TRI-CITY HEALTHCARE DISTRICT AGENDA FOR A REGULAR MEETING OF THE PROFESSIONAL AFFAIRS COMMITTEE OF THE BOARD OF DIRECTORS

January 12, 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"

	unless the item is specifically labeled "Informatio	nal 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		5 min.	Standard
	time regarding that item.			
4.	Ratification of minutes of the October 2016 Meeting	3-9	2 min.	Committee
5.	New Business		7 7	
a.	Consideration and Possible Approval of Policies and Procedures	10-11		All
	Patient Care Services			
	Abduction Shoulder Splint Procedure	12-13		
	Abduction Splint Application (HIP) Procedure	14		
	Allied Health Students in Patient Care Areas Policy	15-16		
	Cardioversion, Elective Procedure	17-18		
	5. Continuous Passive Motion (CPM) Machine Procedure	19		
	Epidural or Intrathecal Catheter Infusion in the Non-Laboring Patient Procedure	20-23		
	7. Fall Risk Procedure and Score Tool Procedure	24-36		
	Interpretation and Translation Services	37-39		
	9. Medication Reconciliation Policy	40-42		
	10. Neutropenic Precautions Policy	43-44		
	11. Nursing Students in Patient Care Areas Policy	45-51		
	12. Surgical Skin Stapling	52		
**	13. Swallowing, Food and Nutrition Considerations for Patients with	53		722
	Oropharyngeal Dysphagia Policy	33		
	Administrative Policies and Procedures			
	Decorative Materials 248	54		
	Unit Specific Emergency Operations Procedure (EOP) Manual Formerly Disaster Manual			
	Emergency Operations Plan 2.	55-64		
	Engineering			
	1. Equipment Repair	65-66		
	Maintenance and Inspection Medical Gas 2003	67-68		
	New Equipment Inventory and Inspection 2007	69-70		15.
	4. Pre-Purchase Evaluations 2009	71		
	5. Purchasing Procedure 2011	72-73		
	Scheduled Equipment Maintenance 2006	74-75		
	7. Utility Management Plan 4003	76-83	1	
	8. Work Order Requests 2010	84-85	1]

	5			
	Environment of Care Manual 1. Fire Safety Hazards 2. Hazardous Material and waste Management and Communication Plan	86-87 88-93		
	3. Life Safety Management Plan 4. Medical Equipment Management Plan 5. Safety Plan	94-100 101-109 110-117		
	6. Security Management Plan	118-126		
	Infection Control 1. Aerosol Transmissible Diseases and Tuberculosis Control Plan 2. Standard and Transmission-Based Precautions 3. Waterborne Illness 4. Zika Virus	127-146 147-152 153-163 164-166		
	Medical Staff 1. Disaster Privileges	167-174		
	Neonatal Intensive Care 1. Amphotericin-B Liposome (AmBisome), Ordering and Infusion of 2. Consultation to Perinatal Unit	175-176 177		
	Women and Newborn Services 1. Epidural Spinal Block Management 2. Laminaria 3. Scheduling Process for Procedures 4. Shift Change Responsibilities 5. Vacuum Extraction	178-181 182-184 185-188 189-190 191-192	-	
	Formulary Requests 1. Formulary Line Item Additions/Deletions DELETIONS: • Albuterol Tablets • Erythromycin/ Sulfixoxazole 200mg/600 mg suspension • Formoterol 12 mcg (Foradil Aerolizer) Zarxio- Admission to Formulary	193-195		
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 February 9, 2017.		1 min	Chair
12.	Adjournment		1 min	Chair

DRAFT

Tri-City Medical Center Professional Affairs Committee Meeting Open Session Minutes October 13, 2016

Members Present: Director Laura Mitchell (Chair), Director Larry Schallock, Director Ramona Finnila 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, Kathy Topp, Lisa Mattia, Rowena Okumura, Kathy R. Topp, Mary Diamond, Jim Dagostino, Oska Lawrence, April Lombardo, Lori Roach, Stephen Chavez-Matzel, Patricia Guerra and Karren Hertz.

Members Absent: Dr. Scott Worman, Dr. Contardo, Dr. Johnson and Sharon Schultz, CNE/ Sr. VP.

Person(s) Responsible	Director Mitchell	Director Mitchell	Director Mitchell
Follow-Up Action/ Recommendations		Motion to approve the agenda was made by Director Finnila and seconded by Dr. Contardo. The group made a decision to cancel the November and December meetings for PAC.	
Discussion	Director Mitchell called the meeting to order at 12:06 PM in Assembly Room 1.	The committee reviewed the agenda and there were no additions or modifications. There was a brief discussion on the meeting dates for November and December due to the holidays and also change of dates of the regular Board Meetings for the next two months.	Director Mitchell read the paragraph regarding comments from members of the public.
Topic	1. Call To Order	2. Approval of Agenda	3. Comments by members of the public on any item of interest to the public before

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
committee's consideration of the item.			
4. Ratification of minutes of September 2016.	Director Mitchell called for a motion to approve the minutes from September 8, 2016 meeting.	Minutes ratified. Director Schallock moved and Director Mitchell seconded the motion to approve the minutes from September 2016. Director Finnila abstain 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. Cardiac Cath Lab Standardized Procedure 2. Catheter Clearance with Alteplase (Cathflo Activase) Procedure 3. CERNER Downtime Policy	There was a clarification made on this policy that the Cath Lab results need to be available before starting any procedure on any patient. There was no discussion on this policy. There was no discussion on this policy.	ACTION: The Patient Care Services policies and procedures were approved. Director Finnila moved and Director Mitchell seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
4. Chest Tube Management	The procedural part of assisting the physician where Mosby's is referenced will		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Procedure	will be modified.		
 Differentiating Intrauterine Fetal Demises from Miscarriage Procedure 	This policy outlines the differentiation of still birth and miscarriage. It was also noted that that the patient gets to keep the baby while waiting for the pathologist report on a stillbirth delivery.		
6. Discharge from Outpatient Post-Anesthesia Nursing Service Standardized Procedure	The premise on the repisratory rate of a pediatric patient should be striked out since the hospital do not deal with that population.		
7. Haloperidol IV Administration Standardized Procedure	There was no discussion on this policy.		
8. Hazardous Drugs Procedure	It was recommended that the kinds of chemotherapy waste that are scheduled for disposal should be enumerated for further clarification. It was also mentioned that a 3 rd category will be added to this policy in the future.		
 Local Anasthetic Prior to Intravenous Insertion Standardized Procedure 	There was no discussion on this policy.		
10. Medical Equipment Brought into the Facility Policy	The form on this policy (Patient Supplied Equipment Waiver) is in the process of being standardized to reflect the role of TCHD representative in the process.		
PAC Minutes 101316	m		

n/ Person(s) ns Responsible					control Patricia Guerra Nere Ia Illock Ipprove
Follow-Up Action/ Recommendations				•	ACTION: The Infection Control policies and procedures were approved. Director Finnila moved and Director Schallock seconded the motion to approve the policies moving forward for Board approved.
Discussion	No discussion on this policy.	No discussion on this policy.	There was a question if there is separate procedure with the eyes; it was explained that the equipment used for the eyes is so finy that nobody can even see it in xray. It was also mentioned that the staff had heightened awareness for this policy due to some incidents in the past.	The MFT/LCSW terminology will be updated.	It was noted that different level of influx patients are triaged in the ED. Some items in the policy need a reference. Lisa will get together with Kevin to have the references be inserted for compliance purposes.
Topic	11. Ordering 12 Lead ECG for Administration of Droperidol and/or Discontinuing Drug Standardized Procedure	12. Pneumoccocal and Influenza Vaccine Screening and Administration Standardized Procedure	13. Sponge, Sharps and Instrument Counts Prevention of Retained Surgical Objects	14. Utilization of Staff, Staffing Patterns Policy	Unit Specific Infection Control 1. Influx of Infectious Patients Epidemic Influenza or Other Respiratory Transmitted Diseases IC 15.0

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Medical Staff 1. Disaster Privileges	Sherry Miller gave a brief summary of this policy. It aims to provide credentialing to volunteer practitioners and allied health professionals in times of disaster. It was also mentioned that the definition of AHP should be spelled out.	ACTION: The Medical Staff policy and procedure were approved. Director Schallock moved and Director Finnila seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
NICU 1. Guideline for Care of the Extremely Low Birth Weight Infant (ELBW) and very Low Birth Weight Infant (VLBW)	There was a brief discussion on the peripheral arterial for the NICU.	ACTION: Director Finnila moved, Director Schallock seconded and the NICU policies were approved to move forward for Board approval.	Patricia Guerra
2. Non-Emergent Neonatal Endotracheal Intubation	There was no discussion on this policy.		
Palliative Care of the Neonates at the End of Life	There was no discussion on this policy.		
 Peripheral Arterial Line Insertion, Maintenance and Removal of 	There was no discussion on this policy.		
Staffing Ratios for Social Services in the NICU	There was no discussion on this policy.		
6. Standards of Care- NICU 2016	There was no discussion on this policy.		
7. Standards of Care- NICU	There was no discussion on this policy.		
8. Visitation in the NICU	The committee had a consensus that		Patricia Guerra
PAC Minutes 101316	5		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	visitors in the NICU need to be checked if they are sick and contagious for the safety of the infants in the NICU.		
Women's and Newborn Services 1. Newborn Sepsis care Guidelines	There was no discussion on this policy.	ACTION: The WCS procedure was approved. Director Finnila moved and Director Schallock seconded the motion to approve this policy moving forward for	Patricia Guerra
Formulary Requests 1. Corticosteroid- Epidural Administration of IR	The corticosteroid is an approved drug that meets FDA guidelines as reported by Oska Lawrence.	Board approval. ACTION: The formulary requests were approved. Director Schallock moved and Dr.	Patricia Guerra
2. Gadavist	Gadavist is used manimly in Radiology and it is very cost comparable.	Contardo seconded the motion to approve the policies moving forward for Board approval.	
 3. Fomularry Line Item Additions/ Deletions • Capsaicin Topical Cream • Ticagrelor 60 mg tablets • Albuteroll oral solution • Potassium Chloride 40 meq/30 ml cup • Vitamin K mg 	There was no discussion of these formularies.		
6. Clinical Contracts	No contracts were reviewed for this month.	ACTION: No action taken.	Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Director Finnila moved, Director Schallock seconded and it was unanimously approved to go into closed session at 12:50 PM.	Director Mitchell
8. Return to Open Session	The Committee return to Open Session at 2:10 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





PROFESSIONAL AFFAIRS COMMITTEE January 12th, 2017 CONTACT: Sharon Schultz, CNE

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Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
 Abduction Shoulder Splint (Airplane Splint, Don Joy Ultra Sling and ARC Shoulder Brace) Procedure 	3 year review, practice change	
Abduction Splint Application (Hip) Procedure	3 year review, practice change	
 Allied Health Students in Patient Care Areas Policy 	3 year review	
4. Cardioversion, Elective Procedure	3 year review, practice change	
Continuous Passive Motion (CPM) Machine Procedure	3 year review, practice change	
Epidural or Intrathecal Catheter Infusion in the Non-Laboring Patient Procedure	3 year review	
Fall Risk Procedure and Score Tool Procedure	practice change	
8. Interpretation and Translation Services	1 year review	
9. Medication Reconciliation Policy	3 year review, practice change	
10. Neutropenic Precautions Policy	3 year review, practice change	
11. Nursing Students in Patient Care Areas Policy	3 year review, practice change	
12. Surgical Skin Stapling	NEW	
13. Swallowing, Food and Nutrition Considerations for Patients with Oro- pharyngeal Dysphagia Policy	3 year review, practice change	
Administrative Policies & Procedures		
Decorative Material 248	3 year review	
Init Chapitia		
<u>Jnit Specific</u> Emergency Operations Procedure (EOP)		
Manual formerly Disaster Manual		
Emergency Operations Plan	1 year review	
ingineering		
Equipment Repair 2008	3 year review	
Maintenance And Inspection Medical Gas	3 year review,	
2003	practice change	
New Equipment Inventory And Inspection 2007	3 year review, practice change	282
4. Pre-Purchase Evaluations 2009	3 year review, practice change	
5. Purchasing Procedure 2011	3 year review, practice change	
6. Scheduled Equipment Maintenance 2006	3 year review, practice change	





PROFESSIONAL AFFAIRS COMMITTEE

	=	L AFFAIRS COMN lary 12 th , 2017	MITTEE
	Janu		ACT: Sharon Schultz, CNE
	Policies and Procedures	Reason	Recommendations
7.	Utility Management Plan 4003	3 year review, practice change	
8.	Work Order Requests 2010	3 year review, practice change	
Enviro	onment of Care Manual		
1.	Fire Safety Hazards	1 year review	
2.	Hazardous Material and Waste Management and Communication Plan	1 year review	
3.		1 year review	
4.	Medical Equipment Management Plan	1 year review	
	Safety Plan	1 year review	
	Security Management Plan	1 year review	4,000,000,000
	ion Control		
1.	Aerosol Transmissible Diseases and Tuberculosis Control Plan IC 11	1 year review	
2.	Standard and Transmission- Based Precautions - IC 5	3 year review, practice change	
	Waterborne Illness - IC 13.1	3 year review, practice change	
	Zika Virus	NEW	
Medic	al Staff		
1.	Disaster Privileges 8710-553	3 year review, practice change	
Neona	tal Intensive Care		
	Amphotericin-B Liposome (AmBisome), Ordering and Infusion of	DELETE	
2.	Consultation to Perinatal Unit	NEW	
Wome	n and Newborn Services		
1.	Epidural Spinal Management	3 year review, practice change	
2.	Laminaria	3 year review, practice change	
3.	Scheduling Process for Procedures	3 year review, practice change	
	Shift Change Responsibilities	3 year review, practice change	
	Vacuum Extraction	DELETE	
	lary Requests		
Deletio			
•	Albuterol tablets Erythromycin/sulfixoxazole 200mg/600mg suspension	DELETE	
	Formoterol 12 mcg (Foradil Aerolizer)	AIFIA	
/ arvin -	 Admission to Formulary 	NEW	

Tri-City Me	edical Center	Distribution: Patient Care Services		
PROCEDURE:	ABDUCTION SHOULDER SPLINT (AIRPLANE SPLINT, DON JOY ULTRA SLING AND ARC SHOULDER BRACE)			
Purpose:	To outline the nursing responsibilities in applying and monitoring shoulder abduction splint and applying and monitoring the <u>ultra sling</u> abduction sling with pillow.			
Supportive Data:				
Equipment:	Shoulder abduction splint (from Orl Abduction Don Joy Ultra Sling wit Abduction and Rotation Control	nopedic Technician) n Pillow (from Orthopedic Technician) ARC) Shoulder Brace (from Orthopedic	Technician)	

A. AIRPLANE SPLINT:

- 1. Assess neurovascular status and skin integrity pre and post-application and ongoing.
- 2. Place cushion beneath affected arm with desired angle side up.
- 3. Secure cushion by using end of strap with single piece of hook and wrapping it across the chest, behind back and then reattach to itself in front. Make sure cushion does not slide down.
- 4. Attach humerus cuff to top of cushion and secure around patient biceps.
- Attach wrist cuff at front center of cushion with buckle extending downward and secure wrist to cuff.
- Bring shoulder strap over shoulder and attach to swathe strap in back. Adjust buckle for patient comfort and correct fit.
- Position head of bed for patient comfort. Place pillow or towels behind affected shoulder for support.
- Record application of splint and patient's tolerance in the medical record.

B.A. ABDUCTION SLING WITH PILLOWDON JOY ULTRA SLING:

- 1. Detach shoulder strap and open front panel, placing arm inside sling with elbow as far back as possible.
- 2. Secure front strap through the lower D-ring.
- 3. Affix the snaps/straps along the top of the sling to secure the arm in its cradle. The thumb may be placed through the loop inside the sling for additional comfort, if desired.
- 4. Bring the shoulder strap across the back and over the unaffected shoulder and fasten through the middle D-ring of the sling per manufacturer's recommendation.
- 5. Trim shoulder strap by removing the Y tab at the end of the strap and cutting the strap then reapplying the Y tab, if there is excess strap.
- 6. Place the pillow at the waistline with the large end facing forward. Attach the sling to the pillow, lining up the hook and loop strips so they adhere. The pillow typically has a groove to place at the patient's waist.
- 7. Secure the waist strap through the D-ring on the front end of pillow.
- 8. Position the pillow for desired internal and external rotation by sliding the pillow anteriorferward or posteriorback along the waistline.
- 9. Position head of bed a minimum of 30 degrees for patient comfort. Place pillow er towels behind affected shoulder for support.
- 10. Document splint application, patient's tolerance, and when the times the splint is on and off in the medical record.

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

C.B. ARC SHOULDER BRACE:

- 1. Brace will be custom fit by outside vendor
- 2. Follow manufacturer's directions for applying brace.
- 1. Release the ratchet release buckle on abduction arc and shape the formable-band to fit the patient's torso.
- 2. Position the abduction arc on the affected side of the body at the level of the elbow. Ensure the ratchet release buckle is at the front of the body.
- 3. Pass the torso strap around the patient. Insert the ratchet tab end of the torso strap into the ratchet release buckle.
- 4. Remove the hook closure at the end of the torso strap and pull the strap to a comfortable tension. If necessary, trim the strap, leaving room for further adjustment. Re-attach the hook closure to secure the end of the torso strap.
- 5. Pull the shoulder strap out of the arm cuff. Slip the patient's arm into the cuff. Lift the shoulder strap over the patient's head.
- 6.— Adjust the shoulder straps length from the front side of the arm sling by pulling it to the desired tension. Adjust the shoulder strap from the back if necessary. Excess strap material may be trimmed if necessary.
- 7. Position the neck pad by releasing the hook closure.
- 8. Adjust the arm cuff length as needed by lifting the hook closure tabs on the front end of the arm cuff. Fold the arm cuff along the first pre-stitched fold line. Re-attach the hook closure tabs to the inside of the arm cuff.
- 9. Adjust the handgrip by placing the patient's handgrip in the patient's hand and adjusting the three tension straps. Re-attach the hook closures.
- 10. Adjust the arm support for internal or external rotation. Remove the rubber band from the arm support.
- 11. Secure arm cuff to the arm support. Remove the plastic sleeve from the arm support. Ensure a proper attachment by applying gentle pressure to both the arm cuff and the abduction arc strut.
- 12.3. Document brace application, patient's tolerance, and times the brace is on and off in the medical record.

D.C. REFERENCES:

- Instruction from insert of shoulder abduction splint.
- 2. Instruction from company insert, Smith and Nephew 2005.
- Instruction from company application and patient instruction pamphlet, Bledsoe 2007.
 National Association of Orthopaedic Nurses (NAON): Core Curriculum for Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.
- 3.2. NAON: Scope and Standards of Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.

Tri-City Medical Center		Distribution:	Patient Care Services	
PROCEDURE:	ABDUCTION SPLINT APPLICATION	N (HIP)		
Purpose:	To outline the nursing responsibilities when applying an abduction splint or abduction wedge.			
Supportive Data:	Splints maintain hip abduction to prevent dislocation in total hip replacement patients. Application requires a physician order.			
Equipment:	Abduction Splint			

A. **APPLICATION:**

- 1. Verify physician order.
- 2. Explain procedure to patient.
- 3. Position splint so the top is as close to patient's perineum as possible.
- 4. Place patient's leg into grooves-on either side of the splint.
- 5. Run dorsal straps under patient's thigh and calf.
- 6. Bring dorsal straps around patient's leg to anterior section and secure-apply Velcro straps (not too-tightsnugly, but not restricting venous flow).
- 7. Ensure splint is in proper placement prior to turning and/or after repositioning patient.
- 8. Loosen Velcro straps on patients received from Post-Anesthesia Care Unit (PACU) on arrival to unit and every four hours for skin inspection of pressure points and alignment.
- 9. Assess splint alignment to patient on arrival to unit and every four hours.
- 10. Assess patient's skin for pressure points every four hours and PRN.
- 11. Document presence of abduction splint in the medical record.

B. **REFERENCES**:

- 1. Orthopaedic Nursing, Fourth Edition, 2004; Maher, A., Salmond, S., Pellino, T., W.B. Saunders Co.
- 1. Medical Surgical Nursing, Sixth Edition, Clinical Concepts and Clinical Practice, 2003, Mosby, Inc. 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
12/93; 02/11, 10/15	03/11, 11/15	03/11 , 12/15	05/16	04/11, 10/16	05/11	5/93, 5/00, 6/00, 7/03, 1/06; 6/08; 05/11

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE:

5/06

SUBJECT: Allied Health Students in Patient

Care Areas

REVISION DATE: 7/08; 05/11

POLICY NUMBER: VIII.O

Department Approval:

Clinical Policies & Procedures Committee Approval:

Nursing Executive Council Approval:

09/1410/16 10/1410/16

Pharmacy & Therapeutics Committee Approval:

n/a

09/16

Medical Executive Committee Approval:

11/1511/16

Professional Affairs Committee Approval:

01/15

Board of Directors Approval:

01/15

A. **POLICY:**

1. Students from several allied health schools are affiliated with Tri-City Medical Center (TCMC) Allied Health Services (hereafter referred as "allied health").

The specific allied health department retains responsibility for allied health care services and 2. related duties where the student is providing care.

For Respiratory Students see Pulmonary Care Services Authorization To Perform (Respiratory Care Students)

Emergency Medical Services (EMS) b.

- Patient care procedures within the Paramedic scope of practice (as established by the State of California and the County of San Diego) may be performed by a Paramedic intern under the direct supervision and guidance of the EMS program instructor, supervising physician or the RN assigned to that patient.
- Emergency Medical Technician (EMT) students in the Emergency Department are ii. only allowed to observe Emergency Department staff in the performance of patient care. EMT students do not provide patient care.
- Allied Health Students may only observe in the Pre-Operative Setting. C.

d. **Imaging Services**

- Students are required to perform procedures in accordance with published imaging i. procedure protocols.
- Imaging procedures may be performed by the students under the supervision and ii. guidance of the Clinical Instructor or assigned staff in accordance with the following:
 - Students use equipment and accessories, employ techniques and perform 1) procedures in accordance with accepted equipment use and radiation safety practices to minimize radiation exposure to patients, selves and
 - Medical imaging procedures are performed under direct supervision of a 2) qualified practitioner until a radiography student achieves competency.
 - Medical imaging procedures are performed under indirect supervision of 3) a qualified practitioner after a radiography student achieves competency.
 - Radiography students repeating unsatisfactory radiographs are under the 4) direct supervision of a qualified practitioner
- The faculty and students of affiliated schools are responsible for knowing and complying with 3. TCMC Policies and Procedures.

- 4. The allied health school is responsible for planning the education program and providing Allied Health Services with outlined goals and objectives relating to the clinical experience. The clinical coordinator is responsible for updating and reviewing clinical goals for each student for all department rotations.
- 5. The allied health clinical coordinator is responsible for establishing orientation dates for the student. Orientation shall include time spent in the department to learn the standards, physical layout, fire and code responsibilities, communication skills, methodology of patient care, documentation system, daily schedules and roles of the staff and students. The student must review the Hospital Orientation for Non Employees of Tri-City HealthCare District Orientation Manual and complete the appropriate orientation paperwork
- 6. Each student will be assigned a preceptor or specified allied health staff member in their department who will be accountable for all of the student's actions (hereafter referred to as "preceptor").
- 7. The preceptor has the right and responsibility to intervene or prevent a student from performing any allied health activity that appears inappropriate or potentially injurious to patients. The Director/Operations Manager or designee has the option to discuss behavioral or practice issues with students, preceptors, and school instructors. Staff issues identified by the preceptor are to be directed to the Operations Manager or Director of the unit.
- 8. Students shall report to work at a specified time to receive report on their assigned patients. The preceptor shall also receive a report (if applicable), which provides current information related to the patient population and identifies potential learning activities for the students. Students shall report to their preceptor before leaving the department.
- 9. Student Responsibilities:
 - a. Goal setting, evaluation, communication, and clinical competency.
 - b. Participate in primary care of assigned patients including accurate documentation under supervision of preceptor as applicable.
 - c. Communicate all pertinent information including finding problems, concerns, and questions or learning needs to preceptor.
 - d. Work with all health care and team members in an effective/professional manner.

10. Handoff/Communication:

- a. Students must communicate any/all changes in patient status to preceptor.
- b. Students are not to leave the department without reporting to preceptor.
- c. Documentation must be reviewed and co-signed by preceptor as applicable.
- d. All unfinished work is to be reported to the preceptor.

11. Limitations of Function:

- a. Students shall not perform any procedures/functions identified without the preceptor present.
 - Radiography students may perform medical imaging procedures under indirect supervision of a qualified practitioner after a radiography student achieves competency.
- b. Students may not take verbal or telephone orders.
- c. Students may not perform any procedure requiring specialized certification.
- d. Students may not perform procedures without a physician's order.

12. **Medication Administration:**

- a. All medications shall be administered under the direct supervision of the preceptor following Patient Care Services "Medication Administration" Policy.
- b. Students may only access medications from Pyxis under direct supervision of the preceptor.

Tri-City Me	dical Center Distribution: Patient Care Services				
PROCEDURE:	CARDIOVERSION, ELECTIVE (SYNCHRONIZED CARDIOVERSION)				
Purpose:	To outline the nursing management of adult/adolescent patients undergoing an elective cardioversion				
Supportive Data:	Cardioversion may be used to convert hemodynamically stable atrial fibrillation or atrial				
	flutter into normal sinus rhythm. Elective cardioversion is performed by athe physician				
	only.				
Equipment:	Defibrillator with functioning synchronizer				
	2. Multifunction cable and pads				
	3. Emergency cart -and-medication box				
	3.4. Medications as ordered by physician				
	4.5. Transcutaneous pacemaker				
	5.6. Oral airway, manual resuscitation bag with mask, and suction equipment				
	7. Automatic blood pressure cuff				
	6.8. Infusion Pump				
	7.9. Electrodes				

A. POLICY:

- 1. Elective cardioversions will be performed in procedurales areas, Intensive Care Unit, and Telemetry.
- 2. The Registered Nurses' (RNs) role during an elective cardioversion is to assist the physician as ordered.
- 3. Review Mosby's skill: Synchronized Cardioversion for detailed nursing responsibilities for pre-intra and post-procedure monitoring and assessment.

A.B. PROCEDURE:

- 17.1. Initiate Pre-Op/Pre-Procedure Checklist.
- 18.2. Evaluate laboratory studies prior to the procedure (if available):
 - a. Electrolyte levels
 - b. Digoxin level
- 19.3. Note any special circumstances:
 - a. Anticoagulation
 - b. Permanent pacemaker
 - i. Notify company representative to be present per Cardiologist
 - c. Implantable cardioverter defibrillator (ICD)
 - e.i. Notify company representative to be present per Cardiologist
 - d. Potential airway problems
 - e. **Medication**Drug allergies
- 20.4. Gather and check all necessary equipment and supplies.
- 21.5. Notify and request attendance for respiratory therapist for procedure.
- 22.6. Keep patient NPO as ordered.
- 23.17. Establish patent intravenous access and administer IV solution per physician order using an infusion pump.
- 24.7. Position the patient in supine position or as ordered by physician.
- 25.8. Remove loose-fitting dentures, partial plates, or other mouth prostheses.
- 26.9. Administer oxygen to patient as appropriate to the condition.
- 27.10. Ensure Set up-suction equipment is readily available.
- 28.11. Place automatic blood pressure cuff on patient and set for desired time intervals.
- 29.12. Remove all metallic objects from the patient, as they are conductors of electric current and could result in burns.
- 30.18. Plug the cord from the defibrillator into the grounded wall outlet.

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
8/00, 3/03, 7/03, 03/04 3/06; 4/09	07/11, 01/16	08/11, 01/16	10/16	n/a	10/11, 10/16	11/11	12/11

- 31.18. Connect patient to ECG monitor on defibrillator.
- 32.19. Select monitor lead displaying an R wave of sufficient amplitude to activate the synchronization mode of the defibrillator (Lead II preferred).
- 33.14. Attach multifunction cable to defibrillator and multifunction pads to cable in accordance with the manufacturer's instructions.
- 34.15. Place the multifunction pads on the patient (apex/sternum or anterior/posterior) as specified by physician in accordance with the manufacturer's instructions.
- 35.20. Review patient's status and readiness for procedure.
- 36.21. Administer medications as orderedintravenous sedation as ordered.
- 37.22. Place defibrillator in synchronization mode. Select energy level as ordered by Physician.
- 38.23. Turn on ECG and record continuous wave forms.
- 39.18. Assist physician within operating equipment as necessary.
 - a. Turn off oxygen at flowmeter during actual-cardioversion to decrease risk of combustion.
 - b. Announce "I'm clear, you're clear, we're all clear," and eEnsure all personnel are clear of contact with patient, bed, and equipment during actual cardioversion to prevent from being shocked.
 - c. **Post-cardioversion**, Rrestart oxygen after electrical discharge completed.
- 40-19. Monitor for presence of pulse, and observe monitor for conversion of dysrhythmia immediately after discharge of current. If unsuccessful, the procedure may be repeated with a higher energy level.
- 41.20. Reorient patient to person, place, and time as temporary altered level of consciousness may occur following cardioversion.
- 42.21. Continue monitoring per procedural sedation procedure.
- 43.22. Keep patient NPO until completely awake.
- 44.23. Obtain 12 lead ECG as ordered by physician.
- 45.24. Evaluate patient's skin under multifunction pads for burns.
- 46-25. Document assessment findings in electronic health record (EHR) on the Assessment Post-Procedure Powerform.
- 47.26. Document medications administered on the electronic medication administration record (MAR).
- 48-27. Document patient's response to procedure in the medical record.

C. RELATED DOCUMENTS:

1. Patient Care Services Procedure: Sedation Analgesia Used During Therapeutic or Diagnostic Procedures

B.D. REFERENCE:

- 1. American Heart Association (AHA). (20154). Advance cardiovascular life support: Indications for cardioversion. p. 116.
- 2. Beinart, S. (n.d.) Synchronized electrical cardioversion
- 3. Clinical Mosby's-Skills. (2006-2015). Synchronized cardioversion. Retrieved from Tri-City Medical Center (TCMC) intranet.
- 17.4. Urden, L., Stacy, K., and Lough, M. (2014). *Critical care nursing: Diagnosis and treatment*. Mosby's Inc, St. Louis: MO AACN. *American Association of Critical Care*. 6th ed., 2011. N. pag. Print.

Tri-City Me	dical Center		Patient Care Services			
PROCEDURE:	CONTINUOUS PASSIVE MOTION (CPM) MACHINE					
Purpose:	To outline the nursing management of adult/adolescent patients utilizing a CPM machine.					
Supportive Data:	Continuous passive flexion and extea	ension of the k	nee may speed recovery of function			
Equipment:	CPM Machine					

A. **PROCEDURE:**

- 1. Application requires a physician order.
- 2. Pad pressure areas with sheepskin.
 - a. Keep the opening of the sheepskin padding lined up with the joints of the machine.
 - b. Use all Velcro straps making padding taut over bars.
 - c. Place long end of padding under the patient's hips, assure it is free of wrinkles.
- Adjust leg length of CPM:
 - a. Ensure knee is in bending area of machine and leg is properly aligned.
 - **b.** Ensure foot is in the footplate, leaving enough room in the heel space for the forward motion of the foot during flexion.
 - b.i. The CPM flexion joint should linelike up with the patient's patella.
 - Check to make sure footplate has foot at a neutral position to ensure there is no foot drop.
- 4. Apply and remove CPM machine at full extension and in the off position.
- 5. Slide machine attached to trolley to and from bed.
 - a. When not in use, toggle machine on table and release black knob enabling table to fold up. **Do not remove CPM from trolley.**
- 6. Check alignment every two (2) hours.
- 7. Remove CPM at least once a shift to check for pressure areas.
- 8. Inspect skin for pressure areas every four (4) hours.
- 9. Maintain angle and duration of CPM therapy per physicians order.
 - Advance angle/flexion as ordered.
- 10. Remove CPM for meals, bath, and therapy treatment.
- 11. Remove device if patient complains of unusual pain or discomfort and report findings to physician.
- 12. Elevate the head of the bed no greater than 30 **degrees**→, and ensure the knee mechanism **on the bed** is locked in the **OFF** position.
- 13. Document use, patient tolerance, and angle/flexion in the medical record.

B. **REFERENCE:**

- 1. Smith, N, and D Pravikoff, CINAHL Nursing Guide., 2009. N. pag. Print.
- 2. National Association of Orthopaedic Nurses (NAON): Core Curriculum for Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.
- 2.3. NAON: Scope and Standards of Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Division of Orthopedics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/00; 6/02; 3/03; 7/03, 3/04; 6/06, 6/09; 11/15	07/11, 12/15	08/11, 01/16	05/16	10/11, 10/16	11/11	11/11

Tri-City Medical Center		Distribution:	Patient Care Services		
PROCEDURE:	EPIDURAL OR INTRATHECAL CATHETER INFUSION IN THE NON-LABORING PATIENT				
Purpose:	To outline nursing management for the adult inpatient with an indwelling epidural or intrathecal catheter for narcotic administration.				
Equipment:	 Portless Epidural/Intrathecal Ac Transparent dressing Alaris infusion pump Epidural/Intrathecal insertion kit Epidural/Intrathecal anesthetic/s Blood pressure cuff Pulse oximeter Oxygen delivery equipment & s Narcan® (Naloxone) Kelly clamp Narcotic administration record/A Epidural Medication lock box Epidural Medication lock box k 	t analgesic solu uctioning equi Assessment Ro	tion as ordered by anesthesiologist pment readily available at bedside		

A. **DEFINITIONS:**

- 1. Epidural Infusion: A continuous infusion into the epidural space
- 2. Epidural Bolus: An intermittent injection via the indwelling epidural catheter
- 3. Intrathecal Infusion: A continuous infusion into the intrathecal space
- 4. PCEA infusion: patient controlled epidural anesthesia

B. **POLICY:**

- 1. The anesthesiologist/physician and the assigned Registered Nurse (RN) share the responsibility for the observation and monitoring of patients receiving epidural or intrathecal anesthesia.
- 2. The pharmacy department is responsible for the preparation of the epidural anesthetic/analgesic solution.
- 3. Only the anesthesiologist/physician may insert the epidural or intrathecal catheter. The lot number and brand of the kit will be documented on the procedure form by the nurse assisting with the procedure.
- 4. The patient will not be transferred to the next level of care until the epidural setup is connected, and the Alaris pump has been programmed and verified by two (2) RNs.
- 5. All epidural infusions must be on a dedicated infusion pump with only one module attached, and the **intravenous** (IV) solution contained in an epidural medication lock box.
- 6. Electronic channel label shall be selected via guardrails or channel labels.
- 7. IV access shall be maintained for at least 8 hours after last dose of epidural medicine or discontinuance of epidural/intrathecal catheter.

C. PROCEDURE FOR BAG INFUSION DELIVERY:

- 1. Initiation:
 - a. Obtain physician's order for epidural or intrathecal solution
 - b. Spike the epidural/intrathecal solution, or bag with the yellow striped portless tubing after verification of correct dose with 2nd RN, prime the tubing, and thread the tubing through the epidural pump with the epidural medication lock box according to manufacturer's instructions.
 - c. The epidural will be connected to the infusion tubing and Alaris pump on the sterile field if medication is available.

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Department of Anesthesiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
04/07, 06/09, 07/15, 01/16	07/11, 08/15, 05/16	08/11, 05/16	10/16	02/07, 11/16	10/11, 11/16	11/11	11/11

- d. Attach the epidural-medication lock box.
- e. Lock the box containing the epidural/intrathecal solution with the epidural-medication lock box key stored in the Pyxis.
- f. Program the pump, using Guardrails, to the dosing parameters ordered by the anesthesiologist/physician with 2nd RN to verify settings.
- g. Start the infusion.
- h. Activate the lockout on the Alaris pump controls, located on the back of the infusion device.
- i. Return the epidural medication lock box key to Pyxis
- j. Document on electronic health record (EHR) Narcetic Administration Record (NAR) with 2 RNs
- k. Provide positioning assistance and emotional support to the patient during the epidural initiation procedure.

2. Maintenance:

- Administration of bolus or increase:
 - i. Boluses must be given through infusion pump, do not break the closed system.
 - ii. Program infusion rate on pump per anesthesiologist/physician's order verified with second RN.
 - iii. After the bolus, reprogram pump to continuous infusion rate as ordered by anesthesiologist/physician. Verify with 2nd RN.
 - Document on EHRNarcotic Administration Record (NAR)
- b. Instruct patient, significant other/family:
 - i. Type of pain management
 - ii. Frequency and nature of monitoring
 - 1) Avoid touching or manipulating catheter or tubing.
 - 2) Avoid excessive moving around or overstretching upper extremities.
 - 3) Do not get insertion site wet.
 - iii. Notify RN if catheter is accidentally removed or if any part becomes disconnected.
 - iv. Notify RN if signs of nausea, vomiting, pain, itching, pruritis, severe headache, neck pain, backache, bladder fullness, numbness or tingling or decreased movement or strength in lower extremities.
- c. Changing Infusion Bag:
 - i. Hang pre-mixed solution containing the same medication as ordered by the anesthesiologist/physician after verifying with a 2nd RN.

3. Assessment:

- Assess for complications that may be associated with epidural initiation.
 - i. Local anesthetic toxicity: Assess for drowsiness, light-headedness, tinnitus, circumoral paresthesia, metallic taste in mouth, slurred speech, blurred vision, unconsciousness, cardiac dysrhythmia, and cardiac arrest. Notify anesthesiologist/physician immediately if any of these symptoms are noted. Initiate cardiopulmonary resuscitation as needed.
 - ii. High Spinal: Assess for numbness or weakness of the upper extremities, dyspnea, weak speech or inability to speak, apnea and loss of consciousness. Notify anesthesiologist/physician immediately if any of these symptoms are noted. Initiate cardiopulmonary resuscitation as needed.
 - iii. Hypotension: Position patient in lateral position, notify anesthesiologist/physician, and administer intravenous fluid bolus if ordered.
- b. Assess and document sedation level, pain level, pulse oximetry, blood pressure, heart rate, and respiratory rate every 1 hour times 2; every 2 hours times 6; **then** every 4 hours until epidural or intrathecal catheter is discontinued.
 - i. If dose is increased or bolus given, assess and document every 1 hour times 2; every 2 hours times 6; **then** every 4 hours until epidural or intrathecal catheter is discontinued.

- c. Assess epidural or intrathecal catheter or tubing
 - i. Every 4 hours, verify the portless tubing is connected to the epidural or intrathecal catheter.
 - ii. Every shift, verify catheter, infusion tubing, epidural or intrathecal pump, and epidural or intrathecal solution are properly labeled.
- d. Assess insertion site
 - Every 4 hours, verify catheter site is clean, dry and intact without signs of edema, drainage or infection
- e. Monitor sensory and motor function of lower extremities every 4 hours, and before and after catheter removal
- f. Monitor for the following possible side effects every 4 hours, and see physician orders for appropriate intervention as needed:
 - i. Change in level of consciousness.
 - ii. Nausea and vomiting
 - iii. Itching, pruritis
 - iv. Urinary retention
 - v. Loss of motor function, strength, and sensation of lower extremities
 - vi. Before and after ambulation Before and after epidural catheter removal
- g. Assess and document sedation level, pain level, pulse oximetry, blood pressure, heart rate, and respiratory rate documented every 1 hour times 2; every 2 hours times 6 **then** every 4 hours until epidural or intrathecal catheter is discontinued. If stable, resume previous vital signs order.
- h. If disconnection from the catheter tubing is suspected, cover with sterile gauze, and notify Anesthesiologist. DO NOT USE OR ALCOHOL OR ATTEMPT TO RECONNECT.

D. **PROCEDURE FOR SYRINGE DELIVERY DEVICE FOR PCEA:**

- 1. Obtain physician's order for epidural or intrathecal solution
- 2. Obtain solution filled syringe from Pharmacy and connect the yellow striped portless tubing to the syringe after verifying correct dose with 2nd RN. Prime tubing.
- 3. For <u>PCEA</u>, the nurse will confirm epidural solution concentration and pump settings as ordered by anesthesiologist/physician (i.e. rate mL/hr, bolus amount/ml). Lockout must be documented in patient care record and verified by 2 RN's.
- 4. Insert the syringe into the Alaris pump
- 5. Program the Alaris pump, using Guardrails, to the dosing parameters ordered by the physician and verify settings with 2nd RN.
- 6. The lock box will be pre-labeled "Epidural" to indicate its use for epidural/intrathecal infusion, with a directive to return to SPD after individual use is completed and therapy discontinued.
- 7.6. Start the infusion.
- 8.7. Engage the lockout feature on the Alaris pump.
- 9.8. Return the epidural-medication lock box key to Pyxis.
- 10.9. Document on the electronic health record (EHR) Narcotic Administration Record (NAR) with two2 RNs for Patient controlled anagesia (PCAs) and epidurals.
- 11.10. Provide positioning assistance and emotional support to the patient during the epidural initiation procedure.

E. REMOVAL OF EPIDURAL OR INTRATHECAL CATHETER:

- 1. Verify written physician order to remove catheter.
- 2. Place patient in relaxed position.
- 3. Assess patient for back pain, back tenderness and baseline motor strength and sensation prior to removal of the catheter.
- 4. Assess site for hematoma, drainage and signs of infection.
- 5. Stop infusion and clamp tubing. Document final volume readings.
- 6. Perform hand hygiene.

- 7. Remove dressing while maintaining pressure on tubing just above insertion site. **Do not use** alcohol. (Alcohol is neurotoxic to epidural space.)
- 8. Gently and steadily remove catheter with one slow motion while holding 2x2 gauze over the site. If patient develops pain or parasthesia or resistance is met, STOP procedure, place a sterile dressing over site to secure epidural or intrathecal line, and notify anesthesiologist/physician.
- 9. Verify catheter tip is intact and rounded once catheter is removed.
- 10. If tip is missing:
 - a. Notify physician.
 - b. Place the catheter with the missing tip in a specimen bag and label with the patient's name, date of removal
 - c. Give to the shift-supervisor on duty in your work location.specimen bag with the tip to the ANM/relief charge.
- 11. Place sterile dressing over the area and apply pressure for at least 2 minutes.
- 12. Evaluate patient's motor strength and sensation. Notify physician for decreased motor strength and/or sensation.
- 13. Document procedure and patient response.
- 14. Waste unused medication per the Wasting Narcotics procedure and lock box.
- 15. Return lock box and Alaris pump to SPD.
- 16. Return epidural medication lock box key to unit Pyxis.
- 17. Special Considerations for Anticoagulated Patients:
 - a. Check prothrombin time (PT) levels and platelet level where applicable. For elevated PT levels, or platelet level less than 50,000, consult physician prior to removal.
 - b. Record neurological exam of the lower extremities every 1 hour times 2 hours, every 2 hours times 2 hours, every 4 hours times 2 hours after removal of the catheter.

F. REFERENCES:

- 1. Besuner, P. (2007). Association of wWomen's hHealth, oObstetric and nNeonatal nNurses Templates for Protocols and Procedures for Maternity Services, 2nd Edition. Washington, DC.
- 2. Cohen, S.P. & Dragovich, A. (2007, December). Intrathecal anesthesia. *Anesthesiology Clinics*, 25(4). Retrieved December 2, 2008 from http://www.mdconsult.com
- 3. Grant, P.J. & Wesorick, D.H. (2008, March). Perioperative medicine for the hospitalized patient. *Medical Clinics of North America*, 92(2). Retrieved from http://www.mdconsult.com
- 4. Gregoretti, C. et al (2007, March). Regional anesthesia in trauma patients. *Anesthesiology Clinics*, 25(1). Retrieved from http://www.mdconsult.com
- 5. Perry, A.G. & Potter, P.A. (2006). Patient controlled analgesia. Clinical Nursing Skills & Techniques (6th ed.). Retrieved from http://app32.webinservice.com/MosbySkills/SkillDetails
- 5. Mosby's Skills. (2014) Medication administration patient controlled analgesia. Retrieved from TCMC intranet.

Tri-City Medical Center		Distribution: Patient Care Services			
PROCEDURE: FALL RISK PROCEDURE AND SCORE TOOL					
Purpose:	To provide a comprehensive fall risk assessment on all patients each shift and implement appropriate fall risk interventions based upon the patient's identified fall risk factors.				
Supportive Data:	identify risk factors for falls, develo	quires a Registered Nurse (RN) to evaluate and p an appropriate plan of care for prevention, perform a hat occur, and revise the plan of care as appropriate			
Equipment:	Fall Risk Score Tool				

A. PROCEDURE:

- The RN completes the Morse Fall Risk Assessment is completed on every patient, including visually assessing and interviewing the patient, by the RN to determine the patient's fall risk score and secondary risk factors level. on admission or transfer and on every shift until the patient is discharged from the medical center:
 - a. Complete the Morse Fall Risk Assessment Tool in the electronic health-record. Interview all patient to assess the risk of fall and to identify factors secondary to fall risk.
 - i. Upon admission to the hospital
 - ii. Upon admission or transfer to another level of care area-
 - i-iii. Once a shift
 - ii.iv. After any fall occurs
 - v. When there is a change in the patient's status (physiological, functional, or cognitive)
- 2. Review the patient's medications for any that may alter the patient's ambulatory stability (see Medication Fall Alert Reference Text).
- 3. All patients receive the following Universal Fall Precautions as appropriate:
 - a. Adequate lighting
 - b. Assistive devices within easy reach
 - c. Bed in low position
 - d. Bed wheels and wheelchair brakes locked
 - e. Assure call light and -within possessions are within easy reach
 - f. Clean and dry surfaces
 - g. Hand rails and grab bars accessible within easy reach
 - h. Hourly rounding
 - i. Non-skid slippers or footwear are worn during ambulation
 - j. Orientation patients to their bed area, unit facilities, and how to get assistance to environment
 - k. Patient/family fall prevention education (uses the Patient and Family Guide-Handbook and highlight the patient safety section and review Fall Prevention section).
 - k.l. Rooms free of clutter
 - I.m. Side rails up times X 2
- 4. The patient's primary RN shall implement an individual Interdisciplinary Plan of Care for fall risks identified. Appropriate interventions based on the patient's fall risk score shall be selected and documented on the Interdisciplinary Plan of Care. These include but are not limited to:
 - a. Low Risk Patients (= 0 35 total score):
 - . Orient patients to their bed area, unit facilities, and how to get assistance.
 - i. Call bell/light for patients and ensuring it is placed within reach of patient
 - iii. Involving family in the care of the patient
 - iv. Follow-up with individual caregivers

Department Review	Clinical Policies & Procedures	Nurse Executive Council	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/06, 1/08, 6/09, 09/15, 04/16	11/11, 10/15 , 06/16	11/11, 10/15, 7/16	n/a	11/15, 11/16	2/12, 01/16	2/12, 1/16

- Stabilize beds and bedside furniture
- ₩.i. Reinforce use of Utilize grab bars near toilets.
- ii. Reinforce possible medication side effects that could increase risk of falling.Review prescribed medications every shift
- Limit administration of combinations of medications that may increase fall risk when possible.
- Ensure the patient is able to reach necessary items (phone, water, call light/bell) Viii.
- Use safety measures in chairs and wheelchairs
- x. Use geriatric chairs
- xi.iv. Select suitable chairs with armrests that are an appropriate height for rising and
- xii.v. Encourage patient to move/change position Instruct patients to rise-slowly.
- xiii. Offer material to assess for a fall risk free home
- xiv.vi. Place patients with urgency near toilets or use commodes.
- xv.vii. Instruct male patients prone to dizziness to sit while voiding.
- b. Moderate Risk Patients (= 36 - 44 total score):
 - Implement Universal and Low Risk interventions.
 - ij.-Educate the patient and family about the risk of falling, safety issues and mobility
 - "Patient Safety/Preventing Slips and Falls" handout shall be provided to patient and family
 - iv. Offer toileting every 2 hours to patients who are receiving laxatives or diuretics
 - ∨.ii. Ambulate patients with assistance.
 - Teach patients to make position changes slowly
 - ₩.iii. Re-orient confused patients.
 - vii.iv. Move confused patients close to nurse's station.
 - viii.v. Encourage family members to sit with confused patients.
 - ix.vi. Use bed exit alarms.
 - x.vii. Use chair alarms.
 - xi.viii. Teach activity limits to patient and family.
 - xii.ix. Large "Yellow Stoplightfall risk Laminates sign" shall be placed at the head of the bed for moderate risk patients and small "Yellow Stoplight Laminates" shall be placed on the patient's medical-chart.
 - A "stoplight fall "magnetrisk magnet shall be placed on the patient's doorframe X. with the designated bed indicated on the magnet-using a black sharple pen.
 - xiii.xi. Review Partnering for Fall Prevention- My Safety Plan, with patient and their family. This is not a permanent part of the chart and shall remain at bedside in discharge folders.
- c. High Risk Patients (= 45+ total score) require:
 - Implement Universal, Low, and Moderate Risk interventions.
 - Place designated color-coded fall risk wristband on patient. ii.
 - High Risk Rounding: strongly encourage patient to use the bathroom or Bedside Commode at least every 4-6 hours while awake if they have not gone when offered during hourly rounding (does not include patients with foleysFoleys). Rounds on assigned patients shall be made every hour by the RN, Licensed Vocational Nur), or desi-
 - Hourly rounding shall-be-documented in the electronic medical record at the end of each shift.
 - iii. Remain with patient while toileting or showering if appropriate.
 - iv. Ensure commode is available at bedside if patient is unable to ambulate to the bathroom with assistance.

- iii. Large "Red Stoplight Laminates" shall be placed at the head of the bed for high risk patients and small "Red Stoplight Laminates" shall be placed on the patient's medical chart.
- d. Responsibilities:
 - i. Designated color-codedFall Risk Armbands
 - a. The RN or LVN **Designee** is responsible for placing the armbands on the wrist of patients identified as high (45+) risk.
 - b. The RN or LVNDesignee is responsible for removing the armband upon change in Fall Risk Score or upon discharge.
 - ii. Large "StoplightFall Risk" Laminates
 - a. The RN or LVNDesignee is responsible for placing, updating, and/or removing the large "stoplightFall Risk" laminates over the head of the patient's bed.
 - iii. Small "Stoplight" Laminates
 - a. The RN or LVN is responsible for placing, updating, and/or removing the small stoplight laminate on the patient's chart
 - iv.iii. "StoplighFtall risk" Mmagnets:
 - a. The RN or LVNDesignee is responsible for placing, updating, and/or removing the "stoplightfall risk" magnet on the patient's doorframe with the designated bed indicated on the magnet. using a black sharpie pen.
 - Y-iv. The Assistant Nurse Manager (ANM)/charge nurse shall check for appropriateness of signage during rounds.
- e. The primary RN shall reassess the patient every shift for needs and change in status.
 - i. When patient is reassessed and has a change in risk level, interventions are added or discontinued as indicated.
- f. The primary RN shall note and document the availability of family/friends to stay with the patient. The care plan shall be revised with any patient status change or the absence of family.
- g. The patient's fall risk status and family presence shall be reported during communication hand-offs.
- h. If a patient falls, the Assistant Nursing Manager ANM or designee designee shall conduct an immediate educational debriefing for all staff involved.
 - i. A Quality Review Report (QRR) and Post Fall Risk Analysis Huddle shall be completed by the Assistant Nursing Manager or designeedesignee
 - ii. The QRR and Post Fall Risk Analysis Huddle shall be reviewed by the Director/Manager and forwarded to Risk Management. for review within 24 hours.
- i. Each outpatient care area and Emergency Department will assess the risk for falls based on their own unit specific guidelines, and intervene as appropriate.
- j. All patients are reassessed prior to discharge for their stability: dizziness, observe ambulation assisted and unassisted, educate on fall prevention, rescore and document.

B. **SPECIAL CONSIDERATIONS:**

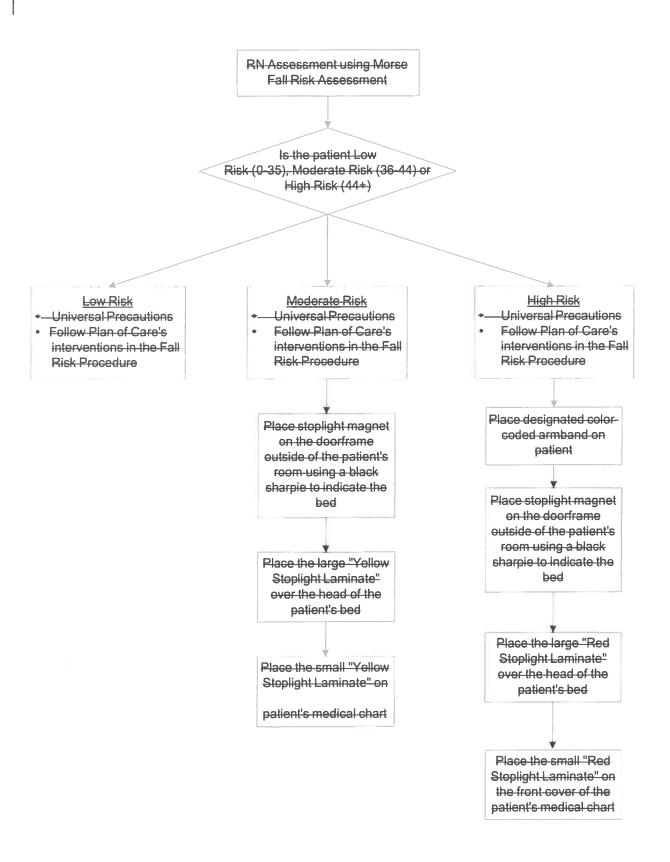
- 1. Intensive Care Unit (ICU) Specific Fall Precautions
 - a. Appropriate interventions shall be used based on the Patient Care Services Fall Risk Procedure with the exception of the following:
 - i. Stoplight magnets and overhead laminates are not required.
 - ii. Due to patient and RN ratios for ICU, observation is ongoing and High Risk Rounding is not required.
 - b. Moderate and/or high-risk patients require RN, Physical Therapist, or Lift Team **Technician** assistance with getting out of bed (requires physician order).
- 2. Peri-Anesthesia (PANS) Specific Fall Precautions
 - a. All patients in PANS area are considered high fall risk due to post anesthesia / sedation status.

- b. Appropriate interventions shall be used based on the Patient Care Services Fall Risk Procedure.
 - i. Including call light within reach of bedside.
 - ii. Patients shall be assisted to bathroom and ambulated wearing shoes or non slip socks.
 - iii. RN family member in attendance behind curtain to assist out-patient while dressing prior to discharge.
- c. Steplight-Fall Risk magnets and overhead laminates are not required.
- 3. Emergency Department (ED) Specific Fall Precautions
 - a. Patients seen in the ED are scored for falls using KINDER1 Falls Scale, which is an evidenced based best practice tool developed specifically for Emergency Departments.
 - b. Fall risk assessment is performed by an RN upon initial assessment.
 - i. The patient is deemed not at risk.
 - ii. The patient is deemed at risk if there is a yes answer to any question.
 - c. Reassessments are performed with any change of condition.
 - d. If a patient falls in the ED the patient automatically becomes an at risk for falls patient.
 - e. The following interventions are instituted based on the patient's risk value:
 - Universal Falls precautions are initiated on all patients in the Emergency Department.
 - ii. At risk for falls precautions (include but not limited to):
 - a. Encourage family to remain with patient
 - b. Encourage patient to change position slowly
 - c. Increase intervals of nursing observation
 - d. Patients shall be assisted to bathroom and with ambulation
 - e. Fall Risk armband placed on patient
- 4. Imaging Services
 - a. See Imaging General Safety Policy for Unit Specific Interventions

C. RELATED DOCUMENTS:

- Administrative Policy: Incident Report Quality Review Report (QRR) RL Solutions
- 2. Fall Risk Algorithm
- 3. Medication Fall Alert Reference Text
- 4. Partnering for Fall Prevention- My Safety Plan Sample
- 5. Post Patient-Fall Huddle & Analysis Tool Sample
- Unit-Specific Fall-Precautions

Fall Risk Procedure Algorithm



RN Assessment using Morse Fall Risk Assessment Universal Fall Precautions as appropriate 1. Adequate lighting 2. Assistive devices within easy reach 3. Bed in law position 4. Bed wheels and wheelchair brakes locked 5. Assure call light and possessions within easy reach 6. Clean and dry surfaces 7. Hand rails and grab bars accessible 8. Hourly rounding 9. Non-skid slippers or footwear are worn during ambulation 10. Orientation patients to their bed area, unit facilities, and how to get assistance 11. Patient/family fall prevention education (use Patient& Family Guide/review Fall Prevention section) 12. Rooms free of clutter 13. Side ralls up times 2 Is the patient Low Risk (0-35), Moderate Risk (36-44) or High Risk (45+)? Moderate Risk (=36 - 44 fotal High Risk (= 45+ total score) score) Low Risk (= 0 - 35 total score) Universal Precautions Universal Precautions Implement Low and Maderate Implement Low Risk Risk interventions Interventions 1. Reinforce grab bar use near 1. Ambulate patients w/ assistance 2. Re-orient confused patients 2. Remioroe possible Rir side 3. Move confused patients close to effects increasing fall risk Limit nurse's station 4. Encourage family members to sit w/ combinations of Rx that may confused patients 8 hours while awake it they have not increase fall risk gone when offered during hourly 3. Select suitable chairs wit 5. Use bed exit alarms armrests of appropriate height for 8. Use chair alarms 7. Teach activity limits to patient/family Holoys I rising and sitting 4. Encourage patient to mover 8. Place large fall risk sign at head of change position slowly 5. Place patients with urgency 9. Attach fall risk magnet to patient's 4. Ensure commade is available at doorframe w/ designated bed. near toilets or provide commodes 10. Review Partnering for Fall 0. Instruct male patients prone to dizziness to sit while voiding. Prevention- My Safety Plan," w/ patient/ tamily. Place in discharge folders.

Morse Fall Scale

Item	Item Score	Patient Score
1. History of falling (immediate or previous)	No 0 Yes 25	
2. Secondary diagnosis (≥ 2 medical diagnoses in chart)	No 0 Yes 15	
3. Ambulatory aid None/bedrest/nurse assist Crutches/cane/walker Furniture	0 15 30	
4. Intravenous therapy/heparin lock	No 0 Yes 20	
5. Gait Normal/bedrest/wheelchair Weak* Impaired [†]	0 10 20	
6. Mental status Oriented to own ability Overestimates/forgets limitations	0 15	
Total Score [‡] : Tally the patient score and record. <25: Low risk 25-45: Moderate risk >45: High risk		

^{*} Weak gait: Short steps (may shuffle), stooped but able to lift head while walking, may seek support from furniture while walking, but with light touch (for reassurance).

[†] Impaired gait: Short steps with shuffle; may have difficulty arising from chair; head down; significantly impaired balance, requiring furniture, support person, or walking aid to walk.

[‡] Suggested scoring based on Morse JM, Black C, Oberle K, et al. A prospective study to identify the fall-prone patient. Soc Sci Med 1989; 28(1):81-6. However, note that Morse herself said that the appropriate cut-points to distinguish risk should be determined by each institution based on the risk profile of its patients. For details, see Morse JM, Morse RM, Tylko SJ. Development of a scale to identify the fall-prone patient. Can J Aging 1989;8;366-7.

Medication Fall Alert Reference Text

Medications (including but not limited to) that may affect Patients Fall risk *Denotes individual drugs associated with highest risk of dizziness or falls in each category

- Category One

 1. Antihistamines
 - a. Chlorpheniramine (Chlor-Trimeton)
 - b. Diphenhydramine Hydrochloride (Benadryl)
 - c. Dimenhydrinate (Dramamine)
 - d. Hydroxyzine (Vistarii)
 - e. Meclizine (Antivert)
- 2. Cardiac Drugs
 - f. Atenolol (Tenormin)
 - g. Captopril (Capoten)
 - h. Diltiazem (Cardizem)
 - i. Enalapril (Vasotec)
 - j. Lisinopril (Zestril)
 - k. Metoprolol (Lopressor)
 - I. Nifedipine (Procardia)
 - m. Propranolol (Inderal)
 - n. Amiodarone (Cordarone)
- 3. Hypotensive Agents
 - a. Clonidine (Catapres)
 - b. Hydralazine (Apresoline)
 - c. Labetalol (Trandate)
 - d. Prazosin (Minipress) (Especially first dose syncope)
 - e. Terazosin (Hyrtin) (Especially first dose syncope)
 - f. Doxazosin (Cardura) (Especially first dose syncope)

Category Two

- a. Neurotoxic Chemotherapeutic Drugs
 - a. Ifosfamide (Ifex)
 - b. Vincristine (Vincasar)
 - c. Cisplatin
 - d. Methotrexate
 - e. Cytarabine
 - f. 5-fluorouracil (Adrucil)
 - g. Paclitaxel
- b. Vasodilating Agents
 - h. Isosorbide dinitrate (Isordil)
 - i. Isosorbide mononitrate (Imdur)
 - j. Nitroglycerin (Nitrostat)
- c. Opiate Agonists
 - k. Codeine (Includes cough syrups and Tylenol #3)
 - I. Hydrocodone (Norco)
 - m. Morphine
 - n. Oxycodone (Percocet)
 - o. Tramadol (Ultram)
- d. Anticonvulsants
 - p. Phenobarbital
 - q. Diazepam (Valium)
 - r. Phenytoin (Dilantin)
 - s. Carbamazepine (Tegretol)

e. Muscle Relaxants

- a. Baclofen (Lioresal)
- b. Carisoprodol (Soma)
- c. Cyclobenzaprine (Flexeril)
- d. Chlorzoxazone (Lorzone)
- e. Metaxalone (Skelaxin)
- f. Methocarbamol (Robaxin)
- g. Orphenadrine (Norflex)

Category Three

- 1. Psychotherapeutic Agents
 - a. Clomipramine (Anafranil)
 - b. Amitriptyline (Elavil)
 - c. Doxepin (Silenor)
 - d. Sertraline (Zoloft)
 - e. Trazodone (Oleptro)
 - f. Imipramine (Tofranil)
 - g. Trimipramine (Surmontil)
- 2. Antipsychotic Agents
 - h.
 - i. Chlorpromazine (Thorazine)
 - j. Clozapine (Clozaril)
 - k. Thioridazine
- 3. Benzodiazepines
 - I. Alprazolam (Xanax)
 - m. Chlordiazepoxide (Librium)
 - n. Flurazepam
 - o. Lorazepam (Ativan)
 - p. Temazepam (Restoril)
 - q. Triazolam (Halcion)
- Diuretics
 - r. Furosemide (Lasix)
 - s. Bumetanide (Bumex)
 - t. Torsemide (Demadex)
- 5. Miscellaneous Anxiolytics, Sedatives & Hypnotics Meprobamate

Partnering for Fall Prevention – My Safety Plan Sample

Directions: This is a tool to partner with the patient and family for education of the patient's fall risk factors and strategies to reduce risk of falls and keep the patient safe.

Partnering for Fall Prevention - My Safety Plan

We care about you and your safety. We want to partner with you and your family to prevent falls. Your medical assessment shows you to be at risk for falls.

You are at risk for falls or injury because:

You are unsteady when you walk.
You may bleed easily if you fall.
You are taking medications that may make you fall more easily.
Your medical history shows an increased risk for broken bones, due to:
Recent surgeries or procedures put you at risk for falling, such as:
Medical equipment (sequential devices, foot pumps, etc.)
Other:

What you and your family can do to help us keep you safe

For Patients at risk for falls we ask that you do the following:

- > I know how to use my call light
 - ☐ RN: Pt demonstrated correct use of call light to notify nursing staff
- > I will always use the call light to contact the nurse. I promise to stay in bed and call my nurse for help.
 - o Whenever I need to get up
 - o Whenever I need help reaching something that is out of my reach
 - o Whenever I am feeling dizzy or sleepy from medications
- > I will always call the nurse and not ask family for help getting out of bed
- > I will wear my skid-proof slipper socks and yellow wrist band
- I have a bed alarm that is active at all times. It will alert nursing staff when I am out of bed. I will not turn off the alarm.
- I will not use the over-bed table to help me stand; it is on rollers and may cause me to fall if I lean on it.

	iedi) on ii.				
	RN: Reviewed falls prevention plan with patient and family				
Patient Initials/Date/Time:					
RN Sic	inature/Date/Time:				

POST FALL HUDDLE/AFTER ACTION REVIEW - Sample

Date: / /Time:		
Setting:FIN #:Entered By:		
Reason for Audit: To involve front line staff in identifying problems and solutions, and in and team building among team members. To promote a positive Culture of Safety without in	creating change in their work en ndividual blame.	vironment. To promote trust
Instructions: 1. Hold the Huddle as soon as possible and after every fall. 2. Involve the patient, staff involved in the care of patient or fall, and assistant nurse managor manager. 3. Meeting is organized by primary RN and is brief.	er or	
* Indicates that an answer is required.		
2013 Post Fall Huddle/ After	Action Review	
2013 Post Fall Huddle	Answer	Comments
1.* Why did this patient fall? Ask the group "why" 3 times to find the root cause. Example: Why did this patient fall? The patient got out of bed alone because he had to go to the bathroom.		Lessons Learned
2.* Why did "answer to question 1" happen? Example: Why did the patient get out of bed alone? The patient got out of bed alone because he did not know where his call light was.		Lessons Learned
3.* Why did "answer to question 2" happen? Example: Why did he not know where his call light was? The call light was not within reach of the patient.		Lessons Learned
4.* What was the latest Fall Risk Score for the patient?		
5.* Were the appropriate interventions in place?	Yes No	What accounted for the difference?
6.* How could the same outcome be avoided next time?		Lessons Learned
7.* What is the follow up plan?		Follow up Plan
3. Patient's account (if able to share)		Patient's Account
Agreement with patient for safety (Promise to use call bell; return demo how to se call bell)		Safety Agreement
0.* Type of Fall? Definitions for Type of Falls Accidental falls- Slipping, tripping, person making errors of judgement Anticipated physiological falls- Related to age and functional ability, Disease(s), Previous Fall(s), Weak or impaired gait, Lack of realistic assessment of their own ability, Person making errors of judgment. Unanticipated physiologic falls- Attributed to physiological causes but created by conditions that cannot be predicted Behavioral falls- Patient who has behavioral issues and voluntarily positions his/her body from a higher level to a lower level.		
Accidental Fall	[]	
Anticipated Physiological Fall	[]	
Unanticipated Physiological Fall	[]	
Behavioral (Intentional) Fall	[]	
1.* Post Fall Checklist		
RL Completed		
IPOC Post Fall Initiated	[]	
Physician Notified	[]	
Documentation in the Medical Record (event, phys exam, intervention)	[]	
Morse Fall Risk Score Updated		
	L	L

DELETE – replaced with new document

Post Patient Fall Huddle & Analysis Tool

Purpose: To provide a mechanism to immediately analyze all patient falls when they occurred to evaluate potential opportunities for the immediate re-assessment of the patients falls risk indicators, to develop a plan for the prevention of additional falls, and to highlight and correct any environmental barriers that may have contributed to the initial fall.

Patient ID:______Date of Fall:______Time of Fall:______Loc

Previous Falls Risk/Lift Assessment category (circle one):

Low Risk (0-35) Moderate Risk (36-44) High Risk (44 and higher)

Check all Fall Risk Factors present

Outcomes of falls:

Psychotropic, analgesics, diuretics, anticoagulants or XXX medication usage within past 12 hours
Noted urinary frequency or diarrhea

Documented agitation, confusion, or disorientation Utilization of the equipment that could contribute to

ambulation problems

Call light unavailable for use

Patient incontinent

Attempting to toilet-alone without assistance or equipment

Patient alone, family member non present

Room and floor area cluttered

Patient lift-assistive equipment not available or not used

Shackles

Patient Interview:

the fall occurred):

No injury

Minor abrasion, contusion or laceration

(include statement from patient about why

Fracture Death

Prevention Plan:

Patient re-educated about importance of calling for assistance

Family re-educated about importance of utilizing assistance

Reinforce patient safety with patient and family through use of lift equipment

Bed-alarm

Chair alarm

Leave light on at all time

Increase frequency of rounds to offer toileting, hydration, and assessment of condition

Obtain patient sitter

Increase utilization of lift assistive equipment (bed to chair/commode transfers, sit to stand and

ambulation for toileting)

Assist to floor

Unwitnessed Fall

Witnessed Fall

Appropriate Documentation

Head to toe assessment

Other:

DELETE - Incorporate content into procedure instead of a related document.

UNIT SPECIFIC FALL PRECAUTIONS

INTENSIVE CARE UNIT (ICU) SPECIFIC FALL PRECAUTIONS

- A. Appropriate interventions shall be used based on the Patient Care Services Fall-Risk Procedure with the exception of the following:
 - 1. Stoplight magnets and overhead laminates are not required.
 - Due to patient and RN ratios for ICU, observation is ongoing and High Risk-Rounding is not required.
- B. Moderate and/or high-risk patients require RN, Physical Therapist, or Lift Team assistance with getting out of bed (requires physician order).

PERI-ANESTHESIA (PANS) SPECIFIC FALL PRECAUTIONS

- A. All patients in PANS area are considered high fall risk due to post anesthesia / sedation status.
- B. Appropriate interventions shall be used based on the Patient Care Services Fall Risk Procedure.
 - 1. Including call light within reach of bedside.
 - 2. Patients shall be assisted to bathroom and ambulated wearing shoes or non-slip socks.
 - 3. RN family member in attendance behind curtain to assist out-patient while dressing prior to discharge.
 - 4. Stoplight magnets and overhead laminates are not required.



PATIENT CARE SERVICES

SUBJECT: Interpretation and Translation ISSUE DATE: 11/11

Services

REVISION DATE: 10/13; 01/14; 01/15 POLICY NUMBER: II.J

09/16 **Department Approval:**

Clinical Policies & Procedures Committee Approval:

Nurse Executive Council Approval:

Pharmacy & Therapeutics Committee Approval:

Medical Executive Committee Approval:

Professional Affairs Committee Approval:

Board of Directors Approval:

12/1510/16 01/1610/16

n/a

02/1611/16

03/16

03/16

A. **PURPOSE:**

To outline the policy and procedure for provision of interpretation services within Tri-City Healthcare District (TCHD) for patients with limited English proficiency.

B. **DEFINITIONS:**

- Communicatively Impaired: A communicatively impaired individual has expressive or receptive language deficits that may be present after an illness or injury. This may include individuals with: voice disorders, laryngectomy, glossectomy, cognitive disorder, or temporary disruption of the vocal cords due to intubation or medical treatment.
- 2. Limited English Proficiency (LEP): A limited ability or inability to speak, read, write, or understand the English language at a level that permits the person to interact effectively with health care providers or social service agencies.
- 3. Primary or Preferred Language: the language the patient wants to use to communicate with his/her provider(s).
- Interpretation and Translation: Interpretation involves the immediate communication of meaning 4. from one language (the source language) into another (the target language). An interpreter conveys meaning orally, reflecting the style, register, and cultural context of the source message, without omissions, additions or embellishments. A translation conveys meaning from written text to written text. A sight translation is the oral rendition of text written in one language into another language and is usually done in the moment. Interpretation and translation require different skills.
- 5. Interpreters:
 - Bilingual Employees: Personnel with validated competency that specifies the parameters a. within which the employee, in the course of providing services, may communicate directly with patients, family members, surrogate decision makers and visitors in a foreign language. Those parameters and requirements are equal to those set for medical/healthcare, service and general information interpreters.
 - Dual-Role Employees: Personnel with validated competency that specifies the parameters b. within which the employee may serve as interpreter in the course of providing services within their unit or in emergency situations. Those parameters and requirements are equal to those set for medical/healthcare, service and general information interpreters.
 - Medical/healthcare Information Interpreter: Personnel with validated competency to C. interpret critical medical communications including but not limited to medical care, treatment, medical decision making. May include in-house healthcare interpreters and assessed/qualified dual role.
 - Service Information Interpreters: Personnel with validated competency to interpret limited d. topics related to critical service information.

- e. General Information Interpreter: Personnel with validated competency to interpret limited topics relating to providing directions, obtaining specific demographic information, and/or assisting patients with registration, basic daily activities, and comfort.
- f. Telephone Interpreters: Contracted provider, designated telephone interpreter focused on quality health care communication to be used when a qualified interpreter (facility identified) is not available.
- g. Video Remote Interpreters: Contracted providers, designated video remote interpreter focused on quality health care communication to be used when a qualified interpreter (facility identified) is not available or in lieu of a telephone interpreter.
- 6. Critical Medical Communications: Generally includes but not limited to:
 - a. Consent and/or acknowledgement of information discussion
 - b. Advance directive discussion
 - c. "Do Not Resuscitate" (DNR) and discussion
 - d. Explaining any diagnosis and plan for medical treatment
 - e. Explaining any medical procedures, tests or surgeries
 - f. Initial medication education
 - g. Patient complaints
 - h. Final discharge instructions
- 7. Critical Service Information: Generally includes but not limited to:
 - a. Agreement for Services
 - b. Notices pertaining to the denial, reduction, modification or termination of services and benefits, and their right to file a grievance or appeal
 - Applications to participate in a program or activity or to receive hospital benefits or services.

C. POLICY

- 1. TCHD provides qualified interpreters at no cost to patients whenever a language or communication barrier exists. Interpretation services are available on the premises or accessible by telephone or video remote interpreting (VRI) 24 hours a day, seven (7) days a week.
- 2. TCHD qualified interpreters will be utilized for interpretation appropriate to their level of competency.
 - a. The telephone interpretation service or VRI shall be used in the absence of a TCHD qualified interpreter whenever necessary for any language.
- 3. After being informed of the availability of interpreters who are qualified to interpret medical information at no charge, patients may refuse the TCHD's interpretation service and select an individual of their choice to assist with their communication needs.
 - a. Patient refusal of TCHD's interpretation service must be documented in the medical record in addition to the name of the individual that the patient has selected to perform interpretation.
 - b. Staff members may access a TCHD medical information interpreter if at any time they feel there is a communication barrier with the interpreter selected by the patient and may have a hospital-designated interpreter monitor the communication.
- 4. Documents and forms shall be either provided in the preferred language of patient/family when available or explained verbally.
- 5. Notices advising patients and families of availability of interpretation services, procedures for obtaining assistance and lodging complaints are displayed in public areas on the Patient Rights posters and patient handbooks.
- 6. Education on interpretation services shall be provided in New Employee Orientation and as needed in department/committee meetings.

D. **PROCEDURE**

- Registration
 - a. Upon first encounter (registration, check-in), Access personnel shall identify the patients preferred language for discussing health care. The designation shall be documented in the electronic health record as appropriate.

- i. A service information interpreter shall be utilized as needed
- 2. Inpatient or Outpatient Areas
 - a. Assess and document patient needs and preferred methods(s) for interpretation services in the medical record and incorporate into the plan of care.
 - b. Contact TCHD qualified interpreter based on the level of interpretation services (general information or critical medical communication) needed (see definitions and reference Tri-City Healthcare District qualified interpreters information on the Intranet).
 - c. If a TCHD qualified interpreter is not available, contact either the facility designated telephone interpreting service (see Language Services Associates instructions on the Intranet), or facility designated video remote interpreting services (see Language Services Associates, NexTalk and Status instructions on the intranet).

E. DOCUMENTATION

1. Document the use of all interpretation/translation services, including patient selected individual for medical interpretation in the patient's medical record and include: date, interpreter's name or ID number, language, and reason for interpretation / call (i.e., "John Smith, patient's wife or "Mary Jones, Official Interpreter, or "telephone Interpreter ID # 123, Language: Korean, Reason: to discuss surgical procedure).

F. FORM/RELATED DOCUMENTS:

1. Interpretation and Translation Resources – Quick Reference & User Guides

G. **REFERENCES**

- 1. National American with Disabilities Act (ADA) www.usdoj.gov/crt/ada/adahom1.htm
- 2. 42 CRF 124.602(c)
- 3. 45 CFR 84.52 (c) and (d)
- 4. Section 504 of Rehabilitation Act of 1973
- 5. Title VI of Civil Rights Act of 1964
- 6. Section 1259, California Health & Safety Code
- 7. National Standards for Culturally and Linguistic Appropriate Services (CLAS)
- 8. National Association for the Deaf: www.nad.org
- 9. Federal Interagency Working Group on Limited English Proficiency: www.justice.gov/crt/lep/
- 10. The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patientand Family-Centered Care: A Roadmap for Hospitals
- 11. Limited English Proficiency (LEP) A Federal Interagency Website (www.lep.gov).

PATIENT CARE SERVICES POLICY MANUAL

SUBJECT: Medication Reconciliation **ISSUE DATE:** 9/05

REVISION DATE: 6/03, 5/05, 4/09, 5/12 POLICY NUMBER: IV.JJ

Clinical Policies & Procedures Committee Approval: 05/1208/16

Nursing Executive Council:

05/1209/16

Medical Staff Department or Division Approval:

Pharmacy & Therapeutics Committee Approval:

n/a 11/16

Medical Executive Committee Approval:

06/1211/16

Professional Affairs Committee Approval:

07/12

Board of Directors Approval:

07/12

POLICY: A.

- Medication reconciliation is an interdisciplinary process between the patient, nurse, pharmacy, and physician designed to decrease medication Adverse Drug Events/Adverse Drug Reactions (ADE/ADR) and ensure accuracy in the list of the patient's current medications at each change in level of care or at discharge.
- All Inpatients shall have all medications reconciled within 24 hours of admission. The final 2. outcome of medication reconciliation is to obtain and document a complete and accurate list of the patient's current medications upon the patient's admission to the organization.
- The most up to date, reconciled medication list is provided at all transitions of care. 3.
- When the patient is discharged, the reconciled list of medications is explained to the patient and 4. the process documented.
- The final reconciled medication list is faxed by Medical Records to the primary care provider 5. (PCP) or other physicians that will follow up with the patient after discharge.

MODIFIED MEDICATION RECONCILIATION PROCESS: B.

- Modified medication reconciliation process shall be done in areas where medications are not used, used minimally, or used for short duration including but not limited to, Emergency Department, Special Procedures, Outpatient Radiology-Imaging Contrast Studies, Outpatient Behavioral Health, Outpatient Chemotherapy, Occupational Medicine, Wound Center, Aesthetics Center, Outpatient Specialty Services Forensies and Crisis Stabilization Unit.
 - Home medication list must be obtained, but does not require dose, route, and frequency. a.
 - Current list of home medications does not need to be provided to the patient. If the b. patient is confused, a list shall be provided to the family/responsible party.
 - If there are short-term medications, the patient is provided a list with short-term medication addition(s).
 - Complete documented medication reconciliation is required when chronic medications are C. prescribed, when there is a change to the patient's medications, or the patient is admitted.
 - When a patient is discharged from the hospital at the end of an outpatient encounter, d. patients will be taught the importance of managing their medication information.
 - When complete medication reconciliation is required, a list is provided to the patient e. and/or the primary care provider upon discharge.

C. INPATIENT MEDICATION RECONCILIATION PROCESS:

- All medications shall be reconciled upon:
 - a. Admission
 - b. Intra-facility transfer (change in level of care)
 - Discharge C.

- d. The nurse shall review and complete the Medication by History screen. Every effort will be made to obtain drug name, dose, frequency and route. At a minimum, drug name will be obtained.
- e. The patient's medication history may be obtained from either the patient, family members, and/or legal representative who are present at the time of admission or from Surescript if consent is obtained. The admitting nurse shall determine if they are reliable historians.
 - i. If the patient, family, or legal representative is able to provide accurate data, no additional source of information is required.
- f. In cases when neither the patient nor the family is considered a reliable source, alternative sources shall be located. Consider the following:
 - i. Surescript database if consent obtained
 - ii. Review the patient's current medical record
 - iii. Discuss with family members and/or caregivers when they are available for patients who are unaccompanied on admission
 - iv. Contact the patient's current pharmacy to determine or validate his/her current medications
- g. Pharmacy **personnel** may assist with the medication reconciliation process as a resource.
- h. The Admitting Physician/Allied Health Professional (AHP) is required to review, complete and reconcile, Admission Medication Reconciliation information in Cerner collected upon admission of the patients within 24 hours.
- i. Once Admission Medication Reconciliation List has been completed and all medications reconciled, the complete list of the patient's medication (MAR) shall be used as the most complete and accurate medication list.
- 2. If new information is later obtained, the physician/AHP or nurse may update the Medication by History List in Cerner.
- 3. <u>Intra-Facility Transfer (Change in Level of Care):</u>
 - a. All medications will be reviewed and revised as appropriate when the patient is being transferred to the next level of care
 - i. Electronic Orders:
 - 1) The physician/AHP will access the Transfer Medication Reconciliation function and will reconcile each medication on the active medication list to either be continued or not continued for the next level of care.
 - ii. Written Orders:
 - 1) The physician from the SENDING unit shall print out the Transfer Reconciliation Order form and place as the first sheet under the Physician Order tab section of the patient's medical record. The physician may use this form as the actual order form or handwrite any changes in a preprinted physician order form or the generic blank physician order form.
 - 2) The nurse shall verify the physician has reviewed and signed all current orders and determined which orders shall be continued at the new level of care.
 - 3) The nurse from the RECEIVING unit will process the transfer orders and scan to the Pharmacy.
- 4. Discharge:
 - a. All medications will be reviewed against HOME medications to create a final discharge mediation list
 - i. Electronic Orders:
 - 1) The physician/AHP will complete the Discharge Mediation Reconciliation application in Cerner and will reconcile each medication on the active medication list and home list to either be continued or not continued upon discharge. New medications will be added as required.
 - 2) Prescriptions to be completed
 - a) ePrescribe electronic prescription transmitted to the patient's pharmacy
 - b) Printed on the unit and handed to the patient
 - c) Handwritten on personal (physician's) prescription pad

ii. Written Orders:

- 1) The physician will print the Discharge Medication Reconciliation Form from Cerner and will review and reconcile each medication on the active list and home list to either be continued or not continued upon discharge and signs. This order sheet will be places as the first sheet under the Physician Order tab section of the patient's medical-record.
- 2) The nurse shall enter these orders into the Discharge Medication Reconciliation application in Cerner and reconcile the medications.
- 3) Physician handwrites prescriptions on personal (physician's) prescription pad.
- b. The nurse shall print and deliver the Patient's Discharge Instructions, which includes the reconciled medications to the patient and/or family. These can be printed in English or Spanish. Education will be provided on any new medications that are being ordered for the patient.
- c. Medical Records shall send a Transition of Care form which includes the discharge medicationsfax the completed Clinical Summary form and Medication Patient History form to the attending physician/AHP and consultant(s) listed in the patient's medical record the day following discharge. This final step in the medication reconciliation process ensures the physicians/AHPs are notified of the list of medications and other instructions given to the patient upon discharge.



PATIENT CARE SERVICES

ISSUE DATE:

06/13

SUBJECT: NEUTROPENIC PRECAUTIONS

REVISION DATE:

POLICY NUMBER: NEW

Clinical Policies & Procedures Committee Approval:

01/1307/16

Nurse Executive Council Approval:

04/1307/16

Infection Control Committee Approval:

10/16

Pharmacy & Therapeutics Committee Approval:

n/a

Medical Executive Committee Approval:

10/16

Professional Affairs Committee Approval:

06/13

Board of Directors Approval:

06/13

A. POLICY:

- 1. To outline steps for preventing infections in patients with neutropenia.
- 2. Patients who are identified as neutropenic have the greatest risk for infection
- 3. Neutropenia is defined as an absolute neutrophil count [ANC] of <500 cells/mL
- 4. The primary nurse must educate the patient and family on these neutropenic precautions.

B. **PROCEDURE:**

- 1. If patient has been identified as having an ANC of <500 cells/mL move patient to a private room.
- 2. Do not place patient in a negative pressure room unless patient requires respiratory isolation for Airbourne Precautions per the Tricity Medical Center's infection control manual.
- 3. Place sign outside of the patient's room that states "please check in with the nurses' station before entering the room". Never place a sign that states "neutropenia". This is a Health Insurance Portability and Accountability Act (HIPAA) violation.
- 4. Do not allow staff or visitors who have symptoms of respiratory infection to visit or care for patient
- 5. All visitors:
 - a. Must be screened for respiratory infections
 - Must perform hand hygiene before entering the patient's room.
- 6. Children must be accompanied by a responsible adult (other than the patient) at all times when visiting.
 - a. Only one child may visit at a time.
 - b. All children must wear a mask if visiting patient.
- 7. Healthcare team, **patient**, **family and visitors** must adhere to f the following neutropenic precautions while patient is hospitalized.
- 8. Neutropenic Precautions:
 - a. Hygiene
 - i. All healthcare team members must use standard precautions and do hand hygiene frequently when caring for neutropenic patients
 - ii. Patient must wash hands frequently and ensure they are dried properly
 - iii. Patient should keep their skin clean and dry at all times (bathe daily)
 - iv. Patient must protect skin from cuts and burns
 - v. Patient must perform frequent oral care (at least 3 4 times a day)
 - vi. Only use an electric shaver to remove hair (no razors).
 - vii. Patient's perineal area should be cleansed after voiding and bowel movement
 - viii. Menstruating women should avoid tampons
 - viii.ix. Rectal thermometers, enemas, suppositories and rectal examinations are contraindicated
 - b. Visitors

- i. No visitors with respiratory infections
- ii. Patient should avoid people with colds or contagious illness such a chicken pox, herpes zoster or influenza

c. Environment

- i. No fresh or dried plants and flowers in patient room
- ii. Change the water of any water containers or pitchers and denture cups daily

d. Food/Food Preparation

- Patient should not eat any foods that have not either been cooked or washed properly.
- ii. Patient should be placed on a neutropenic diet
- iii. Food items for the patient from the cafeteria must be covered when transported to the unit for the patient
- iv. Fruits and vegetables should be well washed before eating
- v. No uncooked meats, seafood, and eggs
- vi. Patient should not share food utensils

e. Vaccinations

- i. Influenza and pneumonia vaccinations are recommended
- ii. Patient should not receive live vaccines such as oral polio, varicella, small pox, or nasal flu vaccine.
- iii. Patient should avoid contact with people who have been vaccinated with a live virus within the past 30 days

f. Miscellaneous

- i. Refrain from providing direct care for pets or farm animals.
- ii. Avoid contact with animal feces, saliva, litter box contents or barns.
- iii. Do not enter or travel through, construction/renovation or where construction material/debris has been placed or where fields have recently been plowed.

C. RELATED DOCUMENTS:

Infection Control Policy: Standard and Transmission Based Precautions

C.D. REFERENCES:

- 1. Oncology Nursing Society (**2014**2009). Chemotherapy Biotherapy Guidelines and Recommendations for Practice Third Edition.
- 2. Oncology Nursing Society (20162009) PEP-Preventions of Infection.
- 2.3. Infectious Diseases Society of America (IDSA) to guide clinicians in the care of patients with chemotherapy and induced neutropenia and in the management of febrile neutropenia. http://cid.oxfordjournals.org/content/52/4/e56.full.



PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 10/97 **SUBJECT: Nursing Students in Patient Care**

Areas

REVISION DATE: 3/05, 4/05; 5/08; 07/09, 07/12 POLICY NUMBER: VIII.M

Department Approval: 10/16

Clinical Policies & Procedures Committee Approval:

12/1210/16 **Nursing Executive Council:** 12/1210/16 n/a

Medical Staff Department or Division Approval: Pharmacy & Therapeutics Committee Approval: n/a

Medical Executive Committee Approval: 01/13-11/16

Professional Affairs Committee Approval: 02/13 **Board of Directors Approval:** 02/13

POLICY: A.

- Students from several professional registered nursing (RN) schools are affiliated with Tri-City Healthcare District (TCHD)TCMCTCHD Nursing Services. All RN students must be affiliated with a school that has an agreement/contract with TCMCTCHD.
 - Student affiliation agreements are maintained in the Education Department and are signed by the Chief Nurse Executive.
- Annually, the schools make clinical requests through the San Diego Nursing Service-Education 2. Consortium. Requested schedules for nursing students are submitted to the Education Department for coordination and approval. Finalized schedules are distributed to the clinical areas prior to the students' arrival There are two types of clinical rotations:
 - Clinical Rotation with Instructor On Site: a group of RN nursing students in one of the four primary clinical areas: Acute Care Services, Telemetry, Behavioral Health Unit or Women's and Children's Service Mother Baby, where the clinical instructor is on site.
 - Clinical Rotation with Instructor Off Site: a RN nursing student in a clinical rotation where b. the nursing student follows an assigned staff nurse for a designated number of hours determined by the school, where the clinical instructor is off site.
 - Any change in approved clinical rotations (department, day, time) must be authorized by C. the TCMCTCHD Academic Liaison through the Education Department.
- 3. The Student Orientation Record from the San Diego Nursing Service-Education Consortium with the list of students and instructors must be submitted 2 weeks before the start of the semester for background checks.
 - Any flagged background checks will be reviewed and any action will be decided by the a. Director of Human Resources and the Director of Education and Clinical Informatics. The background checks must be cleared or resolved before the start of the clinical rotation.
- Responsibility for nursing care and related duties is retained by nursing unit when students are 4. providing care within a patient care unit.
 - The nursing staff has the right and responsibility to intervene or prevent a student from a. performing any nursing activity that appears inappropriate or potentially injurious to patients.
- 5. The faculty and students of affiliated schools are responsible for knowing and complying with **TCMCTCHD** Policies and Procedures.
- The Director or designee and the TCMCTCHD Academic Liaison have the option to discuss 6. behavioral or practice issues with students and/or instructors.

- 7. Staff issues identified by the nursing student instructor are to be directed to the Assistant Nurse Manager (ANM) or designee of the unit.
- 8. All medications shall be administered under the direct supervision of the Instructor/following Patient Care Services (PCS)) Medication Administration Policy (IV.I).
 - a. The staff RN may provide the direct supervision as available.
 - b. If neither the Instructor or staff RN is able to provide direct supervision, the RN nursing student may only observe the medication administration process.
 - c. When removing medications from the Pyxis machine, the Instructor or staff RN will enter their access code and student may remove medications under the direct supervision of the Instructor/staff RN.
 - i. Nursing Students will not be issued their own Pyxis code.
- 9. A skill will be performed by the student under the direct supervision of the nursing instructor until competency is validated. Certain skills may be performed by the RN nursing student without supervision once competency has been validated by the school (RN Nursing Student Skills List attachment 1).
 - a. The staff RN assigned to the patient in may provide direct supervision as available once the student has demonstrated competency with the skill. The school is responsible for validating competency.
 - b. If neither the Instructor or staff RN is able to provide direct supervision, the RN nursing student may only observe the skill.

B. CLINICAL ROTATIONS WITH INSTRUCTORS ON SITE (REQUIREMENTS):

- 1. The nursing school is responsible for planning the education program and providing Nursing Services with outlined goals and objectives relating to the clinical experience. Instructors are also responsible for updating and reviewing clinical goals for each student for every unit rotation.
- 2. Instructor Responsibilities:
 - a. Establish orientation dates for themselves and the student groups.
 - i. Orientation shall include time spent on the unit to learn standards, physical layout, fire and code responsibilities, communication skills, methodology of patient care, documentation system, patient assignment mechanism, call light system, daily schedules and roles of the staff and students.
 - b. The instructor shall turn in all completed forms/tests for faculty and students to Academic Liaison in the Education Department. Once the required documentation is completed and turned in, TCMCTCHD badges and access codes will be issued.
 - i. The orientation forms/tests are available on the consortium website.
 - ii. The completed forms should be returned within the first week of the TCMCTCHD rotation.
 - iii. Instructors/students must complete the TCMCTCHD orientation annually.
 - iv. Access codes shall be issued for each semester.
 - c. Select students' patient assignment and post by start of shift.
 - i. The ANM or designee may change assignment according to unit needs including the number of students and TCMCTCHD orientees assigned to a staff RN.
 - ii. Instructor is to assess needs of the unit as well as educational objectives of students prior to making patient assignments
 - d. Monitor the activities of the students at all times and is present on the units to monitor students or is available to students via pager and/or cell phone.
 - d.e. Ensure students comply with all policies related to protected health information (PHI)
 - e.f. Assessments may only be documented by RN nursing student when performed under the direct supervision of the instructor. The instructor supervising the assessment will authenticate the documentation.
 - Assessments performed without direct supervision may not be documented in the medical record.

- ii. The staff RN assigned to that patient may provide direct supervision as available once the student has demonstrated competency with the skill. If the staff RN provides supervision, they will authenticate the documentation.
- **f.g.** The instructor shall review student documentation including but not limited to:
 - i. Medication administration
 - ii. Vital Signs
 - iii. Plan of care
 - iv. Clinical notes
 - v. The staff RN assigned to the patient may review the student documentation as available.
- e.h. Teach and supervise student education and actions while on the unit.
- h.i. Communicate expectations of student's performance.
- i.j. Evaluate the student's clinical competency prior to arrival on the floor and also during performance of patient care skills.
- **j-k.** Assume final responsibility for management and evaluation of students.
- 3. Student Responsibilities:
 - a. Report to work at a specified time to receive report on their assigned patients from the primary nurse.
 - Perform nursing care according to TCMCTCHD policies and procedures. Care delivery must be under the direct supervision of the Instructor or staff RN according to attachment 1.
 - ii. Students are not to leave floor/unit without reporting to primary nurse.
 - iii. Ensure documentation is reviewed and authenticated by instructor/staff RN.
 - iv. Students shall not be excused until Intake and Output and charting is reviewed by the Instructor and verbal report is given to the primary nurse.
 - v. All unfinished work is to be reported to the primary nurse.
 - b. Communicate all pertinent information including changes in patient status, problems, concerns, and questions or learning needs to patient's primary RN.
 - c. Work with all health care team members in an effective/professional manner.
 - d. Review paper and electronic chart prior to the start of patient care and throughout the shift.
- 4. Staff RN Responsibilities:
 - a. Function as role models and are responsible for the nursing care given to the patients/families.
 - b. Facilitate the student learning experience as available.

C. CLINICAL ROTATIONS WITH INSTRUCTORS OFF SITE (ADDITIONAL REQUIREMENTS):

- Clinical Instructor
 - a. Submit the request for preceptors to the TCMCTCHD Academic Liaison prior to the start of the rotation.
 - b. Ensure students are oriented to TCMCTCHD and forms/tests for faculty and students are completed and turned in within the first week of the rotation.
 - c. Provide to the department goals of the rotation and hours required.
 - e.d. Ensure students have access to clinical application including but not limited to Cerner, capillary blood glucose meter and Supply Pyxis.
 - d.e. Manage any concerns/problems with students including conflicts with schedule
- 2. TCMCTCHD Academic Liaison Responsibilities
 - a. Collaborate with the Clinical Educator/Manager to assign students to a specific department.
 - b. Provide to the department goals of the rotation including dates of the rotation and minimum hours required.
- 3. Clinical Educator/Manager Responsibilities
 - a. Identify staff RN and provide the name of staff RN to facilitate scheduling the RN nursing student with the staff RN

- i. The instructor is responsible for managing any concerns/problems including conflicts with schedules.
- 4. RN Nursing Students Responsibilities:
 - a. Follow designated staff RN's schedule.
 - i. If staff RN is not available (Hospital Requested Time Off or illness) the nursing unit is responsible for assigning an alternative staff RN for that shift.
 - ii. If the student unable to report for an assigned shift, they must notify the nursing unit. The student will make arrangements with the nursing unit to make up the shift.
 - b. Report to nursing unit with academic skills checklist and clinical goals/objectives for each shift. The student may only perform skills for which they have demonstrated competency as validated by the school.
 - c. Discuss any schedule conflicts with Clinical Instructor.
- 5. Staff RN Responsibilities:
 - a. Ensure the student functions appropriately within their scope of practice and in accordance TCMCTCHD policies and procedures.
 - b. Review the skills the RN nursing student has demonstrated competency which have been validated by the school. The staff RN is not responsible for teaching new skills.
 - c. Observe assessments performed by the RN nursing student. The staff RN will authenticate the assessment documentation.
 - d. Review student documentation including but not limited to:
 - i. Medication administration
 - ii. Vital Signs
 - iii. Plan of care
 - iv. Clinical notes
 - e. Provide feedback to the Instructor on the student's performance during the rotation.

RN Nursing Student Skills List

Skill	RN Nursing Student Able to Perform Yes/No	Direct Observation by Instructor or RN Staff Required	Able to Perform after Competency Validated by Instructor
ADLs	Yes		Yes
Ambulation/Transfer (Fall Risk Procedure)			
Assessments	Yes	Yes	Yes
Bath	Yes	res	Yes
Blood Product Administration	NO		res
CAPD, Peritoneal Dialysis Administration	NO		
Capillary Blood Glucose Testing			V.
	Yes		Yes
ECG Monitoring Electrode Application	Yes		Yes
Endotracheal Suctioning Deep	Yes	Yes	
Enema Administer Non-Medicated Solution	Yes	Yes	
Feeding Tube (weighted/non-weighted) Discontinuation	Yes	Yes	
Feeding Tube (weighted/non-weighted) Insertion	Yes	Yes	
Feeding Tube (weighted/non-weighted) Irrigation	Yes	Yes	
Gastrostomy Tube Care	Yes	Yes	
Hand Off Communication	Yes		Yes
Hygiene (personal) Administration	Yes		Yes
Intake/Output	Yes		Yes
Isolation Precautions	Yes		Yes
IV Central Venous Access Dressing Change	Yes	Yes	
IV Peripheral Access/Venipuncture Insertion	Yes	Yes	
IV Peripheral Access Discontinuation	Yes	Yes	
Pulse Oximetry Monitoring	Yes		Yes
Epidural Infusions Maintain/Discontinue	NO		
Meal - Assist with Feeding (Aspiration Precautions)	Yes		Yes
Medication Administration - Chemotherapy	NO		
Medication Administration Investigational/Experimental Drugs	NO		
Medication Administration – Gastrostomy Tube	Yes	Yes	
Medications Administration - Eye	Yes	Yes	
Medications Administration - Intramuscular (IM)	Yes	Yes	
Medications Administration - Oral	Yes	Yes	Her in state with the
Medications Administration - Subcutaneous	Yes	Yes	

Skill	RN Nursing Student Able to Perform	Direct Observation by Instructor or RN Staff Required	Able to Perform after Competency Validated by Instructor
	Yes/No		
Medications Administration IV Peripheral Push*	Yes	Yes	
Medications Administration IV Central Venous Access	Yes	Yes	
Medications Administration IV Peripheral - Infusion pump	Yes	Yes	
Nasogastric Tube Discontinuation	Yes	Yes	
Nasogastric Tube Insertion	Yes	Yes	
Nasogastric Tube Irrigation/Care	Yes	Yes	
Neonatal – Bath	Yes		Yes
Neonatal – Developmental Care	Yes	Yes	
Neonatal – Diaper Change	Yes	Yes	
Neonatal – Heel Sticks	Yes	Yes	
Neonatal - Medication Administration Eyes	Yes	Yes	
Neonatal - Medication Administration IM	Yes	Yes	
Neonatal – Feeding Breast & Bottle	Yes	Yes	
Neonatal – Skin Care	Yes	Yes	
Neonatal – Transcutaneous Bilirubin (TCB) screening	Yes	Yes	
Neonatal – Universal Saturation Screening	Yes	Yes	
Oral gastric tubes insertion/irrigation/discontinuation	NO		
Ostomy maintenance	Yes	Yes	
Ostomy irrigation	NO		
Rectal Tube Insertion/irrigation/discontinuation	NO		
Skin Care Pressure Ulcer Precautions	Yes		Yes
Skin Care Simple Dressing Change	Yes	Yes	
Specimen Collect urine / stool / expectorated sputum	Yes	Yes	
Standardized Procedure Initiation	NO		
Staple Removal	Yes	Yes	
Sterile Procedures / Surgical Skin Preparation (excluding Surgical Area)	Yes	Yes	
Suprapubic catheter Irrigation	NO		
Surgical drains (penrose, constavac, JP) removal	Yes	Yes	
Telephone/Verbal Orders	NO		
Tracheotomy care	Yes	Yes	
Urinary drainage catheters (Foley) Care	Yes		Yes

Patient Care Services-Policy Manual
Scope Responsibilities for Nursing Students and Externs in Patient Care Areas — VIII-M
Page 7 of 7

Skill	RN Nursing Student Able to Perform	Direct Observation by Instructor or RN Staff Required	Able to Perform after Competency Validated by Instructor
	Yes/No		
Urinary drainage catheters (Foley) Discontinuation	Yes	Yes	
Urinary drainage catheters (Foley) Insertion	Yes	Yes	
Vital signs (Temp, BP, HR, RR SpO ₂ , Pain)	Yes		Yes

^{*} Medications Administration IV Peripheral Push: antidysrthmics, intropes and medications for cardiac rhythm control may not be administered by RN nursing students.

PATIENT CARE SERVICES

ISSUE DATE:

NEW

SUBJECT: Surgical Skin Stapling

REVISION DATE:

Clinical Policies & Procedures Committee Approval:

01/16

Nurse Executive Council Approval:

01/16

Operating Room Committee Approval:

09/16

Pharmacy & Therapeutics Committee Approval:

n/a

Medical Executive Committee Approval:

11/a

medical Executive Committee Approval.

10/16

Professional Affairs Committee Approval:

Board of Directors Approval:

A. POLICY:

1. Surgical Technologists and Registered Nurses may fire an automatic skin staple gun under the direct supervision of the Licensed Independent Practitioner (LIP)physician/Allied Health Professional (AHP) for the purpose of skin closure.

a. Deep tissue stapling is not allowed.

B. **PROCEUDRE:**

- 1. Under the direction of the LIPphysician/AHP, lightly position the automatic skin stapler over the approximated skin edges at the diesired position.
 - a. It is not necessary to press the stapler into the skin to get a proper placement; lightly touch the skin.
- 2. Center the staples over the incision line using the locating arrow or guideline on the stapler.
- 3. Press the stapler anvil to deploy the staples as the LIPphysician/AHP approximates the skin edges.
- 4. Place staples approximately ¼" apart, as directed by the physician/AHPLIP.

C. REFRENCES:

1. Rothrock, J. (200714). Alexander's Care of the Patient in Surgery, 135th Edition.

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE:

7/93

SUBJECT: SWALLOWING, FOOD AND

NUTRITION CONSIDERATIONS FOR

PATIENTS WITH ORO-PHARYNGEAL DYSPHAGIA

REVISION DATE: 6/03, 8/05, 7/07, 5/10, 3/13

POLICY NUMBER: IV.AA.2

Department Approval:

08/16

Clinical Policies & Procedures Committee Approval:

03/1309/16

Nursing Executive Committee Approval:

03/1309/16

Pharmacy & Therapeutics Committee Approval:

n/a

Medical Executive Committee Approval:

04/1310/16

Professional Affairs Committee Approval:

05/13

Board of Directors Approval:

05/13

A. **POLICY:**

When thick liquids, thickened liquids, or no thin liquids, are ordered for patients, the unit secretary, nurse, dietician or speech pathologist shall enter diet order into the computer and include ""no thin liquids" in Dietary comments section.

- B-1. An order for thick liquids, thickened liquids, or no thin liquids shall be interpreted by Food and Nutrition Services staff as meals with no thin liquids until further clarification or orders are received from physician.
 - 1.a. When an order for no thin liquids is received, meals sent to the patient shall be without thin liquids. Thin liquids are defined as: water, coffee, tea, iced tea, milk, all fruit juices (except nectars), and broth, broth-based soups, soft drinks, Boost, hot chocolate and milkshakes.
 - 2.b. Thickened milk and thickened juices are available and may be added to the menu.
 - 3-c. Thick liquids shall be offered. These include nectar, vegetable juices, blenderized or thick cream soups, eggnog, and other pre-thickened liquids. Buttermilk shall be sent if requested.
 - Foods of mixed consistencies where one consistency is thin liquid (i.e. fruit cocktail, dry 4.d. cereal with milk, vegetable soup, and pineapple chunks) shall not be included unless otherwise ordered by the physician.
 - 5.e. In cases when speech therapy is involved in the patient's care, the speech pathologist may assess the patient's tolerance of liquids and may consult with the dietician, as appropriate. Recommendations for changes to diet will be made to the physician.
 - 6-f. The dietitian shall assess the patient's status per routine assessment and evaluation. The dietitian shall update the diet order in the electronic health record as appropriate.



Administrative Policy Manual

ISSUE DATE:

11/94

SUBJECT: DECORATIVE MATERIAL

REVISION DATE: 03/00; 02/06; 01/09; 09/10

POLICY NUMBER: 8610-248

Department Approval:

10/16

Administrative Policies & Procedures Committee Approval: Operations Team Committee Approval:

10/1010/16 11/10

Medical Executive Committee Approval:

n/a

Professional Affairs Committee Approval:

01/11

Board of Directors Approval:

01/11

A. **PURPOSE:**

The purpose of this policy is to provide for the safety of patients, staff and visitors of the Medical Center by setting forth guidelines for the use of decorative materials within the Medical Center. This policy is in accordance with local and state Fire Codes.

B. POLICY:

- Stairways, corridors, and exit ways shall not be obstructed and decorations shall not be hung in a way as to obstruct exits, exit lights, fire sprinkler heads, fire alarm pull stations, hose cabinets, or fire extinguishers.
- 2. Decorative materials shall not be hung from the sprinkler heads.
- 3. All decorative materials need to be approved by the Director of Facilities or the Director of Safety/Environment of Care Officer.
- Use only materials labeled nonflammable or flame-retardant in your displays (includes artificial 4. trees).
 - a. Have documentation (i.e., package labeling) to this effect on file in your department for Fire Department review if necessary.
- 5. Live trees are prohibited.
- The Fire Marshall permits electric lights only in the main lobby under strictly controlled conditions. 6. All other areas may use only battery-operated lights.



Emergency Operations Procedure Manual General Information

SUBJECT: Emergency Operations Plan

ISSUE DATE:

06/08

POLICY NUMBER: 4001

REVIEW DATE(S):

06/11

REVISION DATE(S): 05/15

Department Approval Date(s):

05/15, 06/16

Environmental Health and Safety Committee Approval Dates(s):

06/15, 10/16

Medical Executive Committee Approval Dates(s):

N/A

Professional Affairs Committee Approval Date(s):

06/15

Board of Directors Approval Date(s):

06/15

A. SCOPE OF SERVICES:

The scope of Tri City Medical Center's Emergency Operations Plan (EOP) is to provide a program that ensures effective mitigation, preparation, response and recovery to disasters or emergencies affecting the environment of care. The medical center has developed an "all hazards" approach that supports a level of preparedness sufficient to address a wide range of emergencies regardless of cause. The Emergency Operations Plan and associated Emergency Management Program extends to all inpatient and outpatient line programs, ancillary services, support services and facilities including patient care, business occupancies and temporary alternate care sites of Tri City Medical Center. The plan also affects all staff, volunteers, contract staff, medical staff and associates including contracted services of Tri City Medical Center.

B. **OBJECTIVE**:

- The objective of the Emergency Operations Plan is to effectively prepare for, manage an emergency situation and restore the facility to the same operational capabilities as preemergency levels.
- 2. Six (6) critical areas of emergency response shall be managed in order to assess the medical center's needs and prepare personnel to respond to incidents. The six critical areas are:
 - a. Communication
 - b. Resources and Assets
 - c. Safety and Security
 - d. Personnel Responsibilities
 - e. Utilities Management
 - f. Patient Clinical and Support Activities

C. OBJECTIVES:

- 1. The objectives of the Emergency Operations Plan will include the following:
 - a. Identifying procedures to prepare and respond to potential disasters or emergencies.
 - b. Provide education to personnel on the elements of the Emergency Operations Plan.
 - c. Establish and implement procedures in response to an assortment of disaster and emergency situations.
 - d. Identify alternate sources for supplies and services in the event of a disaster or emergency through establishing mutual-aid agreements with neighboring hospitals and/or healthcare systems; public health departments; hazardous materials response teams; local fire department; local police department; area pharmacies; medical supply vendors.

e. Identify recovery strategies and actions to be activated in the event of a disaster or emergency situation.

D. **RESPONSIBILITY**:

- The Safety Officer, in conjunction with the Environmental Health and Safety Committee is responsible for developing, implementing and monitoring all aspects of the Emergency Operations Plan, including the hazard vulnerability analysis, mitigation, preparedness, response and recovery.
 - The Safety Officer shall also track National Incident Management System (NIMS) implementation.
 - b. The Safety Officer will have a working knowledge of emergency management, the medical centers operations (daily/emergency) and the Hospital Incident Command Center operations.
 - c. It will be the responsibility of the medical centers leaders, as well as, medical personnel to actively participate in the organizations Emergency Operations Plan.
 - d. The Emergency Operations Plan shall be developed in coordination with local community agencies. The medical center shall communicate its needs and vulnerabilities to community emergency response agencies and identify the capabilities of the community in meeting the needs of the medical center.

E. SPECIFIC PROCEDURES IN RESPONSE TO A VARIETY OF EMERGENCIES BASED ON A HAZARD VULNERABILITY ANALYSIS PERFORMED BY THE MEDICAL CENTER.

- The medical center has developed specific procedures in response to potential disasters and emergencies that may occur. Additionally, the medical center will create a Hazard Vulnerability Analysis (HVA) to identify areas of vulnerability and to undertake provisions to lessen the severity and/or impact of a disaster or emergency that could affect the services provided by the medical center.
- 2. The HVA is evaluated on an annual basis and input from the local fire department and community agencies and will be obtained to assure the medical center is aware of hazards in the community to which an emergency response may be required.
- 3. The medical center has developed a Utilities Disruption Matrix designed to provide available operational hours prior to departmental shut down or commencing of evacuation procedures. The Utilities Disruption Matrix is based on the medical center having the capabilities of operating self-sufficiently for up to 96 hours without the assistance of external agencies or resources.
- 4. For each emergency identified in the medical center's HVA as a high risk, the following shall be defined:
 - a. Mitigation activities that are designed to reduce the risk of potential damage due to an emergency situation.
 - b. Preparedness activities that organize and mobilize essential resources.
 - c. Response strategies and actions to be activated during an emergency situation.
 - d. Recovery strategies/actions that will help restore the systems that are critical to resuming normal operations of the medical center.
- 5. Will maintain a documented inventory of on-site assets and resources that will be needed during an emergency. At a minimum, this inventory should include:
 - a. Personal Protection Equipment (PPE)
 - b. Water
 - c. Fuel
 - d. Staffing
 - e. Linen
 - f. Cleaning Supplies
 - g. Food
 - h. Medical/Surgical Resources

- i. Pharmaceutical Resources
- 6. The inventory of assets and resources shall be evaluated on an annual basis or as needed.
- 7. Methods shall be in place for the monitoring of the inventory of assets and resources during an emergency situation.

F. DEFINE AND INTEGRATE THE MEDICAL CENTERS ROLE WITH THE COMMUNITYWIDE EMERGENCY OPERATIONS EFFORTS TO PROMOTE INTER-OPERABILITY BETWEEN THE FACILITY AND THE COMMUNITY:

- 1. The Emergency Operations Plan shall be tested and exercises shall be developed based on the medical center's top scoring emergency situations within the Hazard Vulnerability Analysis. The exercise shall validate the effectiveness of the Emergency Operations Plan and will identify opportunities to improve.
- 2. The Emergency Operations Plan shall be tested and exercised a minimum of two (2) times per year, either in response to an actual emergency or in a planned exercise.
- 3. Only one (1) exercise per year shall include an influx of volunteer or simulated patients.
- 4. At least one (1) exercise per year shall be evaluated to see how effectively the hospital performs when the medical center cannot be supported by the local community for up to 96 hours. (Tabletop sessions are acceptable to meet the community portion of this exercise).
- 5. If applicable, the medical center will participate in at least one (1) communitywide exercise annually that is relevant to the priority of emergencies defined in the hazard vulnerability analysis. (Tabletop sessions are acceptable to meet the community portion of this exercise).
- 6. The Director of Safety (Safety Officer) is identified as the designee whose sole responsibility during emergency response exercises is to monitor performance and document opportunities for improvement.
- 7. The medical center cooperates with all local, county and state emergency management exercises. The Safety Officer is a member of the countywide emergency management system and coordinates with other agencies on any large scale exercises. San Diego Department of Public Health and Human Services Agency/EMS and Statewide Disaster planning efforts, coordinate with local police, fire and ambulance services in conjunction with acute care facilities.

G. **COMMAND STRUCTURE**:

1. The command structure utilized by the medical center in coordination with the communitywide structure will be the Hospital Incident Command System (HICS).

H. INITIATING THE PLAN, INCLUDING DESCRIPTION OF PLAN ACTIVATION:

- 1. The Emergency Operations Plan will be activated when it has been determined that a disaster or emergency situation has occurred or has the potential of occurring.
- 2. The Joint Commission's definition of an emergency:
 - a. "a natural or man-made event that significantly disrupts the environment of care; that significantly disrupts care and treatment; or that results in sudden, significantly changed or increased demands for the organizations services. Some emergencies are called 'disasters' or 'potential injury creating events'."
- 3. When the facility is notified of an emergency situation, the person receiving notification will immediately notify the Chief Executive Officer or his/her designee of the situation whether it be an external or internal emergency. The Nursing Administrative Supervisor will respond to the site of an internal emergency and report back to the Chief Executive Officer or his/her designee, the status of the situation.
- 4. The Chief Executive Officer or his/her designee will evaluate the emergency situation to determine whether the Emergency Operations Plan will be activated. If the Emergency Operations Plan is to be activated, the Chief Executive Officer or his/her designee will notify the Switchboard Operator to announce Code Orange External/Internal overhead.
- 5. The Chief Executive Officer or appointed designee will assume responsibility of the Hospital Incident Command center and activate the appropriate positions noted on the Incident

Management Team Chart as deemed necessary for the occurrence:

- a. Until the Incident Command System is in place, the Chief Executive Officer or his/her designee will determine if the Labor Pool will be opened depending on the size of the emergency situation. If the Labor Pool is not opened, the Nursing Administrative Supervisor may assign additional assistance to the Emergency Area as needed. Additional personnel will be called in as needed via the staff call back system.
- b. The Nursing Administrative Supervisor will notify additional outside agencies that may need to assist the medical center in the event of an internal emergency (i.e. fire department, police department or other agencies).
- 6. The recovery phase will be initiated after the emergency situation is over and the medical center has been evaluated. The recovery phase of the plan is to be initiated by the Chief Executive Officer or his/her designee.

COMMUNICATION:

- 1. Notification of External Authorities:
 - a. The medical center shall have a communications system in place, including two-way radio equipment and operators who are familiar with the equipment's operation.
 - b. The medical center will provide for alternate communication methods in the event of a failure. Two-way radio equipment and cell phones shall be available in the event of an emergency. In the event that cell phones are not working, microwave communications, satellite phones, ham radios or portable 800 MHZ radios may be used.
- 2. The Safety Officer will approve media access to the facility, with only the Public Information Officer (PIO) interacting with the media.
- 3. A medical record system will be used to meet the minimum requirements of emergency management operations.

J. PERSONNEL RESPONSIBILITIES:

- 1. Notification of Personnel When Emergency Operations Plan is initiated:
 - a. In an emergency situation which is so wide spread to be considered an emergency and/or involving mass casualties, all medical center personnel, regardless of position, are expected to report to the medical center as soon as it is feasible to travel. Each department director maintains a current callback list of all personnel assigned to their department. Once the Emergency Operations Plan has been activated, the department director in cooperation with Human Resources will assign a staff member to initiate the call back list.
 - b. In the event there are excess personnel, the Hospital Command Center will communicate with department directors regarding rescheduling of personnel future needs. The medical staff will report to the Chief of Medical Staff or Medical Specialist Officer for their assignments.
- 2. Alternate Roles and Responsibilities of Personnel during Emergencies:
 - a. Personnel may not be assigned to their regular duties. Personnel will be asked to perform various jobs which will be considered vital to the effective operation of the hospital during the emergency situation. Personnel will be assigned duties based on the needs of the medical center. If personnel are not needed in their perspective units/departments, they will be sent to the Labor Pool for assignment.
- 3. Identification of Personnel in Emergencies:
 - a. Personnel on duty during activation of the Emergency Operations Plan will be identified by their picture identification name badge, which is mandated to be worn at all times while on duty.
 - b. Only persons wearing proper identification or possess valid credentials shall be allowed entrance into the medical center during an emergency situation.
- 4. Personnel Activities and Support:
 - a. The medical center has made provisions for staff support that can be implemented in the event of a communitywide emergency. Such provisions may include but not limited

to:

- i. Temporary housing/lodging needs.
- ii. Transportation needs.
- iii. Family support needs, as necessary (including short term child care)
- iv. Incident stress debriefing and counseling.
- 5. Orientation and Training:
 - a. Personnel will attend orientation upon hire and annually thereafter, reviewing their specific roles and responsibilities during an emergency/disaster situation.
 - b. In-service education will be given to the specific staff on the backup communication system and obtaining supplies/equipment in the event of an emergency/disaster situation.
 - c. The Safety Officer or designee is responsible for in-servicing personnel to the Emergency Operations Plan.
 - d. The department directors are responsible for in-servicing their department personnel on the department specific responsibilities during an emergency/disaster situation.

K. <u>EMERGENCY CREDENTIALING OF CAREGIVERS:</u>

- 1. To provide a mechanism for emergency credentialing and granting privileges to volunteer/non-staff licensed independent practitioners in the event of a disaster.
- 2. The Chief Executive Officer or Chief of Staff or their designee(s), may grant emergency privileges upon presentation of a valid picture ID (issued by a state, federal or regulatory agency) e.g., driver's license or passport and at least one of the following:
 - a. A current license to practice or primary source of verification of the license.
 - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT)
 - Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity.
 - d. Presentation by current facility or medical staff member with personal knowledge regarding practitioner's identity.
- 3. Verification of Information:
 - a. Verification of the required information shall be done by the Medical Staff Office or designee as soon as feasible. A record of this information will be retained in the Medical Staff Office.
- 4. Conditions of Emergency Privileges:
 - a. The emergency designee must practice under the direction and supervision of an existing member of the Tri City Medical Center.

L. RESOURCES AND ASSETS:

- The medical center keeps a documented inventory of assets it has on site that would be needed in the event of an emergency or disaster situation. At a minimum, the inventory should include:
 - a. Linen
 - b. Cleaning Supplies
 - c. Personal Protective Equipment (PPE)
 - d. Water
 - e. Food
 - f. Fuel
 - g. Staffing
 - h. Medical Resources and Assets
 - i. Surgical Resources and Assets
 - Pharmaceutical Resources and Assets
- 2. Methods are established to monitor quantities of assets and resources during an emergency or disaster situation.

- 3. Arrange for emergency/disaster supporting services to be performed by local businesses, utility companies, government agencies and individuals. Emergency/ disaster supporting services may include:
 - a. Transportation
 - b. Communications
 - c. Traffic Control
 - d. Food Supplies
 - e. Utility Maintenance
 - f. Medical Supplies
- 4. These arrangements must be coordinated with the assistance of the Safety Officer, San Diego Department of Public Health or the local Office of Emergency Services (OES) whenever possible.
- The medical center shall estimate its emergency needs for each kind of support and when feasible arrange to have supporting supplies, equipment and manpower pre-designated for medical center use.
- 6. Essential supplies, pharmaceuticals, medical supplies, equipment, food, water, linen, cleaning supplies and utilities shall be provided to meet shelter requirements for up to 96 hours when the medical center cannot be supported by the community. Procedures are in place for the procurement of additional supplies in an emergency.
- 7. In the event that the medical center cannot be supported by the local community for at least 96 hours, the Chief Executive Officer/Incident Commander, Incident Command Staff and in consultation with community leaders, will evaluate the following options and implement those options that best serve the medical center and community:
 - a. Conservation of Resources
 - b. Curtailment of Services
 - Supplementing of resources from outside of the local community
 - d. Staged Evacuation
 - e. Total Evacuation

M. SAFETY AND SECURITY:

- 1. Efficient traffic flow must be established:
 - a. Prepare floor plans which designate areas for specific patient care functions and ensure that personnel are familiar with these plans.
 - b. Prepare and have available traffic control tools to show external and internal routing of casualties and other traffic.
 - Assign and train volunteers to perform traffic control and security functions.
- 2. At the time the Emergency Operations Plan is activated, the Security Department personnel will be responsible for locking all exits and entrances with the exception of the ambulance entrance which will be manned. The Security Staff shall maintain control of entry and egress from the facility. Personnel of the medical center are required to wear badges identifying them as personnel. Only persons with proper identification shall be admitted to the medical center during an emergency situation.
- 3. Radioactive or Chemical Isolation and Decontamination:
 - a. There is a designated decontamination room with separate ventilation system or ventilation shut off available for radioactive or chemical isolation and decontamination. Staff is trained in the response to radiological, biological, chemical or hazardous material contamination.
 - b. Arrange with a local or State Emergency Management Agency Director (if applicable) for the training of staff who would perform the radiological monitoring of casualties and hospital areas and the acquisition of necessary radiological monitoring equipment. This equipment shall be stored in the medical center as part of its essential emergency supply equipment.

N. UTILITIES MANAGEMENT:

- 1. The medical center will provide for alternative sources of essential utilities, including:
 - a. An emergency source of electrical power capable of operating all essential electrical equipment and plan for failure of back-up generators
 - b. An alternate source for medical gas and vacuum delivery
 - c. An alternate means of waste disposal in the vent of sewage system failure
 - d. Sufficient fuel to last for at least 96 hours of expanded operation

O. PATIENT CLINICAL AND SUPPORT ACTIVITIES:

- 1. Management of Patients during Emergencies (i.e. Scheduling, Modification or Discontinuation of Services, Control of Patient Information and Patient Transportation)
 - a. Upon activation of the Emergency Operations Plan, normal admission requirements will be modified. Initially, admissions to the medical center will be limited to those whose survival depends upon services obtainable only through medical care.
 - b. Outpatient care will be restricted to those whose lives may be ultimately depending upon the present expenditure of medical supplies and health manpower time.
- 2. All elective admissions and procedures will be canceled, including elective surgery, no emergent outpatient and transferring patients who are stable to be discharged.
 - a. Patients may be transferred to other facilities so those emergency victims may be accommodated.
 - b. Individuals may be redirected or relocated for a Medical Screening Exam in the event that the Emergency Operations Plan has been activated. (Section 1135(b) of the Social Security Act §489.24(a)(2)).
 - c. In the event the Emergency Operations Plan is activated, persons may be transferred prior to being stabilized, if, based upon the circumstances of the emergency the medical center is unable to provide proper care or treatment of services. (Section 1135(b) of the Social Security Act §489.24(a)(2)).

P. EVACUATION OF THE FACILITY:

- 1. When an emergency situation arises requiring evacuation of patients from threatened or affected areas, the safety of lives at Tri City Medical Center is the primary concern. Authority to order an evacuation is vested only with the Chief Executive Officer, his/her designees, or the Safety Officer. Patients shall be evacuated to an area of safety by whatever means are available. Formal agreements are in place with ambulance services and alternate care sites to transfer patients as necessary.
- 2. All personnel have been trained in evacuation procedures. Evacuation routes are posted throughout the medical center.
- 3. Relocation to alternate health facility or place of safety (i.e., churches, schools)
 - a. Prepare maps of routes to relocation site
 - b. Confirm periodically the availability of the relocation site
 - c. Establish lists of supplies and equipment, by priority, to be relocated
 - d. Arrange adequate transportation for evacuation and relocation
- 4. Establishing an Alternate Care Site When the Environment Cannot Support Adequate Patient Care
- 5. Formal agreements should be in place so that patients may be transferred to a facility that can provide adequate patient care. The Liaison Officer will be responsible for the inter-facility communication between the medical center and the designated alternative care site, and for retaining records of which patients were transferred to and/or from an alternative care site. The patient care unit transferring the patient is responsible for obtaining copies of the patient's medical records, gathering personal belongings and ensuring the patient's medications are continued throughout the transfer. If an medical equipment is transferred with the patient care unit is responsible for documenting what equipment was transferred with the patient so that equipment may be retrieved during the recovery phase post emergency. The following agreements are in place:
 - Ambulance contract agreements for transfer of patients between facilities

- b. Transfer agreements will be made between neighboring facilities
- c. Emergency acquisitions of medical supplies, pharmaceuticals, food, equipment, water, linen, emergency repair services, etc

Q. CONTINUING AND/OR RE-ESTABLISHING OPERATIONS FOLLOWING AN EMERGENCY:

- 1. The medical center has mechanisms in place to restore the operational capabilities of the facility to pre-emergency levels. Once the emergency is over, the Engineering Department, including the Director of Facilities, Safety Officer, Risk Manager and other administration representatives, will begin assessing the damage to the facility and the environmental concerns to determine whether the medical center can safely provide medical care to the community and proved a safe environment for patients, personnel and visitors.
 - a. Picture and/or videos will be taken of all damages to the facility's buildings, grounds, equipment, etc., including all off campus facilities.
 - b. Architects, building inspectors and structural engineers may be called in to determine if the buildings are safe for occupancy.
 - c. All potential environmental concerns will be evaluated for proper function, i.e., hazardous waste, fuel tanks, to ensure there is no leakage into the local sewer or water system or any other impact on other environmental concerns.
 - d. Ensure personnel support programs have been instituted, i.e., crisis counseling, flexible work hours, cash advances, day care, particularly if your personnel and the medical center have been directly impacted by the emergency.
 - e. Clear debris and secure unsafe buildings as necessary.
 - f. Restore internal and external communication devices
 - g. Inventory equipment and supplies for damage and determine if additional supplies need to be obtained from suppliers. Picture/videos will be taken of all damaged supplies and equipment for insurance purposes. Damaged supplies and equipment will be retained until approval is received from insurance providers for disposal.
- Notify the community through local media services regarding the services the medical center will be providing and the location they will be provided in the event that services are moved offcampus.
 - Notify the medical center's insurance provider and contact third-party expert to prepare the claim.
 - b. Ensure records and data have been protected and restore information as necessary from backup tapes.
 - c. Keep detailed records.
- 3. A proactive process shall be developed and implemented to seek other federal funding to support preparedness that takes advantage of developing interoperability training with local and regional multi-disciplinary partners.

R. PERFORMANCE STANDARDS:

- 1. There is a planned, systematic, interdisciplinary approach to process design and performance measurement analysis and improvement related to organization wide safety. The Environmental Health and Safety Committee will develop and establish performance measures and related outcomes in a collaborative fashion, based on those priority issues known to be associated with the healthcare environment. Performance measures and outcomes will be prioritized based upon high risk; high volume, problem prone situations and potential or actual sentinel event related occurrences. Criteria for performance improvement measurement and outcome indicator selection will be based on the following:
 - a. The measure can identify the events it was intended to identify
 - b. The measurement has a documented numerator and denominator statement or description of the population to which the measure is applicable.
 - c. The measure has defined data elements and allowable values
 - d. The measure can detect changes in performance over time
 - e. The measure allows for comparison over time within the organization or between the

organization and other entities.

- f. The data intended for collection is available.
- g. Results can be reported in a way that is useful to the organization and other interested stakeholders.

S. NIMS PREPAREDNESS FUNDING:

- 1. Tri City Medical Center shall establish a working relationship with State and San Diego County Department of Health and Human Services Agency/EMS and state associations to identify activities to obtain and appropriately allocate preparedness funding.
- 2. The Environmental Health and Safety Committee on an on-going basis monitors performance regarding actual or potential risk related to one or more of the following:
 - a. Personnel knowledge and skills
 - b. Level of personnel participation
 - c. Monitoring and inspection activities
 - d. Emergency and incident reporting
 - e. Inspection, preventative maintenance and testing of safety equipment
 - f. Other performance measures and outcomes will be established by the Environmental Health and Safety Committee based on the criterion listed above. Data sources, frequency of data collection, individual(s) responsible for data collection, aggregation and reporting will be determined by the Environmental Health and Safety Committee.
- 3. To identify opportunities for improvement/corrective action, the Environmental Health and Safety Committee will follow the organization's improvement methodology. The basic steps to this model will consistently be followed and include planning, designing, measuring, analyzing/assessing, improving and evaluating effectiveness. Should the Environmental Health and Safety Committee feel a team approach is necessary for performance and process improvement to occur, the Environmental Health and Safety Committee will follow the organization's performance improvement guidelines for improvement team member selection.
- 4. Determination of team necessity will be based on those priority issues listed (high-risk, volume and problem prone situations and sentinel event occurrence). The Environmental Health and Safety Committee will review the necessity of team development, requesting primarily, team participation only in those instances where it is felt the Environmental Health and Safety Committee's contributions toward improvement would be limited (due to specialty, limited scope and/or knowledge of the subject matter). Should team development be deemed necessary, team members will be selected on the basis of their knowledge of the subject identified for improvement and those individuals who are "closest" to the subject identified. The team will be interdisciplinary, as appropriate to the subject to be improved.
- 5. Performance Improvement monitoring and outcome activities will be presented to the Environmental Health and Safety Committee by the Safety Officer at least on a quarterly basis, with a report of performance outcome to the Quality Assurance Performance Improvement (QAPI) Committee.

T. ANNUAL EVALUATION OF THE EMERGENCY OPERATIONS PLAN OBJECTIVES, SCOPE, 'PERFORMANCE AND EFFECTIVENESS:

- 1. The annual evaluation of the Emergency Operations Plan will include a review of the scope according to Joint Commission standards and NIMS requirements to evaluate the degree in which the program meets accreditation standards, NIMS requirements and the current risk assessment of the medical center.
 - a. A comparison of the expectations and actual results of the program will be evaluated to determine if the goals and objectives of the program were met.
 - b. The overall performance of the program will be reviewed by evaluating the results of performance improvement outcomes. The overall effectiveness of the program will be evaluated by determining the degree that expectations were met.
 - c. The Emergency Operations Plan shall be revised and updated based on the annual evaluation of the Emergency Operations Program, including the Hazard Vulnerability

Emergency Operations Procedure Manual – General Information Emergency Operations Plan Page 10 of 10

Analysis.

The performance and effectiveness of the Emergency Operations Plan shall be reviewed by the Environmental Health and Safety Committee, the QAPI Committee, Administration and reported to the Board of Directors as well.

ENGINEERING OPERATIONS

	Section: ENGINEERING DEPARTMENT
TRI-CITY MEDICAL CENTER	Subject: Equipment Repair
Engineering Policy & Procedure	Policy Number: 2008 Page 1 of 1
Department: Hospital-Wide	EFFECTIVE: 11/1/87 REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 5/09, 8/11, 6/12

SUBJECT: Equipment Repair

ISSUE DATE:

11/87

REVIEW DATE(S):

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

Department Approval Date(s):

7/16

Environmental Health and Safety Committee Approval Date(s):

7/16

Professional Affairs Committee Approval Date(s):

Board of Directors Approval Date(s):

A. **PURPOSE**

1. To outline the procedure by which damaged or malfunctioning equipment will be repaired.

B. **GENERAL INFORMATION:**

1. CMMS- A computerized information system used to facilitate the scheduling, monitoring and documentation of equipment and environmental maintenance.

C. PROCEDURE:

- 1. In response to a work order submitted by a user department, the Eengineer inspects damaged or malfunctioning equipment to determine what repairs or adjustments are needed, if any.
- 2. If the **Engineerassigned** individual determines that the work cannot be done in house, he/she obtains approval of the Engineering Supervisor to have the work performed by an external vendor.
- When the work has been completed by the Engineerassigned individual or the external vendor, the assigned individual documents the repairs made and the date the work was completed on the work order for entry in the CMMS.
- 4. If the repair work is done at or near the time of the equipment's scheduled preventive maintenance, the preventive maintenance schedule is updated accordingly.
- 5. If the repairs cannot be completed within 24 hours, the assigned individual Engineer notifies the user department.
- 6. If the repair work is performed by an external vendor, the Eengineer inspects or tests the equipment upon its return to make certain the repairs have been made properly and that the equipment meets appropriate electrical safety standards before returning it to the user department.
- 7. If the Eengineer or external vendor determines that the equipment cannot be repaired, the

Engineering Manual Equipment Repair Page 2 of 2

Eengineer or Ssupervisor returns the equipment to the user department with instructions to dispose of it in accordance with TCMC Policy #8610-200 and Procedure "Equipment Transfer/Disposal."Transfer, Storage, Trade-in, and Disposal".



ENGINEERING OPERATIONS

TOP COME AND ICAL CENTER	Section: ENGINEERING DEPARTMENT	
Engineering Policy & Procedure	Subject: Maintenance And Inspection Medical Gas System	
	Policy Number: 2003 Page 1 of 1	
Department: Hospital-Wide	EFFECTIVE: 11/01/87— REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 6/09, 8/11, 5/12	

SUBJECT: Maintenance and Inspection Medical Gas System

ISSUE DATE:

11/87

REVIEW DATE(S):

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

Department Approval Date(s):

7/16

Environmental Health and Safety Committee Approval Date(s):

7/16

Professional Affairs Committee Approval Date(s):

Board of Directors Approval Date(s):

A. PURPOSE:

1. To describe the process by which the medical gas systems are maintained and inspected.

B. **GENERAL INFORMATION**:

 Computerized Maintenance Management System (CMMS) - A computerized system used to facilitate the scheduling, monitoring and documentation of equipment and environmental maintenance.

C. POLICY:

- Normal and reserve supplies.
- 2. The Duty Engineer checks the normal and reserve supplies of liquid oxygen once each shift and documents the levels levels on the daily round sheetin the Engineering Services Log. Oxygen is reordered when the tank gauge reads 75" 30"-maintained between 75" and 25".
- 2.3. It is the responsibility of the Duty Engineer to reorder oxygen when the level is between 25" and 30".
- 3.4. The Duty Engineer checks the normal and reserve supply of nitrous oxide once each shift and documents the levels on the daily round sheetln the Engineering Services Log. Nitrous Oxide is re-ordered when the primary supply is exhausted and the secondary supply is activated. The Duty Engineer then shuts off the valve on the empty tanks to prevent backflow.
- 4.5. The Duty Engineer observes the delivery and transfer of oxygen. Invoices indicating volumes and purity delivered are kept on file in the Engineering Department.
- 5.6. Following periods of construction or evidence (e.g., alarms) that the system has been breached,

Engineering Manual Maintenance and Inspection Medical Gas System Page 2 of 2

- the medical gas system will be tested by the Projects Department-a 3rd party to verify that the gases being delivered are pure. Documentation of such testing will be kept on file in the Engineering Department.
- In accordance with the CMMS environmental maintenance procedures for non-flammable anesthetizing locations, critical care areas and general patient care areas, an Engineer inspects the wall outlets and fittings for medical gas delivery and makes repairs as necessary. It is also verified that zone and control valves are labeled appropriately.
- 7. The Duty Engineer tests the low pressure alarm on the master control panel once each shift and documents such testing on the daily round sheetin the Engineering Services log.
- 8.7. An outside-qualified vendor is contracted annually to perform an inspection of all master signals, area alarms, automatic pressure switches, shut off valves, flexible connections, outlets and purity from source in accordance with NFPA and Joint Commission standards to ensure compliance with Authorities Having Jurisdiction (AHJs).

ENGINEERING OPERATIONS

	Section: ENGINEERING DEPARTMENT
TRI-CITY MEDICAL CENTER	Subject: New Equipment: Inventory And Inspection
Engineering Policy & Procedure	Policy Number: 2007 Page 1 of 2
Department: Hospital-Wide	EFFECTIVE: 11/1/87 REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 5/09, 8/11, 6/12

SUBJECT: New Equipment: Inventory and Inspection

ISSUE DATE:

11/87

REVIEW DATE(S):

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

Department Approval Date(s):

7/16

Environmental Health and Safety Committee Approval Date(s):

7/16

Professional Affairs Committee Approval Date(s):

Board of Directors Approval Date(s):

A. **PURPOSE:**

1. To outline the procedure by which new equipment is inventoried and inspected before release for patient care or other use.

B. **GENERAL INFORMATION**:

- 1. <u>CMMS</u>- A computerized information system used to facilitate the scheduling, monitoring and documentation of equipment and environmental maintenance.
- 2. <u>Environmental Unit</u>- A space of manageable size in terms of square footage or work intensity classified by the principal activity which takes place within it.
- 3. <u>Equipment Identification Number (EIN)</u>- A number assigned to a specific piece of equipment, equipment grouping, or environmental unit for the purpose of identification and maintenance scheduling in CMMS.

C. POLICY:

- 1. Except as indicated in Policy Statement 2 Aall patient care equipment designated for use anywhere within the hospital shall be inspected and tested by the Engineering Department or Biomedical Department before initial use.
- 2. Radiologic and nuclear imaging equipment will be inspected and tested before use by contracted Physicians.
- 3.2. New equipment which fails to pass the applicable electrical safety test will not be approved for use in the hospital until such the deficiencies have been corrected.

D. **PROCEDURE**:

1. The receiving department (Materials Management) notifies the Engineering Department that new equipment has been received.

Engineering Manual New Equipment: Inventory and Inspection Page 2 of 2

- 2. Following his inspection Engineering performs new equipment inspection (places a safety sticker if successful), and the engineerdeterminationes is made whether the equipment should be assigned an individual EIN, and maintenance schedule and instructionse or should be considered part of its environmental unit and maintained as such.
- 2.3. If the equipment fails to pass the required tests or does not meet the standards specified by the hospital, the equipment will be returned to the supplier by the Materials Management Department. (See Scheduled Equipment Maintenance Policy 2010.
- 3. When he assigns an individual EIN, the engineer also assigns to the equipment an instruction set and maintenance schedule (or prepares them if they do not already exist).
- 4. The engineer then performs a series of electrical tests on the equipment as outlined under Biomed Electrical Safety Test Procedure Manual, and if the equipment has been assigned an EIN, documents the inspection in the "comments" section of the Equipment File Form: "Incoming inspection performed (date)."
- 5. If the equipment fails to pass the required tests or does not meet the standards specified by the hospital, the engineer will note this in the "Comments" section of the Equipment File Form in the following manner: "To be held in the Materials Management Department pending U.L./City of Los Angeles approval (or correction of deficiency)."
- 6.4. The engineerOnce above steps are completed, Engineering completes the rest of the Equipment File Form and -enters all the equipment information into the CMMS.

ENGINEERING OPERATIONS

	Section: ENGINEERING DEPARTMENT
TRI-CITY-MEDICAL CENTER	Subject: Pre-Purchase Evaluations
Engineering Policy & Procedure	Policy Number: 2009 Page 1 of 1
Department: Hospital-Wide	EFFECTIVE: 11/1/87 REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 5/09, 8/11, 6/12

SUBJECT: Pre-Purchase Evaluations

ISSUE DATE:

11/87

REVIEW DATE(S):

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

Department Approval Date(s):

07/16

Environmental Health and Safety Committee Approval Date(s):

07/16

Professional Affairs Committee Approval Date(s):

Board of Directors Approval Date(s):

A. **PURPOSE:**

1. To outline the policy under which the Engineering Department will make pre-purchase equipment evaluations.

B. POLICY:

- The Engineering Department will make pre-purchase evaluations of equipment at the verbal or written request of a user department, the medical center administration or a member of the professional staff.
- 2. Such pre-purchase evaluations shall be confined to:
 - a. Construction quality
 - b. Mechanical reliability
 - c. Ease of maintenance
 - d. Compatibility with existing systems and environment of anticipated use
 - e. Underwriters Laboratories, or other agency approval
 - f. Other information concerning the equipment about which Engineering Department personnel may be expected to be knowledgeable.
- 3. Pre-purchase evaluations will not be made regarding the following types of equipment:
 - a. Imaging equipment
 - b. Clinical laboratory testing equipment
 - c. Word processors
 - d. Data processing equipment
 - e. Typewriters
 - F. Telecommunications equipment
- 4. Evaluations will be given verbally unless a written evaluation is requested.

DISTRIBUTION:

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ENGINEERING OPERATIONS

	Section: ENGINEERING DEPARTMENT
TRI-CITY-MEDICAL CENTER	Subject: Purchasing Procedure
Engineering Policy & Procedure	Policy Number: 2011 Page 1 of 1
Department: Hospital-Wide	EFFECTIVE: 11/1/87 REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 5/09, 8/11, 6/12

SUBJECT: Purchasing Procedure

ISSUE DATE:

11/87

REVIEW DATE(S):

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

Department Approval Date(s):

7/16

Environmental Health and Safety Committee Approval Date(s):

7/16

Professional Affairs Committee Approval Date(s):

Board of Directors Approval Date(s):

A. PURPOSE:

 To define the procedure for the purchasing of material or services by the Engineering Department.

B. POLICY:

- 1. Fill out Purchase Requisition"Material / Services Information" form as applicable.
- 2. Obtain approval from Director of Engineering or his/her designee.
- 3. Procure a Purchase Order (P.O.) number# from Materials Management. and place on form.
- 4. Place the order with the vendor being sure to get prices and obtain delivery dates whenever possible. Be sure to place this information on the form.
- 5. P.O. will be marked as received/completed in one of the following fashions:
 - a. When the goods are received at the receiving dock, the Purchasing Department will close the P.O. as received.
 - 4.b. For all other services, Engineering Department will approve invoice received against the appropriate PO and email a copy of the approved (by Director of Engineering or his/her designee) invoice to the Purchasing Department to mark the P.O. as received/completed.
- 5. Secretary to enter P.O. in the computer system (Materials Management). A copy of signed P.O. and Material Service Information Form is sent to Accounting.
- 6. Goods or service received. Stamp receiver "Received Complete" and give to secretary to close out P.O. in computer.
- 7. If received incomplete, so note on receiver and process as above except do not stamp
 "Received Complete". When order or service send additional receiver to Accounting stamped
 "Received Complete".

Engineering Manual Purchasing Procedure Page 2 of 2

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ENGINEERING OPERATIONS

TDI CUTU MEDICAL CONTED	Section: ENGINEERING DEPARTMENT
TRI-CITY MEDICAL CENTER	Subject: Scheduled Equipment Maintenance
Engineering Policy & Procedure	Policy Number: 2006 Page 1 of 2
Department: Hospital-Wide	EFFECTIVE: 11/1/87—————————————————————————————————

SUBJECT: Scheduled Equipment Maintenance

ISSUE DATE:

11/87

REVIEW DATE(S):

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

Department Approval Date(s):

7/16

Environmental Health and Safety Committee Approval Date(s):

7/16

Professional Affairs Committee Approval Date(s):

Board of Directors Approval Date(s):

A. **PURPOSE:**

1. To define the procedure for inspection, maintenance and repair **of Engineering equipment.**-of equipment deemed essential for life support or which is inherently more hazardous or complex.

B. **GENERAL INFORMATION:**

- 1. <u>Scheduled Maintenance</u> Includes, as appropriate, inspection; preventative and corrective maintenance; functional testing, performance testing, calibration and safety testing.
- 2. <u>Equipment</u> As used in this procedure, equipment shall mean those individual inventoried items of equipmentlife support, life safety, infection control and non-life support equipment which meets one or more of the following-criteria:maintained by the Engineering Department.
 - a. Essential, directly or indirectly, for life support. Associated with a higher than normal incident risk during routine operation.
 - p. Requires, by reason of its complexity, a more intensive maintenance schedule.
 - c. Supplied, or maintained, by an external vendor.
- 3. <u>Computerized Maintenance Management System (CMMS)</u> A computerized information system used to facilitate the scheduling, monitoring and documentation of equipment and environmental maintenance.
- 4. <u>Inventory Data Table Equipment Inventory</u>: A table listing of all types of individually inventoried equipment and distinct environmental units or equipment groups, and including for each, the appropriate maintenance instructions, location number and frequency of maintenance.

 This table includes non-patient care equipment that may pose an electrical hazard during intended use.
- 5. Equipment File Listing by Location: A computerized list of all patient care and non-patient care equipment, powered and non-powered, in the facility, arranged by location of its use.

Engineering Manual Schedule Equipment Maintenance Page 2 of 2

maintenance performed on all patient care and non-patient care equipment in the facility, arranged according to the cost center of us

- 1. Preventive Maintenance (P.M.) Work Orders will be printed and issued assigned on a monthly basis.
- 2. Assigned individuals, upon completing inspection and preventive maintenance, will note significant findings. The individual will then generate a corrective maintenance work order stating problem found. The corrective maintenance work order number will be logged on the Preventive Maintenance Work Order for equipment history purposes and noted in the comments section when closing out the Preventive Maintenance Work Order.
- 3. Scheduled P.M. work orders should be completed within 30 days of scheduled start date with the exception of beds which have 90 days by the assigned due date. If the scheduled maintenance cannot be performed for any reason, (i.e., equipment unavailable, departmental scheduling service contract schedule), the assigned individual must notify his/her immediate supervisor and document such reason-is documented on P.M. work order. After reasonable attempts to perform procedure have failed, a statement will be sent to respective departments informing the Department Head that equipment was unavailable for inspection. The Department Head will be asked to make said equipment available for inspection.
- 4. Upon second consecutive incidence of failure to inspect due to equipment not being found, the equipment will be dropped from inspection inventory. A statement regarding this drop will be sent to appropriate department. If scheduled maintenance is performed by an external vendor, the vendor will be instructed to perform maintenance in accordance with the work order and contract agreement. Any associated maintenance shall be documented. Equipment and documentation shall be returned to Engineering Department within 30 days.



ENGINEERING EQUIPMENT

SUBJECT: Utility Management Plan

ISSUE DATE:

9/94

POLICY NUMBER: 4003

REVIEW DATE(S): 8/15

REVISION DATE(S): 2/97, 5/00, 5/03, 6/06, 5/09, 6/12, 6/15, 10/15

Department Approval Date(s):

08/15, 10/16

Environmental Health and Safety Committee Approval Date(s):

09/15, 10/16

Professional Affairs Committee Approval Date(s):

10/15

Board of Directors Approval Date(s):

10/15

EXECUTIVE SUMMARY: A.

The Environment of Care and the range of patient care services provided to the patients served by Tri-City Healthcare District (TCHD) present unique challenges. The specific utility system risks of the environment are identified by conducting and maintaining a proactive risk assessment. A Utility Systems Management Plan based on various risk criteria including risks identified by outside sources such as, The Joint Commission (TJC) is used to eliminate or reduce the probability of adverse patient outcomes.

The Utility Systems Management Plan describes the risk and daily management activities that 2. TCHD has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people, coming to the organization's facilities. The management plan and the Utility Systems Management program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to the TCHD and all outlying facilities operated and or owned by TCHD. 3. The Utilities Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care and business occupancies of TCHD. The plan also affects all staff, volunteers, medical staff and associates including contracted services of TCHD.

PRINCIPLES: B.

- Utility systems play a significant role in supporting complex medical equipment and in providing an appropriate environment for provision of patient care services.
- Orientation, education, and training of operators, users, and maintainers of utility systems is an 2. essential part of assuring safe effective care and treatment are rendered to persons receiving
- Assessment of needs for continuing technical support of utility systems and design of 3. appropriate calibration, inspection, maintenance, and repair services is an essential part of assuring that the systems are safe and reliable.

OBJECTIVES: C.

- Design, operate and maintain utility systems serving the buildings that house the healthcare services of TCHD to provide a safe, comfortable, appropriate environment that supports patient care and business operations.
- Perform recommended maintenance to maximize system service life and reliability. 2.
- Manage the Utility Systems Management program to assure compliance with The Joint 3. Commission requirements.

D. PROGRAM MANAGEMENT STRUCTURE:

- 1. The Director of Engineering assures that an appropriate utility system maintenance program is implemented. The Director of Engineering also collaborates with the Director of Safety/EOC to develop reports of Utility Systems Management performance for presentation to the Environmental Health and Safety Committee (EHSC) on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other utility systems issues.
- 2. The Hospital's Board of Directors receives regular reports of the activities of the Utility Systems Management program from the EHSC. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Director of Engineering and appropriate clinical staff. The Board of Directors collaborates with the Chief Executive Officer (CEO) and other senior managers to assure budget and staffing resources are available to support the Utility Systems Management program.
- 3. The Hospital's Chief Operating Officer (COO) or designee receives regular reports of the activities of the Utility Systems Management program. The COO or designee collaborates with the Director of Engineering and other appropriate staff to address utility system issues and concerns. The COO or designee also collaborates with the Director of Engineering to develop a budget and operational objectives for the program.
- 4. The facility maintenance technicians and selected outside service company staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe reliable performance of utility systems in a timely manner. In addition, the technicians and service company staff perform necessary repairs.
- 5. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

E. PROCESSES OF THE UTILITY SYSTEMS PLAN:

- 1. UM.EC.01.01.01 EP8 Plan for the Safe, Reliable, Effective Operation of Utility Systems
 - a. The Utility Systems Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other individuals coming to the facilities of TCHD that may experience an adverse event while being monitored, diagnosed, or treated with any type of medical equipment or being housed in an environment supported by the utility systems of TCHD.
- 2. UM.EC.02.05.01 EP1 Design and Installation of Utility Systems
 - a. The Director of Engineering works with qualified design professionals, project managers and the intended end users of the space of TCHD to plan, design, construct, and commission utility systems that meet codes and standards and the operational needs of the patient care and business activities of TCHD. The construction and commissioning procedures are designed to assure compliance with codes and standards and to meet the specific needs of the occupants of every space. In addition, the design process is intended to assure performance capability meets current needs and sufficient additional capacity is available to manage unusual demands and to help assure that future demands on utility systems can be met.
- 3. UM.EC.02.05.01 EP2 Determining System Risks and Developing and Inventory of Utility Systems and Equipment
 - a. All utility systems components and equipment are included in a program of planned calibration, inspection, maintenance, and testing. The components and equipment are inventoried at the time of installation and acceptance testing. The inventory is maintained on an ongoing basis by the Plant Operations staff. The inventory includes utility system equipment maintained by the Engineering and Maintenance staff and equipment maintained by vendors.
- 4. UM.EC.02.05.01 EP3 Maintenance Strategies
 - a. The Director of Engineering evaluates all utility system equipment to determine the appropriate maintenance strategy for assuring safety and maximum useful life. The

Director of Engineering uses manufacturer recommendations, applicable codes and standards, accreditation requirements, and local or reported field experience to determine the appropriate maintenance strategy for assuring safety and maximizing equipment availability and service life. The strategies may include fixed interval inspections, variable interval inspections, preemptive maintenance, predictive maintenance, and corrective maintenance.

5. UM.EC.02.05.01 EP4 - Inspection, Testing, and Maintenance Intervals

- a. The Director of Engineering uses manufacturer recommendations, applicable codes and standards, accreditation requirements, and local or reported field experience to determine the appropriate maintenance intervals for assuring safety and maximizing equipment availability and service life.
- b. A maintenance management system is used to schedule and track timely completion of scheduled maintenance and service activities.
- c. The Director of Engineering is responsible for assuring that the rate of timely completion of scheduled maintenance and other service activities meets regulatory and accreditation requirements.

6. UM.EC.02.05.01 EP5 – Management of Water Systems

- a. The Director of Engineering and the Infection Preventionist are responsible for identifying needs for procedures and controls to minimize the potential for the spread of infections through or by the utility systems.
- b. Each clinical care service and support service is evaluated to determine the potential for hospital-acquired illness. Each potential is further evaluated to determine what role physical barriers and utility systems can play in contributing to or minimizing the potential.
- c. The Director of Engineering and the Infection Preventionist are responsible for developing procedures and controls to manage any identified potential for growth and/or transmission of pathogenic organisms in the domestic hot water system, cooling tower water, and other potential sources of waterborne pathogens.
- d. The procedures may include periodic testing or treatment to control the risk and to inhibit the growth and spread of waterborne pathogens.

7. UM.EC.02.05.01 EP6 – Management of Ventilation Systems

- a. The Director of Engineering and the Infection Preventionist are responsible for designing procedures and controls for monitoring the performance of air handling equipment. The procedures and controls address maintenance of air flow rates, air pressure differentials in critical areas, and managing the effectiveness of air filtration systems.
- b. Air handling and filtration equipment designed to control airborne contaminants including vapors, biological agents, dust, and fumes is monitored and maintained by Plant Maintenance.
- c. The performance of all new and altered air management systems is verified by a qualified service provider. At a minimum flow rates and pressure relationships are measured as part of the commissioning of all new building projects and major space renovations.
- d. Periodic measurements of air volume flow rates and pressure relationships are tested in sensitive areas throughout the hospital. When the measured system performance cannot be adjusted to meet code requirements or occupant needs, the Director of Engineering and Infection Preventionist develops, when appropriate, a temporary Infection Control Risk Management plan to minimize the potential impact of the deficient performance.

8. UM.EC.02.05.01 EP7 – Mapping of Utility Systems

- a. The Director of Engineering is responsible for maintaining up-to-date documentation of the distribution of all utility systems. The documents include as-built and record drawings, one line drawing's, valve charts, and similar documents. The documents include original construction documentation and documentation of renovations, alterations, additions, and modernizations. Hard copies of the documentation are maintained in the Plant Operations department. Documents that are available in electronic format are maintained on the Engineering Shared Drive.
- 9. UM.EC.02.05.01 EP8 Labeling of Controls for System Shutdown and Recovery

- a. The Director of Engineering is responsible for assuring that current documents showing the layout of utility systems and the locations of controls that must be activated to implement a partial or complete shut-down of each utility system are available at all times.
- b. The documents must include the original layout of the systems and all modifications, additions, and renovations that affect the process for implementing a partial or complete shutdown of a system. The documents must include information that can be used to identify specific controls. The controls must be identified by a label, numbered tag or other device that corresponds to the information on the documents.

10. **UM.EC.02.05.01 EP9 – 13 – Emergency Procedures**

- a. The Director of Engineering and appropriate clinical caregivers collaborate to identify lifecritical medical equipment supported by the utility systems. Life-critical equipment is defined as equipment, the failure or malfunction of which would cause immediate death or irreversible harm to the patient dependent on the function of the equipment.
- b. The Director of Engineering and the caregivers are responsible for developing appropriate resources to manage the response to the disruption of the identified life-critical equipment. The resources are designed to minimize the probability of an adverse outcome of care.
- c. The resources must include but are not limited to information about the availability of spare or alternate equipment, procedures for communication with staff responsible for repair of the equipment, and specific emergency clinical procedures and the conditions under which they are to be implemented.
- d. Copies of applicable emergency procedures are included in the emergency operations manual of each clinical department. Training addressing the medical equipment emergency procedures is included in the department or job related orientation process. All utility systems emergency procedures are reviewed annually.

11. UM.EC.02.05.03 EP1 – 6 and EC.02.05.07 EP1 - 10 – Inspection, Testing, and Maintenance of Emergency Power Systems

- a. The Director of Engineering is responsible for identifying all emergency power sources and for developing procedures and controls for inspection, maintenance, and testing to assure maximum service life and reliability. TCHD uses battery-powered lights, engine driven generators, and large UPS stored energy systems to provide power for emergency lighting, operation of critical systems, and operation of information systems equipment.
- b. Each required battery powered emergency lighting device is tested for 30 seconds each month and for 90 minutes annually.
- c. The Emergency Power Supply Systems (EPSS) supply power for emergency exits, patient ventilation, fire and life safety equipment, public safety, communications, data and processes that if disrupted would have serious life safety or health consequences. Each required EPSS system is tested in accordance with the code requirements for the class of device.
- d. The Director of Engineering is responsible for assuring that appropriate inspection, maintenance, and testing of the essential electrical system is done. Each motor/generator set serving the emergency power system is tested under connected load conditions 12 times a year. All automatic transfer switches are tested as part of each scheduled generator load test.
- e. Testing parameters are recorded and evaluated by the Plant Operations staff. All deficiencies are rectified immediately or a temporary secondary source of essential electrical service is put in place to serve the needs to critical departments or services until the primary system can be restored to full service.
- f. If a failure during a planned test occurs, a full retest will be performed after appropriate repairs are made and essential electrical system is functional again.
- g. Each diesel engine powered motor/generator not loaded to 30% or more of its nameplate capacity during connected load tests undergoes further evaluation to determine if the exhaust gas temperature reaches or exceeds the manufacturer's recommended temperature to prevent wet stacking. Each diesel engine failing to meet the temperature

- recommendation will be exercised annually by connecting it to a dynamic load bank and performing the three step test process specified by NFPA 99 and NFPA 110.
- h. Batteries, fuel stored on site, controls, and other auxiliary emergency power equipment is inspected, maintained, and tested as required. The Administrative Director of Facilities, Engineering staff and contracted service providers are responsible for assuring the reliability of each component part of the emergency power systems by performing all required calibration, inspection, maintenance, and testing in a timely manner.

12. UM.EC.02.05.05 EP1 - Utility Systems Inventory and Initial Testing

- a. The Director of Engineering establishes and maintains a current, accurate, and separate inventory of all utility systems equipment included in a program of planned inspection or maintenance. The inventory includes equipment owned by TCHD and leased or rented equipment.
- b. The Director of Engineering is responsible for implementation of the program of planned inspection and maintenance. All utility systems equipment is tested for performance and safety prior to use.

13. UM.EC.02.05.05 EP3 - Testing of Life Support Equipment

a. The Director of Engineering assures that scheduled testing of all utility systems that play a role in life support is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Director of Engineering will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

14. UM.EC.02.05.05 EP4 - Testing of Infection Control Support Equipment

a. The Director of Engineering assures that scheduled testing of utility systems equipment that supports critical infection control processes is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Director of Engineering will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

15. UM.EC.02.05.05 EP5 - Testing of Non-Life Support Equipment

a. The Director of Engineering assures that scheduled testing of all non-life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Facilities will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it

16. UM.EC.02.05.09 EP1 - Medical Gas System Testing

a. All medical gas systems are maintained and periodically tested to assure system performance. All testing and inspection is done in accordance with the requirements of the current edition of NFPA 99.

17. UM.EC.02.05.09 EP2 - Modifying / Repairing Medical Gas Systems

a. When a new medical gas system is installed or an existing system is breached for any reason, the Director of Engineering coordinates certification of the system by a qualified service provider. The certification testing is done in accordance with the requirements of the current edition of NFPA 99. The Director of Engineering maintains a permanent record of all certification testing.

18. UM.EC.02.05.09 EP3 - Labeling & Accessibility of Medical Gas Controls

- a. The Director of Engineering is responsible for assuring that all medical gas system control valves and monitoring stations are identified appropriately.
- b. In addition, the Director of Engineering is responsible for assuring that each monitoring station and valve is accessible. Accessibility is evaluated during scheduled environmental tours. Deficiencies are reported to the appropriate manager for resolution.

19. **EC.04.01.01 EP1 – 11 – The hospital monitors conditions in the environment**

a. The Sr. Director of Risk Management coordinates the design and implementation of the incident reporting and analysis process. The Director of Safety/EOC works with the Sr.

- Director of Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions. Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported.
- b. The completed reports are forwarded to the Sr. Director of Risk Management who in turn works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.
- c. In addition, the Sr. Director of Risk Management and the Director of Safety/EOC collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the EHSC and the Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Director of Safety/EOC provides summary information related to incidents to the CEO or designee and other leaders, including the Board of Directors, as appropriate.
- d. The Director of Safety/EOC coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of TCHD. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the six EC functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.
- e. The EHSC and the Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.
- f. The Director of Safety/EOC and the Environmental Health and Safety Committee and the Patient safety Committee prepare a quarterly report to the leadership of TCHD. The quarterly report summarizes key issues reported to the Committees and their recommendations. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders of management responsibilities have been carried out.
- 20. EC.04.01.01 EP15 Every twelve months the hospital evaluates each Environment of Care Management Plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.
 - a. The Director of Safety/EOC coordinates the annual evaluation of the management plans associated with each of the Environment of Care functions.
 - b. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, benchmarking programs, findings of external reviews or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the EHSC by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.
 - c. In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Director of Safety/EOC.
 - d. The results of the annual evaluation are presented to the EHSC. The Committee reviews

and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, organizational leaders, the Board of Directors, the Patient Safety Committee, and others as appropriate. The manager of each Environment of Care program is responsible for implementing the recommendations in the report as part of the performance improvement process.

- 21. EC.04.01.03 EP1 3 Analysis and actions regarding identified environmental issues
 - a. The EHSC receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.
- 22. **EC.04.01.05 EP1 3 Improving the Environment**
 - a. When the leadership of the hospital, performance improvement, or patient safety concurs with the EHSC recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The EHSC works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.
 - b. The EHSC also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, performance improvement, and patient safety leadership.
- 23. LD.03.01.01 EP6 & EP8; HR.01.04.01 EP1 and EC.03.01.01 EP1 3 Orientation and Ongoing Education and Training
 - a. Orientation and training addressing all subjects of the environment of care is provided to each employee, volunteer, contract staff and to each new medical staff member at the time of their employment or appointment.
 - b. In addition, all current employees, as well as volunteers, physicians, and students participate in an annual update of the orientation program as deemed appropriate. The update addresses changes the procedures and controls, laws and regulations, and the state of the art of environmental safety.
 - c. The Human Resources Department with assistance from the Education Department coordinates the general orientation program. New staff members are required to attend the first general orientation program after their date of employment. The Human Resources Department maintains attendance records for each new staff member completing the general orientation program.
 - d. New staff members are also required to participate in orientation to the department where they are assigned to work.
 - e. The departmental orientation addresses job related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.
 - f. The Director of Safety/EOC collaborates with the Environment of Care managers, department heads, the Director of Performance Improvement, the Director of Infection Control, and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care Program and revised as necessary.
 - g. The Director of Safety/EOC gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job related physical risks are to be managed or eliminated as part of daily work.
 - h. In addition the Director of Safety/EOC evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when

Engineering Manual Utility Management Plan Page 8 of 8

- an environmental incident occurs and how to report environment of care risks or incidents.
- i. Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the EHSC. When deficiencies are identified action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

F. AFFECTED PERSONNEL / AREAS:

1. GOVERNING BOARD; MEDICAL STAFF; ALL HOSPITAL EMPLOYEES; VOLUNTEERS; VENDORS; CONTRACT SERVICES AND STAFF;

G. REFERENCES:

1. The Joint Commission

ENGINEERING OPERATIONS

	Section: ENGINEERING DEPARTMENT
TRI-CITY MEDICAL CENTER	Subject: Work Order Requests
Engineering Policy & Procedure	Policy Number: 2010 Page 1 of 1
Department: Hospital-Wide	EFFECTIVE: 11/1/87 REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 5/09, 8/11, 6/12

SUBJECT: Work Order Requests

ISSUE DATE:

11/87

REVIEW DATE(S):

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

Department Approval Date(s):

7/16

Environmental Health and Safety Committee Approval Date(s):

7/16

Professional Affairs Committee Approval Date(s):

Board of Directors Approval Date(s):

A. PURPOSE:

To describe the process by which requests for Engineering will be processed and documented.

B. **GENERAL INFORMATION:**

- 1. <u>Work Order Requests</u>- Work orders generated by a user department and transmitted via the Computerized Maintenance Management System.
- 2. <u>Computerized Maintenance Management System (CMMS)</u> A computerized information system used to facilitate the scheduling, monitoring and documentation of equipment and environmental maintenance.
- 3. <u>Emergency Services</u> Those Engineering services needed to resolve problems or conditions which pose an immediate threat to patient or employee safety or which may significantly affect the ability of a department or area to carry out an essential function. Emergency service is normally obtained via a telephone call to the Facilities Management Office (see "Hours of Service").

C. POLICY:

- 1. The priority with which work orders (received either by telephone or CMMCNS will be handled will be determined by the Engineering Supervisor or designee.
- 2. Emergency work orders, orders as defined above, will be assigned to an **E**engineer for immediate handling.

D. PROCEDURE:

1. The Engineering Supervisor or designee checks the computer terminal in the Engineering ShopCMMS at least twice each hour for work orders which have been generated by user

Engineering Manual Work Order Requests Page 2 of 2

departments.

- 2. The Engineering Supervisor or designee reviews the work orders received, determines the priority with which they must be handled, and assigns them to an Eengineer.
- 3. The Eengineer to whom the request is assigned completes the work or notifies the Engineering Supervisor or designee of any reason why it cannot be completed promptly, (i.e., lack of parts, lack of familiarity with equipment, etc.).
- 4. When the work has been completed, the assigned Eengineer documents the total man hours and materials used, and closes the work order in CMMSsigns the work order.
 - 5. The assigned engineer closes out the work order.



Environment of Care Manual Life Safety Management

SUBJECT:

Fire Safety Hazards

ISSUE DATE:

10/15

REVIEW DATE(S): REVISION DATE(S):

Department Approval Date(s):

08/15, 6/16

Environmental Health and Safety Committee Approval Dates(s):

09/15, 6/16

Professional Affairs Committee Approval Date(s):

10/15

Board of Directors Approval Date(s):

10/15

A. POLICY:

- Hazards that personnel shall recognize and correct, or cause to be corrected, or prevent from existing, are as follows:
 - a. Careless Smoking Be careful to observe all "No Smoking" rules and regulations. This includes any product containing tobacco intended to be lit, burned, or heated to produce smoke as well as any device used to smoke the tobacco, including but not limited to a pipe, cigar, or cigarette, (including electronic cigarettes & vapor devices).
 - b. Exit Ways Do not permit the obstruction of aisles, doorways, fire escapes or allow their use as storage places.
 - c. Combustible Waste All combustible waste shall be placed in all metal containers with tight fitting covers; so that any fire occurring will be kept entirely within the container. When materials capable of spontaneous ignition are stored, they shall be kept in separate containers until safely disposed.
 - d. Fire Doors The proper operation of fire doors is necessary to protect or isolate one section of the building from another, thus providing protection to other areas and persons within the building. Keep all fire doors properly closed, except those equipped to close automatically. Fire doors wedged or propped open are of no value in preventing the spread of fire.
 - e. Flammable Liquids (Such as acetone, alcohol, benzene, and ether) Limit the amount on hand to a minimum working supply. If possible, keep in metal container. Where safety cabinets or storage rooms are available, keep these materials in them and maintain the door to such storage in the closed position. No smoking, open flame or sparking device shall be allowed around flammable liquids or compressed gas. Oxygen and nitrous oxide shall not be stored with flammable gases, such as cyclopropane and ethylene, or with flammable liquids.
 - f. Electrical Hazards Report promptly any frayed, broken or overheated electrical cords or electrical equipment. Do not operate light switches, or connect or disconnect equipment where any part of your body is in contact with metal fixtures or is in water. Specially built equipment is in use in the operating and delivery rooms to eliminate electric sparks, and to control static electricity.
 - g. Acids All concentrated or corrosive acids must be handled with extreme care. Avoid storing these materials on high shelves, or in locations where they are likely to be spilled or the containers broken. Organic acids and inorganic acids shall not be stored together. Any spillage shall be immediately diluted or neutralized and cleaned up.
 - h. Electric Heaters These units, particularly the portable type, are not permitted anywhere on the hospital premises unless approved by Engineering. No portable heaters are

Environment of Care Manual Fire Safety Hazards Page 2 of 2

allowed in patient care areas.

i. Heat generating devices or substances such as candles, teasters, teaster evens, hot plates, electric blankets, heating pads, propane fueled devices, strand lights and oil lamps are not appropriate for the hospital environment and are not allowed on hospital property. Toasters, toaster ovens, microwaves and coffee machines are allowed in break rooms/offices with the approval of the Safety Officer or Director of Facilities. Devices must have an Engineering Electrical Safety sticker. Persons who do not comply with these directions will be subject to the disciplinary process.

B. AFFECTED AREAS/PERSONNEL:

1. Governing Board; Medical Staff; All Hospital Employees; Volunteers; Vendors

C. REFERENCE(S):

- 1. The Joint Commission
- 2. NFPA
- 3. CA State Fire Marshall

SUBJECT: Hazardous Material and Waste Management and Communication Plan

ISSUE DATE:

11/87

POLICY NUMBER: 6000

REVIEW DATE(S):

REVISION DATE(S): 09/94, 07/97, 09/00, 04/03, 12/10, 05/15

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04/15, 06/16

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04/15, 09/16

Professional Affairs Committee Approval Date(s):

05/15

Board of Directors Approval Date(s):

05/16

DEFINITIONS OF HAZARDOUS MATERIALS: Α.

Those materials that by their nature are a potential threat to the health and safety of persons coming into contact with them.

Corrosives - having a pH less than or equal to 2 or greater than or equal to 12.5

and liquids that corrode steel at a rate of greater than .25 inch per year.

Toxics (EP Toxicity) - a waste whose constitutes have a tendency to leach or migrate b. when disposed of in an improperly designed landfill; able to cause illness, death or restrict awareness enough to present a danger.

Flammable liquids (ignitable) - flammable gases, oxidizers, liquids with a flash point C. of less than 140F, and solids that ignite spontaneously through absorption of

moisture or friction.

- Reactive (Explosives) substances that are unstable and readily undergo violent d. change, react violently with water, form potentially explosive mixtures with water, capable of detonation when exposed to a strong initiating source, generate significant quantities of toxic gas when exposed to water or in the case of cyanide or sulfide bearing waste, pH conditions between 2 and 12.5.
- Pharmaceutical waste and Expired Medications Expired or unusable parenteral/oral e. liquids; dextrose/saline I.V. admixtures/solutions containing: antibiotics, multivitamins, dopamine, dobutamine, electrolytes epinephrine, epi-cal, heparin, insulin, lidocaine, lorazepam, magnesium sulfate, meperidine, midazolam, morphine, nitroglycerin, norepinephrine, oxytocin, theophylline, TPN; Maalox, Mylanta, alcohol containing liquids with less than 24% alcohol. Expired Unusable Pharmaceuticals: Intact expired or unusable medications.

B. **PURPOSE**

The purpose of the management plan is to define how hazardous materials and waste are identified, labeled, handled, whose responsibility they are, how training and communication is managed, and how monitoring occurs.

POLICY

Tri-City Medical CenterHealthcare District is committed to providing a safe and healthy environment for all employees, medical staff, patients and visitors by establishing ongoing mechanisms for controlling and monitoring the use of hazardous materials and waste in compliance with State and Federal regulations.

Right to Know Law 2.

Employees and contractors are to be provided with information about the known and suspected health hazards that may result from working with Hazardous and Infectious Materials. While performing duties at Tri-City Medical CenterHealthcare District facilities, employees and contractors shall be informed so they can make a

Environment of Care Manual – Hazardous Material Management Hazardous Material and Waste Management and Communication Plan Page 2 of 6

more knowledgeable and reasoned decision with respect to any associated personal health hazards.

- b. General Orientation: New employees will be informed of "Right to Know Law" during the Safety portion of Employee Orientation.
 - i. Employees have the right to refuse to work with a hazardous substance if they have not been provided with Material Safety Data Sheet information.
 - ii. Employees, former employees, or applicants may not be terminated or discriminated against in any way for exercising any rights they are given under the law.
- c. Instructional signs informing employees of their rights under the law are posted.

 Department Specific Orientation: At the time of initial assignment, all employees will receive training on any chemical which is known to be present in the workplace in such a manner that employees may be exposed under normal conditions of use or in a foreseeable emergency. If an employee is not ordinarily in a position to be exposed to hazardous chemicals, he or she need not be trained.
- d. Contracting for Outside Services:
 - i. Departments that obtain outside services through contracts or service agreements will insure that the contractor has been informed of all hazardous materials to which their employees may be exposed. The department will insure that the contracted employee has completed the Non-Non-Tri-City Medical CenterHealthcare District Employee Orientation Program.

D. **GUIDELINES**:

- 1. Method of Identification of Hazardous Material:
 - a. Material is identified as hazardous by evaluation produced by Manufacturer, information disseminated from a reliable source, or by professional knowledge and experience.
 - b. Directors of Engineering, Surgery, Nutrition, Laboratory, Pharmacy, and EVS, will submit a list of substances determined to be hazardous by this policy to the Safety Officer. This list will be updated as new products determined to be hazardous are introduced to the department.
 - c. Labels are required on all hazardous substances to identify the hazardous material(s) contained therein and to provide warning about the type of hazard and the type of precautions required. This includes all containers with toxic substances in a concentration greater than or equal to 1% of the total composition, or 0.1% if carcinogens; unless specifically exempted.
- 2. Safety Data Sheets (SDS)-3 E Company Fax on Demand:
 - a. Request an SDS when assistance is needed with medical emergencies, chemical spills, and employee
 - i. **Emergency Request** Immediate to 15 minutes: Poisoning, chemical exposure, chemical spill, human or environmental contamination, fire.
 - ii. **Immediate to 30 minutes:** Regulatory Agency Request (OSHA, EPA, The Joint Commission).
 - iii. Immediate to 3 hours: Employee request (non-emergency)
 - iv. **Standard Request** Immediate to 24 hours: Customer Request, Contractor Request.
 - v. **Mail Request** Rush: mailed within 24 hours Standard: mailed within 3 business days: Request of 10 or more Safety Data Sheets.
 - b. To initiate SDS request follow the following procedure:
 - i. Call Toll Free: 1-800-451-8346 or 760-602-8703, to request up to nine SDS.
 - ii. Fax request to (760-602-8888 for orders and numbers on SDS of SDS sheets
 - iii. DO NOT FAX EMERGENCY SDS REQUESTS CALL IMMEDIATELY
 - c. To request a SDS complete the attached request form then call, fax or mail to 3 E Company. Provide as much of the following information as possible:
 - i. Product name.

Environment of Care Manual – Hazardous Material Management Hazardous Material and Waste Management and Communication Plan Page 3 of 6

- ii. Manufacturer name.
- iii. Product number.
- iv. UPC Code (if available).
- v. Be specific when request is for a product. Separate SDS are maintained for products that have even very minor differences from others (e.g. colors, aerosol vs. pourable, concentrated vs. ready to use).

3. Employee Training:

- a. Department directors are responsible for providing training to employees on hazardous materials in their work area at the time of their initial assignment/ or reassignment and when a new hazard is introduced into their work area. All employees must complete the Annual Computer Based Learning (CBL's) modules which include a section on Hazardous Materials/Global Harmonization/Right-to-know training. The CBL instructions include the following items:
 - i. Employee rights under the law.
 - ii. Explanation of the (SDS)
 - iii. Explanation of the labeling system and pictograms
 - iv. Explanation of methods used to identify hazards and how to detect the presence of toxic substances in the work place, and routes of entry into the body.
 - v. Safety and control devices to include personal protection.
 - vi. Location of hazardous substance list.
 - vii. Emergency procedures for spill control.
 - viii. Review of blood-borne diseases and potential for transmission.
 - ix. Types of protective equipment and proper use.
 - x. Situations requiring use of protective equipment.
 - xi. Review of concept of standard precautions as it applies to the employees specific work practices.
 - xii. Review of methods to determine and designate infectious waste and linen along with instructions for proper disposal.
 - xiii. Training in proper handling of needles and sharps along with proper disposal
 - xiv. Training in completion of Employee Health Injury Report to indicate exposure to potential infectious agents.
 - xv. Department Directors will ensure that all employees annually complete the Computer Based Learning module on Hazardous Materials.

4. Hazardous Chemical Waste & Infectious Medical Waste Disposal

- a. General Disposal Guidelines:
 - Disposal methods must comply with all federal, state and local regulations. Flammable materials are not to be disposed of into the drainage system.
 - ii. Wear appropriate protective equipment (i.e. gloves, safety glasses, lab coat and respirator where applicable).
 - iii. Date must be filled in on the substance's hazardous material storage label upon final use or disposal. All Chemical Waste will placed into the Chemical Waste Storage Shed for final disposal.
 - iv. All empty discarded containers will be disposed of according to the manufacturer instructions and/or in accordance with Federal, State and local regulations.
 - v. Tri-City Healthcare District is contracted with an outside company for the disposal of hazardous materials and waste in accordance with local, State and Federal regulations.
 - vi. Medical Infectious Waste will be placed into the RED Bio-Hazardous Container or Sharp Container and collected by the EVS Department and placed into the Bio-Hazardous Waste Storage shed until collected by the Waste Disposal Vendor final disposal (See Infection Control Manual).
 - vii. Waste Pharmaceuticals Refer to AP&P # 276 Handling of

Pharmaceutical Waste, Expired Medications & Expired IV Solutions.

- b. Monitoring
 - i. Waste Gas Levels (Surgical Suites):
 - ii. Waste gas levels in surgical areas are to be tested at least quarterlyannually.
 - iii. Testing is to be conducted by an independent testing company contracted by Tri-City Healthcare District.
 - iv. Results of such testing are to be kept on file by the respective departments.
 - v. Results of the quarterly annual testing should be posted along with the maximum permitted levels of the gases tested for employee review.
 - vi. In the event levels exceed permitted levels, the Engineering Department and the Environment of Care/Safety Officer shall be notified in order that corrective measures can be taken.
- c. Airflow Testing:
 - i. Airflow and air changing systems will be monitored and tested by the Engineering Department on an as needed basis. All new equipment is to be certified at the time of installation.
 - ii. Areas using or storing hazardous materials must have adequate ventilation in order to comply with room air change and flow standards as governed by the California Building Codes.
 - iii. Fume hoods should be utilized when using volatile or gaseous-forming hazardous materials to insure that gas levels remain at safe levels and do not affect air quality, fumehoods should remain running at all times.
- d. Radiation
 - All monitoring of radiation levels will be conducted according to departmental policies per State regulations by the Radiation Safety Officer.
- e. Formaldehyde Testing
 - i. Air monitoring for formaldehyde will be conducted annually. Methods will be in accordance with OSHA regulations and will be of two (2) types: 1) Personal and 2) Area.
 - ii. Engineering controls will be utilized to reduce airborne concentrations whenever feasible.
 - iii. Employees working with solutions of 1% or more formaldehyde will utilize protective equipment as follows:
 - 1) Safety Glasses.
 - 2) Gloves.
 - Disposable chemical resistant Lab coats.
- f. Work Test Area:
 - Work areas suspected of containing airborne hazardous materials will be evaluated and tested immediately by Engineering Department and or the Environment of Care/Safety Officer.
 - ii. Levels exceeding permitted safe limits will be reported to the Safety Officer.
 - iii. A consultation with Administration, EOC/Safety Officer and the Director of the department involved will be made to determine whether or not work can continue in the affected area or to determine steps to be taken to insure employee safety.
- g. Employee Monitoring and Medical Testing:
 - i. A Flammable Storage Cabinet will be provided for flammable materials in order to prevent the spreading of fire. Further, flammable liquids will be stored away from flammable gasses. Thus, in the event of fire the possibility of explosion is reduced and containment is readily achieved.
 - ii.i. Appropriate medical testing will be conducted to determine the effects of the exposure and in order that an effective diagnosis and proper treatment can be conducted.

Environment of Care Manual – Hazardous Material Management Hazardous Material and Waste Management and Communication Plan Page 5 of 6

iii.i. Testing will be done under the supervision of a licensed qualified physician.

h. Storage and Transportation:

- i. A Flammable Storage Cabinet will be provided for flammable materials in order to prevent the spreading of fire. Further, flammable liquids will be stored away from flammable gases. Thus, in the event of fire the possibility of explosion is reduced and containment is readily achieved.
- ii. All openings will be controlled with approved self-closing fire doors.
- iii. Every inside storeroom will have a mechanical exhaust system that provides at least six complete air changes per hour. The Hazardous Material Storage Building has a switch that controls the ventilation system as well as the lights.
- iv. Cylinders will be stored at least 20 feet from flammable and combustible liquids and other ignitable.
- v. Cylinders will be stored separately (rooms) from flammable material
- vi. Hazardous wastes/materials will not be stored with nonhazardous waste in order to prevent accidental contamination.
- vii. Incompatible materials will be stored away from each other.
- viii. Materials will be transported in approved safety containers or in their original shipping packages.
- ix. No hazardous material will be transported to and stored in areas other than work or storage areas.
- x. Materials will be transported in amounts comparable to regulated daily or weekly limits.
- xi. Materials will not be transported and then stored in unapproved areas or in an unsafe manner.
- xii. All materials packaged and shipped for outside disposal must comply with Department of Transportation (DOT) regulations.
- xiii. Daily limits will be stored in approved safety cabinets.
- i. Emergency Response Procedures:
 - i. Various hazardous chemicals are used throughout the hospital which could pose a threat of danger if a moderate or major spill should occur. The following procedure is outlined in the event that such a chemical spill occurs within the hospital environment. All personnel will be familiar with the proper procedure for handling these events to minimize the risk towards patients, visitors and staff members.
 - 1) Areas of concern:
 - a) Laboratory Large variety of chemicals.
 - b) Pharmacy Large variety of chemicals.
 - c) Materials Management Cleaning supplies and hospital chemical supplies.
 - d) Environmental Services Cleaning supplies and solvents.
 - e) Radiology Materials used in x-ray development and radioactive-Radioactive material.
 - f) Food and Nutrition Degreasers and cleaning supplies.
 - g) Respiratory Disinfectants-.
 - h) Facilities Management Large variety of chemicals.
 - i) Sterile Processing Department Disinfectants.
 - j) Surgical Services Tissue Fixative.
- j. Chemical Spills:
 - i. Immediately alert personnel in area.
 - ii. Dial "66" and tell PBX Operator that there is a chemical spill and the location.
 - iii. The PBX Operator will alert: The Environment of Care/Safety Officer, Manager of Environmental Services or Lead EVS, Manager of Security or Lead Officer, and Engineering.

Environment of Care Manual – Hazardous Material Management Hazardous Material and Waste Management and Communication Plan Page 6 of 6

- iv. Evacuate and seal off areas from a safe distance; if flammable are involved, eliminate ignition source if possible. Allow no one to enter area until Environmental Services, Security, and the Environment of Care/Safety Officer has been notified and arrives on scene.
- ii.v. Contact 3 E Company 1-800-451-8346 for Safety Data Sheet (SDS) information on how to handle the spill and what type of Personal Protective Equipment is needed. 3 E Company will fax the information within minutes to the closest fax machine number provided. Employees will need to know the name of the chemical to tell the 3 E Company operator.
- iii.vi. If at this time an evacuation is necessary the Hospital Evacuation Procedure will be implemented. The Environment of Care/Safety Officer will consult with Management and area personnel as to proper containment, identification, and disposal procedure as prescribed by the EPA or other written instructions that provide measures that are approved by law or ordinance.
- iv-vii. Notification of the fire department will depend on the type of the spill and the potential danger involved.
- v.viii. If a minor spill of flammable, corrosives, toxics or reactive occurs and there is no immediate danger to employee(s) then:
 - 1) Properly trained employees may clean-up the spill using approved spill kits/supplies/equipment that meet or exceed the PPE requirements listed on the SDS notice.
 - 2) Contact Environmental Services (EVS) who will contain the spill, and clean the chemical up per departmentSDS guidelines.
 - 3) All collected chemicals must be handles per hazardous waste requirements and placed in an appropriate container, then labeled with the chemical name and other hazardous waste properties.
 - 4)4) Contact the Environment of Care/Safety Officer with any questions. specific policy and who will contact the Environment of Care/Safety Officer.
- k. Treatment Of of Contaminated Area:
 - i. Wash area immediately.
 - ii. Clothing contamination: Take item of clothing off immediately to prevent soaking through and contaminating skin. This includes all clothing affected.
 - iii. First Aidr:
 - 1) If skin/eye/mouth area(s) have been contaminated, flush affected area with large amounts of water for at least 15 minutes.
 - 2) Do not try to neutralize.
 - a) Go to the Emergency Department immediately after flushing affected area.

E. GOALS/OBJECTIVE FOR FY17

- 1. Provide face-to-face training to all applicable Pharmacy and Engineering employees on how to properly respond to a chemical spill. Measurement will be number of applicable employees/number of employees receiving the spill management training. Goal is 100% of applicable employees.
- 2. Complete the conversion over to Stericycle as the hazardous waste management provider and complete an assessment of new options related to disposable of controlled substances.

E.F. REFERENCES

1. AP&P # 276 Handling of Pharmaceutical Waste, Expired Medications & Expired IV Solutions



Environment of Care Manual Life Safety Management

SUBJECT: Life Safety Management Plan

ISSUE DATE:

11/87

REVIEW DATE(S): 03/00, 04/106, 04/09

REVISION DATE(S): 04/13, 05/12

Department Approval Date(s):

05/15, 06/16

Environmental Health and Safety Committee Approval Dates(s):

06/15, 08/16

Professional Affairs Committee Approval Date(s):

06/15

Board of Directors Approval Date(s):

06/15

A. **EXECUTIVE SUMMARY:**

- Each environment of care and the physical condition of occupants poses unique fire safety risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Life Safety Management Program is designed to identify and manage the risks of the environments of care operated and owned by Tri-City Healthcare District. The specific fire safety risks of each environment are identified by conducting and maintaining a proactive risk assessment. A fire safety program based on applicable laws, regulations, codes, standards, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Tri-City Healthcare District.
- The Management Plan for Life Safety describes the risk and daily management activities that 2. Tri-City Healthcare District has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people, coming to the organization's facilities. The management plan and the Life Safety Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.
- The program is applied to the Medical Center and all offsite clinics and care facilities of Tri-3. City Healthcare District. The Life Safety Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care and business occupancies of Tri-City Healthcare District.

B. **PRINCIPLES:**

- All buildings of Tri-City Healthcare District housing patient care services must be 1. designed, operated, and maintained to comply with the 2000-2012 edition of the National Fire Protection Association (NFPA) Life Safety Code, and the 2012 Edition of the NFPA Health Care Facilities Code.
- All fire alarm, detection, and extinguishing systems and equipment must be maintained 2. to comply with applicable codes and standards.
- All staff must be educated and trained to respond effectively to fire, smoke, or other products 3. of combustion to minimize the potential of loss of life or property in the event of a fire.
- Appropriate temporary administrative and engineering controls must be designed, implemented, 4. and maintained whenever existing deficiencies or conditions created by construction activities significantly reduce the level of life safety in any area where patients are cared for or treated.

C. **OBJECTIVES:**

Design and construct all spaces intended for housing patient care and treatment services to

Environment of Care Manual – Life Safety Management Life Safety Management Plan Page 2 of 7

meet national, state, and local building and fire codes.

- 2. Conduct required fire drills in all buildings of Tri-City Healthcare District housing patient care services.
- 3. Calibrate, inspect, maintain, and test fire alarm, detection, and suppression systems in accordance with codes and regulations.
- 4. Inspect and maintain all buildings housing patient care services to assure compliance with the applicable requirements of the 2000-2012 edition of the NFPA Life Safety Code and the 2012 Edition of NFPA Health Care Facilities Code.
- 5. Train all staff, volunteers, and members of the medical staff to respond effectively to fires.

D. PROGRAM MANAGEMENT STRUCTURE:

- 1. The Director of Engineering (Facilities Manager) assures that an appropriate maintenance program is implemented. The Director of Engineering (Facilities Manager) also collaborates with the Safety Officer to develop reports of Life Safety Management performance for presentation to the Environmental Health & Safety Committee on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other fire safety issues.
- 2. The facilities management technicians and selected outside service company staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe reliable performance of fire safety equipment in a timely manner. In addition, the technicians and service company staff perform necessary repairs.
- 3. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.
- 4. The Board of Directors of Tri-City Healthcare District receives regular reports of the activities of the Life Safety Management program from the Environmental Health & Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Director of Engineering (Facilities Manager) and appropriate clinical staff. The Board collaborates with the CEO and other senior managers to assure budget and staffing resources are available to support the Life Safety Management program.
- 5. The CEO or designee of Tri-City Healthcare District receives regular reports of the activities of the Life Safety Management program. The CEO or designee collaborates with the Director of Engineering (Facilities Manager) and other appropriate staff to address fire safety issues and concerns.

E. <u>ELEMENTS OF THE LIFE SAFETY MANAGEMENT PLAN:</u>

- 1. Life Safety Management Plan (FS.EC.01.01.01 EP6)
 - a. The Life Safety Management Program is described in this management plan. The Life Safety Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of Tri-City Healthcare District experience an adverse outcome in the event of a fire.
- 2. Processes for Protecting Building Occupants and Property (FS.EC.02.02.01 EP1)
 - a. The Director of Engineering (Facilities Manager) and Safety Officer are responsible for coordinating the development of design, operations, maintenance, and training processes to minimize the potential for fires and of adverse consequences related to the presence of fire, smoke, or other products of combustion.
 - b. Design
 - i. The Director of Engineer (Facilities Manager) and other project managers collaborate with qualified design professionals, code enforcement, and facility licensing agencies to assure that buildings and spaces are designed to comply with local, state, and national building and fire codes. American Institute of Architects (AIA) guidelines are also considered in the design process for compliance with the International Building Codes with California amendments.

The Director of Engineer (Facilities Manager) assures that all required permits and inspections are obtained or completed prior to occupancy. The Director of Engineer (Facilities Manager) permanently maintains all plans, inspection reports, and other documents related to the design and construction of any building or space housing patient care or treatment services of Tri-City Healthcare District.

c. Management

- i. The **Director of Engineer** (Facilities Manager) oversees the design, implementation, and documentation of processes designed to assure optimal performance and continual compliance with code requirements of fire alarm, detection, and suppression systems. Similar programs are in place for maintenance of building elements operating conditions that play a role in the fire safety level of the environment.
- ii. The Director of Engineer (Facilities Manager) is responsible for assuring that all renovation and new construction within existing buildings is done in a manner that preserves compliance with codes and standards.

d. Fire Response Process

- i. The Safety Officer is responsible for the design and management of a fire response plan that meets the unique needs of the occupants of each department or service of Tri-City Healthcare District. The current fire response plan is based on the remove from immediate danger, activate alarms, confine fire, extinguish or evacuate area "RACE" principle. Area specific response and evacuation plans that include training and equipment required to manage unique risks identified in areas are in place. The plans are evaluated annually as part of the overall program review.
- ii. The emergency number "66" is to be dialed to report a fire.
- iii. The unattached buildings located on the Medical Center campus will dial "66" to report a fire.
- iv. All buildings off the main Medical Center campus will dial "911" for assistance in case of a fire.
- 3. The hospital prohibits smoking on all facility grounds (FS.EC.02.03.01 EP2 & EC.02.01.03 EP1)
 - a. Tri-City Healthcare District has implemented a Smoke- Free Environment policy. The policy prohibits smoking of all kinds (ie: cigarettes, cigars, pipe, chewing tobacco, ecigarettes, and all vapor producing devices) in any hospital building or campus grounds by all, including staff, visitors and patients.
 - b. Tri-City Healthcare District has identified alternatives to tobacco products that are offered to all. Tri-City Healthcare District has developed tobacco replacement resources to assist staff and patients with smoking cessation as desired.
 - c. The procedures for managing the use of tobacco replacement materials are followed and enforced by all managers and staff.
- 4. The hospital maintains free and unobstructed access to all exits (FS.EC.02.03.01 EP4)
 - a. Leaders in all areas of the hospital are responsible for assuring that equipment, furniture, and supplies are not stored in corridors. The condition of corridors is evaluated during each environmental rounds activity. All violations are reported to the Director and/or Manager of the area where the deficiency was identified, the Safety Officer, and the Environmental Health & Safety Committee.
- 5. The hospital has a written fire response plan (FS.EC.02.03.01 EP9-10)
 - a. The Safety Officer is responsible for coordinating the implementation of the fire response plan. All staff is oriented to the RACE response model and effective use of portable fire extinguishers. In addition, all staff are oriented to the department or service specific plans that account for the unique challenges posed by the condition of occupants and the design of space in which they work.
 - b. The department and area specific fire response plans include information about:
 - i. The roles of all employees, medical staff, volunteers, contract staff and students

near the point of fire origin.

- ii. The roles of all employees, medical staff, volunteers, contract staff and students away from the point of fire origin.
 - Note: Tri-City Healthcare District believes strongly in the principle of life safety. The organization recognizes as a practical matter that members of the medical staff and many volunteers and students are not present much of the time and are not likely to be a reliable resource during a fire response. Therefore, the medical staff, volunteers, and students do not have a specific defined role in the fire response plan. They are instructed to remain in the area they are located at the time an alarm sounds and to render assistance under the direction of the manager or employees of the area as needs arise.
- iii. Operation of the fire alarm system.
- iv. Exit routes and use of equipment used to relocate or evacuate patients, visitors, and staff.
- 6. Fire Drills (FS.EC.02.03.03 EP1 5)
 - a. Regular fire drills are conducted to reinforce training and education. At least 50% of the drills are unannounced. The frequency of drills is based on regulations and accreditation requirements. All healthcare, ambulatory healthcare and overnight sleeping areas are drilled at least once per shift per quarter.
 - b. If conditions evaluated as part of the Interim Life Safety Measures (ILSM) indicate a need for additional drills to enhance staff awareness of degraded life safety protection in various areas, there is documentation that the additional drills are performed. All freestanding business occupancies are drilled at least once per shift per year.
 - c. All fire drills are evaluated to determine if individual areas respond appropriately. An aggregate evaluation of fire drills is done at least twice a year. The aggregate analysis looks for patterns or trends of deficiencies. When deficiencies are identified, there is documentation that the deficiencies are corrected.
- 7. Inspection, Testing, and Maintenance of Fire Safety Systems (FS.EC.02.03.05 EP1 20)
 - a. The Director of Engineering (Facilities Manager) works with qualified contractors and staff to design a program of calibration, inspection, maintenance, and testing to assure the reliability of all fire safety systems and equipment. The program includes systems and equipment such as fire sprinklers, smoke detection, fire pumps, fire dampers, doors, and shutters, and smoke control elements of the environment. Each system or piece of equipment is maintained to comply with requirements of the National Fire Protection Association or other applicable codes and standards. The hospital conducts annual tests of battery powered exit lights for 90 minutes. The hospital conducts monthly evaluations of nuclear powered exit signs and verified for expiration dates and replaced accordingly.
 - b. When deficiencies are identified, they are corrected within 48 hours. If a deficiency cannot be corrected within 48 hours, the Facilities Manager evaluates the impact of the deficiency using the ILSM criteria to determine if an ILSM plan needs to be put in place until the deficiency can be corrected. All ILSM plans are monitored for effect and documentation demonstrating compliance with the plan is maintained by the Safety/Security Officer.
- 8. Life Safety Management (LS.EC.01.01.01 EP1 3)
 - a. The Director of Engineering (Facilities Manager) is responsible for maintaining the Statement of Conditions. The Director of Engineering (Facilities Manager) prepares a quarterly report of the rate of completion of any Plan for Improvement for the Environmental Safety Committee. If any items will not be completed within the established timeframe plus The Joint Commission allowed six month grace period, the Director of Engineering (Facilities Manager) is responsible for preparing a letter to the appropriate Joint Commission staff requesting an extension of the timeframe or a change of the method of correction.
- 9. Management of Fire Safety Risks (LS.01.02.01 EP1 14)

- a. A program of Interim Life Safety Management based on Interim Life Safety Measures (ILSM) is used to manage degradation of the level of life safety required by NFPA 101 2000-2012 Life Safety Code. The ILSM program consists of a screening tool used to assess the severity of the potential impact of a degraded level of life safety. When risk factors indicate a need to implement one or more of the ILSM, a project specific Interim Life Safety Management Plan (ILSMP) is designed.
- b. The Director of Engineering (Facilities Manager) and Safety Officer are responsible for implementation of the ILSMP. The implementation may include training, installation of engineering controls, posting of temporary advisory signs, and other actions deemed necessary. Affected staff are oriented and drilled, as appropriate, to familiarize them with the Interim Life Safety Management Plan.
- c. The Director of Engineering (Facilities Manager) and Safety Officer are responsible for monitoring the effectiveness of the implementation of the ILSMP. When deficiencies are identified, the Safety Officer and/or the Director of Engineering (Facilities Manager) take appropriate action to resolve the deficiencies.
- d. All monitoring and actions to resolve deficiencies related to an ILSMP are documented. The documentation is presented to the Environmental Health & Safety Committee as part of the quarterly Life Safety Management report to the Committee. All ILSM evaluations, plans, and monitoring documentation are maintained for at least three years.
- 10. The hospital monitors conditions in the environment (EC.04.01.01 EP1 EC.04.01.01 EP11)
 - a. The Director of Risk Management coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Director of Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.
 - b. Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to the Director of Risk Management who in turn works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.
 - c. In addition, the Director of Risk Management and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated form environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Environmental Health & Safety Committee and the Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Officer provides summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.
 - d. The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of Tri-City Healthcare District.
 - e. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven management of the environment of care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.
 - f. The Environmental Health & Safety Committee and the Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.
 - g. The Safety Officer prepares a quarterly report to the leadership of Tri-City Healthcare District. The quarterly report summarizes key issues reported to the Committees and the recommendations of them.

- h. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders of management responsibilities have been carried out. Semi-annual reports are provided to the Board of Directors related to the EC activities.
- 11. Every twelve months the hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan. (EC.04.01.01 EP15)
 - a. The Safety Officer coordinates the annual evaluation of the management plan associated with the Life Safety Management Program functions.
 - b. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care Program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Environmental Health & Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care Program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.
 - c. In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety/Security Officer.
 - d. The Environmental Health & Safety Committee reviews and approves the annual reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, organizational leaders, The Board of Directors, the Patient Safety Committee, and others as appropriate. The manager of each Environment of Care Program is responsible for implementing the recommendations in the report as part of the performance improvement process.
- 12. Analysis and actions regarding identified environmental issues (EC.04.01.03 EP1 3)
 - a. The Environmental Health & Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.
- 13. Improving the Environment (EC.04.01.05 EP1 3)
 - a. When the leadership of the hospital, quality improvement, or patient safety concurs with Environmental Health & Safety Committee recommendations for improvements to the Environment of Care Management Programs, a team of appropriate staff is appointed to manage the improvement project. The Environmental Health & Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.
 - b. The Environmental Health & Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital leadership, performance improvement, and patient safety leadership.
- 14. Orientation and Ongoing Education and Training (LD.03.01.01 EP6 & EP8; HR.01.04.01 EP1

and EC.03.01.01 EP1 – 3)

- a. Orientation and training addressing subjects of the environment of care is provided to each employee, volunteer, and to each new medical staff member at the time of their employment or appointment.
- b. In addition, all current employees complete an annual review of life safety via a CBL module and documented in the Netlearning system.
- c. The Human Resources Department assisted by the Education Department coordinates the general New Employee Orientation (NEO) program. New staff members are required to attend the general NEO program within 30 days of their date of employment. The Human Resources Department maintains attendance records for each new staff member completing the general orientation program.
- d. New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.
- e. The Safety Officer collaborates with the Environment of Care managers, department heads, the Director of Regulatory Compliance and Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed and updated to meet all applicable laws and regulations as necessary.
- f. The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff is able to describe or demonstrate how job related risks are to be managed or eliminated as part of daily work. In addition the Safety Officer evaluates the degree to which staff members understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.
- g. Information about staff knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Environmental Health & Safety Committee. When deficiencies are identified action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

F. GOALS /OBJECTIVES FOR FY17

- Complete an assessment of TCHD compliance to the new 2012 Life Safety Codes and Health Care Facilities Codes and have action plans for any areas found to not meet the new standards.
- 2. Complete a thorough hospital-wide review of all fire alarm and suppression systems by Red Hawk.
- 3. Work with staff to create a better working knowledge and adaption of NFPA 2012 standards to existing policies and procedures.
- 4. Continue to work with staff and contractors in regards to both pre and post activities during construction phases that are necessary to maintain the safety of staff, patients and visitors to the facility.

F.G. REFERENCES:

- 1. The Joint Commission/NFPA Life Safety Book for Health Care Organizations (2013)
- 2. The 2012 Edition NFPA 101 Life Safety Code
- 4.3. The 2012 Edition NFPA 99 Health Care Facilities Code