCS: Provider Orders Policy.
   d. Critical test values shall be reported per PCS Procedure: Critical Results and Critical Test/Diagnostic Procedures.
   e. Patient's specimens shall be handled per PCS: Specimen Handling Procedure or by selecting the appropriate Mosby's Online Specimen Collection Procedure.
   f. Electronic or medical equipment brought to TCMC shall be evaluated, used, and stored per PCS: Medical Equipment Brought into the Facility Policy.
   g. Patients shall be assessed for falls per PCS: Falls Risk Procedure.
   h. Hand-off Communication shall be provided per PCS: Hand-off Communication Policy and unit specific hand-off policies.
   i. Medication shall be reconciled per PCS: Medication Reconciliation Policy.

j. All alarms shall be reviewed for appropriateness based on patient's status and maintained in the ON position with the volume at an audible level.

SYSTEM REVIEW

A. All maternal patients will have a general system review in all systems completed and documented. Detailed system assessments shall be completed and documented as indicated by the patient's condition.

B. **STANDARD OF CARE 1: ASSESSMENT:**

1. All patients admitted to ~~WCS~~**WNS** nursing units shall be assessed by a Registered Nurse per the following:
2. Admission and/or Transfer: Assessment
   ~~1. All patients admitted or transferred to a higher level of care shall have a head to toe assessment initiated within 30 minutes of arrival to unit. A detailed or disease specific assessment shall be document as needed.~~
3. Admission Assessment- Patient History:
   a. All inpatients shall have the Admission Assessment-Patient History completed and documented within 24 hours of admission to the unit.
      i. This assessment-patient history shall include an assessment for obstetric hemorrhage
4. Medication Patient History Form
   a. All patients shall have a Medication Patient History completed as soon as possible upon arrival to the unit per the Medication Reconciliation Policy.
5. Initial Shift Assessment
   a. RN shall initiate an ongoing head to toe assessment as follows: within 3 hours of the start of the shift
6. Reassessment/**focused assessment may be documented as no change since last assessment**
   a. After completion of an Admission or an Initial shift Assessment, all patients shall have a:
      i. Focused reassessment (to usually include fundus, lochia, bladder~~,~~ **incision if applicable** ~~breasts and nipples~~) performed and documented in the EMR.
      ~~a. Ongoing Assessment during the shift every 6 hours until discharge or transferred to another level of care.~~
      ~~i.~~**ii.** **Aa** more detailed assessment may be completed dependent on clinical condition or per PCS Magnesium Sulfate procedure.
      ~~ii.~~**iii.** If the patient refuses a reassessment, document their refusal in the medical record.
      ~~2.~~**iv.** System Specific Assessment (Focus assessment/postpartum assessment) shall ~~be also~~**also be** completed as follows:
         ~~a.~~**1)** Change in patient's condition from the initial shift assessment or reassessment.
         ~~b.~~**2)** Response to treatment provided to a patient
   b. Postpartum assessment **and frequency**:
      i. Uterine assessment (to include lochia assessment):
         1) Fundal height/relationship to umbilicus (-3, -2, -1, 0, +1, +2, +3)
         2) Location (midline (ML), right of ML, left of ML, displaced – bladder assessment)
         3) Consistency (firm, boggy - firms with massage, boggy)
         4) Time intervals, beginning post-delivery:
            a) Birth – 2 hrs.: every 15 minutes x4, then at 2hours
            b) 2hrs-6hrs: upon admission to MBU, then every 6 hrs. post-delivery

c) **Vaginal Delivery:** 6- 24 Hrs. every 6 hrs. or sooner if clinically indicated times 24 hours, then q shift until discharge
d) **Cesarean Section:** 6-48 hours: every 6 hours or sooner if clinical indicated times 24 hours then q shift until discharge.

ii. Evaluation of blood loss/lochia: include at the same time intervals for uterine assessment
1) Slight, Scant, Moderate, Heavy (with or without clots)
2) Rubra, serosa or other
3) Note presence of foul odor
4) Risk assessment for obstetric hemorrhage
a) Refer to ~~WCS~~**WNS** Obstetrical hemorrhage procedure.

iii. Perineal/hemorrhoid assessment as applicable.
1) Approximated
2) Color (presence or absence of ecchymosis)
3) Edema
4) Presence or absence of Hemorrhoids

C. **STANDARDS OF CARE 1.1: ASSESSMENT NEUROLOGICAL SYSTEM REVIEW ADMISSION ASSESSMENT:**

1. Neurological: System Review
a. Assess the following:
i. Level of consciousness
ii. Orientation
iii. Presence of Headache
iv. Visual disturbances, e.g. blurred vision or scotoma
v. Deep Tendon Reflexes
vi. Patellar or brachial
vii. Clonus
b. Effects of epidural/regional anesthesia on lower extremities
i. Progressive return to pre-anesthesia response, accompanied by increased voluntary movement of legs
ii. Assessment of epidural site, removal of catheter post-delivery per procedure (Reference: ~~WCS~~**WNS** procedure: "Epidural Medication Administration")

D. **STANDARDS OF CARE 1.2: ASSESSMENT CARDIOVASCULAR SYSTEM REVIEW ADMISSION ASSESSMENT:**

1. Cardiovascular System Review
a. Assess heart sounds in all auscultatory areas; note regular or irregular
b. Check capillary refill
c. Check edema location and grade
d. Palpate bilateral peripheral pulses: radial and dorsalis pedis
~~3. Palpate bilateral brachial~~
e. Assess peripheral perfusion; skin warm and dry
f. Assess Homan's sign for presence of thrombophlebitis

E. **STANDARDS OF CARE 1.3: ASSESSMENT PULMONARY SYSTEM REVIEW ADMISSION ASSESSMENT:**

1. Pulmonary: System Review
a. Check oxygen delivery devices if applicable
b. Check amount oxygen flow if applicable
c. Assess pulse oximetry
i. For Magnesium Sulfate administration for preeclampsia/preterm labor see Reference: PCS procedure: "Magnesium Sulfate Administration in Obstetric Patients"

d. Assess respiratory effort
e. Auscultate breath sounds all lobes
f. Assess sputum amount, color, and consistency if applicable
g. Assess for presence of cough
h. Assess for presence of artificial airway, tubes, and drains if applicable
i. Assess chest expansion for symmetry

F. **STANDARDS OF CARE1.4: ASSESSMENT GASTROINTESTINAL (GI) SYSTEM REVIEW ADMISSION ASSESSMENT:**

1. GI: System Review
   a. Assess abdomen
      i. Round, distention
      ii. Soft, firm, distended, non-distended
   b. Assess for nausea and/or vomiting
   c. Auscultate for presence of bowel sounds in all four quadrants
   d. Assess bowel function including passing flatus or last stool

G. **STANDARDS OF CARE 1.5: ASSESSMENT GENITOUTINARY SYSTEM REVIEW ADMISSION ASSESSMENT:**

1. Genitourinary (GU) System Review
   a. Assess urine color and clarity, frequency and voiding difficulties/dysuria
   b. Assess for bladder distension

H. **STANDARDS OF CARE 1.6: ASSESSMENT MUSCULOSKELETAL SYSTEM REVIEW ADMISSION ASSESSMENT:**

1. Musculoskeletal System Review
   a. Presence of assistive devices
   b. Presence of joint or musculoskeletal abnormalities
   c. Full range of motion against gravity, some to full resistance of all extremities
   d. Mobility appropriate for age

I. **STANDARDS OF CARE 1.7: ASSESSMENT INTEGUMENTARY SYSTEM REVIEW ADMISSION ASSESSMENT:**

1. Integumentary System Review:
   a. Assess mucous membranes
   ~~a.~~**b.** ~~and S~~skin color; consistent with person's ethnicity
   ~~b.~~**c.** Palpate skin for temperature and moisture
   ~~c.~~**d.** Assess skin turgor
   ~~d.~~**e.** Assess skin integrity, temperature, and condition of any dressings
   ~~e.~~**f.** Complete Braden Scale
   ~~f.~~**g.** Assess for presence of specialty mattress/bed or overlay
   ~~g.~~**h.** Assess for the presence of skin abnormalities
   ~~h.~~**i.** Assess for the presence of pressure ulcers

J. **STANDARDS OF CARE 1.8: ASSESSMENT PSYCHO/SOCIAL ADMISSION ASSESSMENT:**

1. Psychosocial assessment shall consist of the following:
   a. Coping
   b. Affect/Behavior
   c. Social Service (SS) Referral Reason
   d. Distress
   e. Stressors
   f. Support/Coping Interventions
2. Psycho/Social: Nursing Interventions **will be documented on initial admission assessment and prn if change occurs**

a. In ordered to promote family centered care, the nurse shall:
   i. Introduce bedside health care providers to the patient/family.
   ii. Review visitation and unit policies to patient/family on admission and as needed.
   iii. Assess and then verify with patient/family age appropriate needs.
   iv. Assess and then verify patient/family's ability to understand and participate in the plan of care.
   v. Encourage the family to have periods of uninterrupted sleep/bonding when appropriate.
   vi. Promote patient/family centered care
      1) Discuss expectations and collaborate with patient/family
      2) Encourage patient/family to ask questions
   vii. Promote patient independence in Activities of Daily Living (ADL)
   viii. Promote comfort measures (if ordered or request order) by:
      1) Music therapy
      2) Therapeutic recreation
      3) Spiritual comfort
      4) Guided imagery
      5) Reminiscence therapy
      6) Encourage family/friend to visit
      7) Arrange for a child's visitation
      8) Arrange for pet therapy
      9) Arrange for physical and/or occupational therapy.
   ix. Patients shall be informed of their responsibilities upon admission and as necessary thereafter.
      1) These responsibilities include:
         a) Providing information
         b) Asking questions
         c) Following instructions
         ~~1) Accepting consequences~~
         d) Following rules and regulations
         e) Showing respect and consideration
         f) Meeting financial commitments.
            i) See TCMC Patient Handbook.
   x. Encourage patient and/or their family to participate in their plan of care.
   xi. Observe bonding behaviors when applicable:
      1) Eye contact
      2) Holding infant
      3) Talking to infant
      4) Participating in care of infant – feeding, diaper changes, comforting
   xii. Request social services as appropriate.
      1) Initiate social services referrals for the following (including, but not limited to:
         a) Adoptions; surrogates
         b) Infants going to foster care
         c) Patients with no prenatal care
         d) Teen moms
         e) Positive toxicology results
         f) Mothers of infants in Neonatal Intensive Care or in another facility
         g) All mothers and families experiencing Perinatal loss
         h) Assistance with post-partum home care~~.~~

K. **STANDARDS OF CARE: INFUSION THERAPY:**
1. Central venous lines shall be assessed per PCS Central Venous Access Devices Procedure
2. Peripheral IV site shall be assessed on admission, ongoing and transfer from other nursing unit.

a. The following shall be assessed:
   i. IV insertion date
   ii. IV access type
   iii. IV site and condition
   iv. Patency
   v. Dressing type and condition
   vi. Date infusion changed
   vii. Date central venous dressing changed

3. Saline lock insertion site(s) shall be assessed every shift, with flushes, prior to the administration of medications and PRN.
4. Maintenance or continuous infusion shall be assessed every 2 hours and PRN
5. Infusion Therapy: Nursing Interventions
   a. Peripheral IV sites shall be changed every 4 days unless otherwise ordered.
   b. Document initials and date IV started directly on the dressing.
   c. Pre-hospital IV starts shall be discontinued and restarted within 48 hours of admission.
   d. IV site shall be discontinued and restarted with complaint of persistent discomfort not relieved by comfort measures, the presence of an infiltration, inflammation, pallor phlebitis, bleeding at insertion site, or leaking of IV solution at insertion site
   e. IV solutions and tubing shall be changed as follows:
      i. Change every 4 days
         1) All IV tubing
         2) Add-on devices (neutral displacement connector MicroClave), antireflux, extension set, etc.) and with tubing change
         3) Rotate IV insertion sites
         4) Commercially prepared solutions, if the bag is spiked once with initial start
         5) Piggyback tubing (back flush with a minimum of 10 mL before and after each piggyback
      ii. Change every 24 hours
         1) All IV solutions mixed by pharmacy or nursing, unless manufacturer's expiration recommends less than 24 hours
         2) Lipids or lipid containing products
         3) Neutral displacement connector (MicroClave, anti-reflux, extension set, etc.) and with tubing change
   f. Label IV tubing and/or neutral displacement connector (MicroClave) with *change date sticker* indicating date tubing is to be changed using numerical day and month.
   g. Label IV solutions with date and time IV solution hung **and document in the EMR**
   h. Dressings shall be changed when damp, loose, soiled, or whenever dressing prevents direct visualization of the site
   i. Infusion pumps shall be used per TCMC Infusion Pump-Infusion System with Guardrails.
   j. A separate site shall be used for research study drugs per TCMC Investigational Drugs Policy.
   k. Needleless components added to IV administration sets shall be changed every 4 days unless contaminated or a catheter related infection is suspected or documented.
   l. Swab Cap
      i. When a Central Venous line injection port is not in use, place an ~~orange~~ Swab Cap on the unused port(s).
      ii. Apply a new Swab Cap
         1) Every time the cap is removed
         2) Every 8 hours with routine IV flushing
      iii. PRN IV flushing

L. **STANDARDS OF CARE: IMMUNIZATIONS/OTHER:**

1. Rhogam will be administered if indicated
2. Rubella will be administered if needed

3. During the flu season: patients will be screened for influenza and vaccination will be administered if indicated per Standardized Procedure Pneumococcal and Influenza Vaccine Screening and Administration
4. All patients will be screened for Tetanus, Diphtheria, Pertussis (Tdap) and vaccination will be administered if indicated per Standardized Procedure Tetanus, Diphtheria, and Pertussis (Tdap) Vaccine Administration for Postpartum Patients.

M. **REFERENCES:**

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