TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE PROFESSIONAL AFFAIRS COMMITTEE
OF THE BOARD OF DIRECTORS
March 9, 2017 – 12:00 p.m. – Assembly Room 1
Tri-City Medical Center, 4002 Vista Way, Oceanside, CA 92056

The Committee may make recommendations to the Board on any of the items listed below, unless the item is specifically labeled "Informational Only"

	Agenda Item	Page Nos.	Time Allotted	Requestor/ Presenter
1.	Call To Order/Opening Remarks		2 min.	Chair
2.	Approval of Agenda	1-2	2 min.	Chair
3.	Public Comments NOTE: During the Committee's consideration of any Agenda item, members of the public also have the right to address the Committee at that time regarding that item.		5 min.	Standard
4.	Ratification of minutes of the February 2017 Meeting	3-10	2 min.	Committee
5.	New Business			
a.	Consideration and Possible Approval of Policies and Procedures **Patient Care Services** 1. ALARIS System Data Set Approval and CQI Activities Procedure 2. Cardiac Wellness Center (On Campus) Emergency Treatment Standardized Procedure 3. Care of the Newborn Standardized Procedure 4. Deceased Newborn Stillborn, Care of Procedure 5. Enteral Feeding Preparation, Storage, Distribution, and Administration Policy 6. Food Brought in From Outside the Hospital Policy 7. Food Expiration Dates Policy 8. Needle Aspiration Neonates Standardized Procedure 9. Pertussis Nasopharyngeal (NP) Swab, Adult Procedure 10. Physicians Orders for Life Sustaining Treatment (POLST) 393 11. Rapid Response Team and Condition Help Policy 12. Stroke Code, Emergency Department Procedure 13. Telephone Service for Patient Rooms Policy 14. Therapeutic Hypothermia After Cardiac Arrest Procedure 15. Visiting Guidelines **Administrative Policies and Procedures** 1. Code Gray- Hostage Response Plan 283 2. Control for Locks and Keys 243 3. Helicopters on District Policy 4. Mandatory Reporting Requirements **Unit Specific Education** 1. AHA & AWHONN Course Card Acceptance Policy 2. AHA Care and decontamination of AHA Equipment Policy 3. AHA Continuing Education Statement Policy 4. AHA Mission Statement and Goals Policy 5. AHA Quality Assurance Program Policy 6. AHA TC Course Card Management Policy			All

	7. Copyright Policy **Infection Control** 1. Meningococcal Exposure IC 6.2 2. Risk Assessment and Surveillance Plan IC 2 3. Toy Cleaning IC 9.1 **NICU** 1. Blood product Aliquot Syringes, Emergent preparation of 2. Cardio-Respiratory Monitoring in the NICU 3. Neonatal Abstinence Syndrome, Management of Scoring **Women and Newborn Services** 1. Infant Safety and Security			
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 April 13, 2017.		1 min	Chair
12.	Adjournment		1 min	Chair

DRAFT

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

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

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

Others present: Jody Root, General Counsel, Marcia Cavanaugh, Sr. Director for Risk Management, Kathy Topp, Kevin McQueen, Lori Roach, Michelle Musich, Priscilla Reynolds, Mary Diamond, Sharon Davies, Carol Reeling, Patricia Guerra and Karren Hertz.

Members Absent: Jami Piearson, Director of Regulatory Compliance.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell called the meeting to order at 12:01 PM in Assembly Room 1.		Director Mitchell
2. Approval of Agenda	The committee reviewed the agenda; there were no additions or modifications.	Motion to approve the agenda was made by Director Dagostino and seconded by Director Grass.	Director Mitchell
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Mitchell read the paragraph regarding comments from members of the public.		Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Ratification of minutes of January 2017.	Director Mitchell called for a motion to approve the minutes from January 12, 2017 meeting. There were a couple of corrections regarding the Interpretation and Translations Services policy and also in the follow-up section where Director Schallock's name was erroneously written.	The minutes were ratified following the amendments made. Dr. Ma moved and Director Dagostino seconded the motion to approve the minutes from January 2017.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:** 1. Child Passenger Restraint System Education Policy 2. Consent for Operative or Other Procedures 3. Diabetes Education Procedure	There was no discussion on this policy. There was question regarding the consent for surrogates; the issue is there always need to be two physicians present for consent but the policy states only one is needed. Marcia clarified that there are two physicians needed for interdisciplinary conference only but not for the procedural part. There seems to be a continuous challenge with the diabetes education. The challenge is in monitoring the patient's diet to keep their blood sugar at a stable rate. It was also noted that patients with gestational	**ACTION:** The Patient Care Services policies and procedures were approved. Director Dagostino moved and Director Grass seconded the motion to approve the policies moving forward for Board approval with the appropriate corrections noted by the Committee members.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	diabetes are being currently referred to the Sweet Success program.		
4. In Custody Patients' Policy	A clarification made by Diretor Mitchell indicated the difference between an inmate on physical arrest and patients that are in custody. Director Dagostino also noted of the new term "justice involved" for the description of forensic patients.		
5. Knee Immobilizer Application and Range of Motion (ROM) Brace	This policy is being amended and will be approved with the amendments made. Priya Joshi made some modifications to this policy.		
6. Swallow Screening in the Adult Patient Procedure	There was no discussion on this policy.		
Administrative Policies and Procedures:			
1. Administrator On-Call 281	It was noted that there are two separate administrator on-call—one is for clinical since most of the emergent issues are patient-related and other one is administrative which calls out the C-suite involved when there is a house-wide issue after hours.	**ACTION:** The Administrative policies and procedures were approved. Director Dagostino moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Lost and Found Articles-202	Director Dagostino clarified to the group that tthe hospital has a safe for lost and found articles.		
Unit Specific			

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Infection Control 1. Transmissible Spongiform Encephalopathies (TSE)	Dr. Contardo mentioned that new regulations just came out regarding some issues mentioned in this policy.	**ACTION:** This policy will move forward for approval after putting in some updated information provided by Dr. Contardo.	Patricia Guerra
Surgical Services 1. Block Time Policy	It was discussed that Dr. Lee, the Medical Director of OR and Mary Diamond, in coordination with the OR Committee regularly reviews the surgery schedule to avoid unnecessary block of time that the OR is not being used.	**ACTION:** This Surgery policies were approved. Dr. Ma moved and Director Dagostino seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Bumping Surgery Procedures Policy	In cases of emergent situation, the communication between physicians is very vital to avoid bumping surgery cases.		
3. Disaster and Emergency Preparedness Policy	This policy encompasses the emergency preparedness of the OR.		
4. OR Committee Policy	Dr. Dandy Lee is doing a good job of addressing all the issues in the OR as he heads the OR Committee as well.		
5. Pre-Operative Requirements Policy	There was no discussion on this policy.		
6. Safe Medical Device Act-Tracking and reporting Policy	There was no discussion on this policy.		
7. Scheduling Surgical Services Policy	Mary Diamond emphasized that sometimes there needs to be clarity in the time		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	specified. If a patient was told that he/she is having surgery at 7:30AM; that means he/she needs to be inside the OR area being prepped up and not in the waiting area.		Patricia Guerra
8. Scope of Services for Surgical Services Policy	It was noted that there needs to be a parameter for the scope of services intended for adults and then for pediatrics.		
Telemetry			
1. Assignments	Sharon mentioned that RNs in Telemetry unit have ACLS assignment too.	**ACTION:** The Telemetry policy and procedure was approved. Director Dagostino moved and Director Grass seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Women's and Newborn Services			
1. Hydralazine Hydrochloride	This policy is being deleted since the policy pertaining to hypertension includes this policy already.		
2. Neonatal Team Attendance at a Delivery	Sharon Davies reported that a neonatologist is always present in the OB department for either in emergent or elective deliveries. It was also noted that only a neonantologist or NP can intubate a baby.	**ACTION:** Upon Dr. Johnson's recommendation, it was agreed that Sharon D. will ask the people to introduce themselves on deliveries so the staff and patient is aware of who is present in the room.	Sharon Davies
3. Standards of Care: Newborn	The checking of vitals signs is always a part of the standards of care for a newborn.		
4. Standards of Care:	There was no discussion on this policy	**ACTION:** The Women's and Newborn Services policies were	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Postpartum		approved. Director Dagostino moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.	
6. Clinical Contracts	No contracts were reviewed for this month.	**ACTION:** No action taken.	Director Mitchell
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Director Dagostino moved, Dr. Ma seconded and it was unanimously approved to go into closed session at 1:00 PM.	Director Mitchell
8. Return to Open Session	The Committee return to Open Session at 2:10 PM.		Director Mitchell
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Mitchell
10. Comments from Members of the Committee	No comments.		Director Mitchell
11. Adjournment	Meeting adjourned at 2:11 PM.		Director Mitchell

PROFESSIONAL AFFAIRS COMMITTEE
March 9th, 2017

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Alaris System Data Set Approval and CQI Activities Procedure	3 year review, practice change	
2. Cardiac Wellness Center (On Campus) Emergency Treatment Standardized Procedure	2 year review, practice change	
3. Care of the Newborn Standardized Procedure	2 year review, practice change	
4. Deceased Newborn, Stillborn, Care of Procedure	3 year review, practice change	
5. Enteral Feeding Preparation, Storage, Distribution, and Administration Policy	3 year review, practice change	
6. Food Brought in from Outside the Hospital Policy	3 year review, practice change	
7. Food Storage on Nursing Units Policy	3 year review, practice change	
8. Needle Aspiration Neonates Standardized Procedure	2 year review, practice change	
9. Pertussis Nasopharyngeal (NP) Swab, Adult Procedure	3 year review, practice change	
10. Physicians Orders for Life Sustaining Treatment (POLST) 393	3 year review, practice change	
11. Rapid Response Team and Condition Help (H) Policy	3 year review, practice change	
12. Stroke Code, Emergency Department Procedure	3 year review, practice change	
13. Telephone Service for Patient Rooms Policy	3 year review, practice change	
14. Therapeutic Hypothermia after Cardiac Arrest Procedure	3 year review, practice change	
15. Visiting Guidelines 301	3 year review	
Administrative Policies & Procedures		
1. Code Gray - Hostage Response Plan 283	3 year review, practice change	
2. Control of Locks and Keys 243	3 year review, practice change	
3. Helicopters on District Policy 207	3 year review, practice change	
4. Mandatory Reporting Requirements 236	practice change	
Unit Specific		
Education		
1. AHA & AWHONN Course Card Acceptance Policy	3 year review, practice change	
2. AHA Care and Decontamination of AHA	3 year review,	

PROFESSIONAL AFFAIRS COMMITTEE
March 9th, 2017

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Equipment Policy	practice change	
3. AHA Continuing Education Statement Policy	3 year review, practice change	
4. AHA Mission Statement & Goals Policy	3 year review, practice change	
5. AHA Quality Assurance Program Policy	3 year review, practice change	
6. AHA TC Course Card Management Policy	DELETE	
7. Copyright Policy	3 year review, practice change	
Infection Control		
1. Meningococcal Exposure IC 6.2	3 year review, practice change	
2. Risk Assessment and Surveillance Plan IC 2	1 year review, practice change	
3. Toy Cleaning IC 9.1	3 year review, practice change	
NICU		
1. Blood Product Aliquot Syringes, Emergent Preparation of	2 year review, practice change	
2. Cardio-Respiratory Monitoring in the NICU	3 year review, practice change	
3. Neonatal Abstinence Syndrome, management of Scoring	3 year review, practice change	
WNS		
1. Infant Safety and Security	3 year review, practice change	

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**ALARIS SYSTEM DATA SET APPROVAL AND CQI ACTIVITIES**
Purpose:	To outline the process for modification/approval of the Guardrails data set on infusion pumps and evaluation of CQI reports and data.

A. **PROCEDURE**

1. **Modification of existing Data Set**
   a. Requests for data set revision by Registered Nurses (RNs):
      i. Requests for data set revision may be submitted by any RN to the Clinical Educator for their unit.
      ii. The Clinical Educator shall determine if the change has merit and if a consensus from the staff utilizing that data set profile approve of the change.
      iii. If the change is still recommended, then the Clinical Educator shall forward the request to the Alaris CQI Task Force.
      iv. Changes shall be submitted to the Pharmacy & Therapeutics (P&T) Committee and forwarded to Medical Executive Committee (MEC) for Medical Staff approval.
      v. Upon Medical Staff approval, changes shall be submitted to the Board of Directors (BOD) for final approval.
   b. Requests for data set revision by the Medical Staff: Requests for data set revision may be submitted by any medical staff member to the Pharmacy Clinical ~~Specialist~~**Manager**. These requests shall be submitted to P&T Committee, MEC, and BOD for approval.
2. **Fast-track Approval of Data Sets**
   a. Fast-track approval of data set changes/edits may be granted by the Pharmacy Clinical ~~Specialist~~ **Manager** if deemed necessary and in the best interest of patient safety. These changes may be put into effect without delay, but must be submitted through the standard approval process after fast-track approval.
3. **CQI Data Review**
   a. CQI Data and Reports – Medical Staff: CQI data and reports shall be submitted to the P&T Committee on a quarterly basis. Pertinent information, trends identified, and recommended CQI initiatives shall be summarized and reported to MEC.
   b. CQI Data and Reports – Hospital Staff: A multi-disciplinary task force (Nursing, Pharmacy, Process Improvement) shall have access to the CQI data and reports via the Alaris CQI data software. Profile specific CQI initiatives shall be identified and improvement tracked and trended. Reports to Nursing Professional Practice Council (NPPC) shall occur on an ongoing basis (at least quarterly).
   c. Practitioners for Each Profile shall be identified as *CQI Champions* to facilitate the dissemination of progress made to the unit staff and the communication between the NPPC and the end-users of the Alaris pump system.

Revision Dates	Clinical Policies & Procedures	Nurse Executive Council	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
10/05; 12/00; 06/08, **11/16**	04/11, **12/16**	04/11, **01/17**	**n/a**	**02/17**	05/11, **n/a**	06/11	06/11

Tri-City Medical Center
Oceanside, California

~~STANDARDIZED PROCEDURES MANUAL~~PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: CARDIAC WELLNESS CENTER (ON CAMPUS) EMERGENCY TREATMENT

I. **POLICY:**

A. Function: Safe and standardized management of unexpected cardiovascular events or exercise related changes in cardiovascular status including, but not limited to, acute angina or change in anginal pattern, stable angina, chest wall/incisional/musculoskeletal pain, cardiac dysrhythmias, hypotensive/syncopal episodes, and acute dyspnea.

B. Circumstances:
1. Setting: Cardiac Rehabilitation service area (on campus), Tri-City Medical Center
2. Supervision: RN; upon arrival of a physician, nursing staff shall follow physician orders instead of standardized procedure.
3. Patient contraindications – Patients with written orders to the contrary of the Standardized Procedure. Patients with Special Considerations:
   i. No Code – A no-code is synonymous with "no resuscitation" or "do not resuscitate".

C. Definitions:
1. Acute angina: Pain, pressure, heaviness, burning sensation, indigestion. May be felt in center of chest, arms, neck, jaw, and shoulders. Other symptoms may include weakness, shortness of breath, diaphoresis, nausea vomiting (1 or more symptoms may be present.)
2. Change in Anginal pattern: Change in frequency, duration, and pattern of angina.
3. Stable Angina: Angina symptoms are relieved with rest or nitroglycerin.
4. Chest wall/incisional/musculoskeletal pain: Atypical pain associated with movement, stretching, straining, coughing, and palpable tenderness.
5. Cardiac Dysrythmias: Any rhythm other than sinus rhythm that requires immediate intervention due to life threatening potential or that results in the patient becoming symptomatic (compromised).
6. Hypotensive/syncopal episodes: Any decrease in blood pressure of 30 - 40 mmHg or more from pre-exercise levels or less than 80 mmHg systolic associated with symptoms.

D. Data Base:
1. Subjective: Patient complaints including, but not limited to, pain, pressure heaviness, burning sensation, indigestion felt in center of chest, arms, neck, jaw, shoulders. Other symptoms may include weakness, shortness of breath, nausea, dizziness, light-headedness, and confusion.
2. Objective: Cardiac rate and rhythm disturbances, decreased level of responsiveness, hypotension, labored respiration, oxygen saturation less than 92%, diaphoresis, vomiting.
3. Assessment: Unexpected cardiovascular events/exercise related changes in cardiovascular status.
4. Plan:
   i. Initiate standardized procedure as appropriate and notify cardiologist or primary physician (if no cardiologist) as soon as possible.
   ii. Call CODE BLUE by dialing 66 to respond to Cardiac Wellness Center as appropriate.

Department Review	Clinical Policies & Procedures	Nurse Executive Council	Division of Cardiology	Pharmacy & Therapeutics Committee	Interdisciplinary Practice Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
9/02; 3/10;12/12, **6/16**	3/10;2/13, **08/16**	12/10;2/13, **09/16**	**10/16**	1/11;5/13, **11/16**	1/11;9/13, **01/17**	2/11;10/13, **02/17**		8/03, 1/05, 6/06, 8/08, 2/11;10/13

iii. Assist with transportation of patient to Emergency Department (ED) via wheelchair or gurney as appropriate. Provide protection of umbrella to protect patient from rain or inclement weather during transportation.

II. **PROCEDURE:**

A. **ACUTE ANGINA OR CHANGE IN ANGINAL PATTERN:**

1. Stop exercise
2. Assess patient's blood pressure, SpO_2, heart rate and rhythm, lung sounds, respirations, color and mentation. Assess chest pain (location, severity, character).
3. Administer oxygen to maintain SpO_2 greater than 95%.
4. Administer nitroglycerin (NTG) spray or tablets 0.4 mg sublingual at 5-minute intervals, not to exceed three sprays for symptoms of angina unrelieved by rest.
   i. If chest pain is unrelieved after 3 NTG sprays, transport to ED for further evaluation.

B. **STABLE ANGINA:**

1. Administer prophylactic nitroglycerin as indicated and per physician order.
2. Assess and document patient's response to nitroglycerin and exercise.
3. Assess patient's blood pressure, heart rate and rhythm, respirations, color and mentation.
4. Stop activity if angina is unrelieved and proceed as for acute angina.

C. **CHEST WALL/INCISIONAL/MUSCULOSKELETAL PAIN:**

1. Evaluate cause of pain.
2. Assess blood pressure, heart rate and rhythm, respirations, color, and mentation.
3. Discontinue modalities that aggravate symptoms, or decrease workloads.
4. Notify physician if symptoms persist.
5. Document assessment and treatment on patient's chart.
6. Re-evaluate at next exercise session.

D. **TREATMENT FOR DYSRHYTHMIAS THAT MAY RESULT IN CARDIOPULMONARY ARREST:**

1. Assessment
   i. Establish baseline if time allows and patient is stable (Historical Data)
      a) Review baseline ECG
      b) Review medications
      c) Inquire regarding the use of stimulants (i.e. caffeine, smoking, cold remedies)
   ii. Evaluation of new arrhythmias
      a) Evaluate hemodynamic status, i.e., blood pressure, heart rate, skin color and temperature, lightheadedness, dizziness, shortness of breath.
2. Treatment
   i. Ventricular fibrillation and pulseless ventricular tachycardia, asystole, PEA
      a) **Call Code Blue**~~Begin BLS~~
      b) **Begin BLS**~~Call CODE BLUE~~
      ~~c) Administer oxygen to maintain SPO_2 greater than 95%~~
      ~~d)~~**c)** Place on a cardiac monitor
   ii. Symptomatic Cardiac Rhythm: Complete heart block, symptomatic bradyarrhythmia or tachyarrhythmia
      a) Administer oxygen to maintain SPO_2 greater than 95%
      b) Place on a cardiac monitor
      c) Alert Lift Team/Rapid Response Team **(RRT)** to assist with immediate transport to ED
   iii. New changes in cardiac rhythm: stable bradyarrhythmia or tachyarrhythmia, new onset atrial fibrillation, increase in premature ventricular contractions (PVC), or runs of stable ventricular tachycardia
      a) Stop exercise

b) Assess patient's blood pressure, respiratory rate, SPO_2 percentage, skin color, temperature, mentation, and other symptoms
c) Administer oxygen to maintain SPO_2 greater than 95%
d) Contact physician for further orders
e) Transport to ED with assistance of Lift Team if necessary

E. **HYPOTENSIVE EPISODES:**
1. Assist patient to supine position.
2. Assess blood pressure, heart rate, rhythm, respiration, oxygen saturation, skin color, temperature, mentation, and presence of other symptoms.
3. Administer oxygen to maintain SPO_2 saturation greater than 95%
4. Notify physician
5. If no improvement, transport to the ED

F. **ACUTE DYSPNEA:**
1. Stop exercise.
2. Assess oxygen saturation by pulse oximetry
   i. If oxygen saturation is less than 92%, place patient on oxygen and titrate to oxygen saturations greater than 95%.
3. Assess breath sounds
4. Assess patient for use of rescue drug inhalers and encourage patient to use inhaler if available.
5. Notify physician if symptoms do not improve and transport to the Emergency Department **(ED)** via wheelchair or gurney.

G. **LEFT VENTRICULAR ASSIST DEVICE (LVAD):**
1. Check to see if pump is still working**:**
   i. Look to see if all lights are green
   ~~i.~~**ii.** ~~(~~Listen for quiet whirling sound with stethoscope or feel by placing hand over abdomen~~).~~
2. Check that all connections to power source and fix if loose or disconnected.
3. Replace current batteries with a new, fully charged pair.
4. Contact LVAD coordinator
5. If patient unstable, **call RRT to assist with immediate transport to ED**~~start ACLS protocol~~
   i. No~~WITHOUT~~ compressions~~.~~
   ii. Keep all connections together if defibrillation is necessary,
      a) DO NOT stop pump prior to delivering shock.

H. **DOCUMENTATION:**
1. Document event, intervention, and response in the medical record and notify the physician.
2. Record subjective data
3. Record rhythm strip, blood pressure, heart rate, oxygen saturation
4. Send information to primary physician/cardiologist

III. **REQUIREMENTS FOR CLINICIANS PROVIDING INTERVENTIONS:**
A. Current California RN license.
B. Education: Successful completion of ACLS course (with current course completion card), performance of annual mock code.
C. Experience: Initial job requirements.
D. Initial Evaluation: During Orientation period.
E. Ongoing Evaluation: Annually

IV. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**
A. Method: This standardized procedure was developed through collaboration with Nursing, Medicine, and Administration.
B. Review: Every two (2) years.

V. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**

A. All ACLS-certified Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform Cardiac Wellness Center (On Campus) Emergency Treatment Standardized Procedure.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: CARE OF THE NEWBORN

I. **POLICY:**

A. Function: To define the care and immediate treatment post-delivery for the newborn weighing greater than or equal to 2000 grams that is equal to and are greater than 35 6/7 weeks gestational age.

B. Circumstances:

1. Setting: Labor and Delivery **(L&D)**, Newborn Nursery, and Mother-Baby
2. Supervision: None required. Physician's office/answering service will be notified of delivery time and date.
3. Requires that a **Registered Nurse** (RN) provide immediate care to administer medications, provide nutrition and/or nutritional support, and to perform procedures, laboratory and diagnostic tests that are considered to be routine care to the well born term or near term newborn infant.
4. The Women and Newborn Services (WNS) RN must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.

II. **PROCEDURE:**

A. Newborns greater than or equal to 2000 grams and who are greater than 35 6/7 weeks gestational age shall receive:

1. Prophylactic treatment of eyes (Erythromycin ophthalmic ointment) and medication to normalize coagulation (Vitamin K) within 2 hours of delivery time.
   a. Refer to Patient Care Services (PCS) s**S**tandardized p**P**rocedure (SP)**:** Administration of Vitamin K Injection and Erythromycin Ophthalmic Ointment to the Newborns.
   b. Exception: Parents who refuse verbal consent.
2. The newborn shall receive Hep**atitis** B vaccine or Hep**atitis** B vaccine/HBIG immunoglobulin injection if indicated according to the mother's HBsAg status and within 12 hours of delivery time.
   a. Refer to PCS SP: Administration of Pediatric Hepatitis B Vaccine and Hepatitis B Immunoglobulin (H**BIG**~~big~~) (Hyper B Sd®) to Newborns.
   b. Exception: Parents who refuse verbal consent.

B. Infant nutrition:

1. Breastfeeding
   a. Initiate feedings as soon as possible but no longer than 2 hours following delivery.
      i. If cesarean delivery, as soon as possible (ASAP) when mother and infant are reunited.
      ii. If mother and infant are separated for longer than 3 hours, initiate breast-pumping (even if mother going to NICU to breastfeed).
      iii. If mother and infant are separated for longer than 3 hours, initiate breast-pumping (even if mother going to NICU to breastfeed).
         1) Refer to WNS Procedure: Breast Milk, Pumping, Handling and Storage of.
      iv. Assess and attempt to feed 8 or more times within a 24 hour period-approximately every 2-3 hours and on demand.

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Division of Neonatology	Department of Pediatrics	Pharmacy & Therapeutics Committee	Interdis-ciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
04/15	8/12, 11/13, 4/15, 6/16	8/12,11/13, 4/15, 7/16	08/16	05/15, 11/16	9/12,11/13, 05/15, 11/16	11/12, 2/14, 09/15, 01/17	4/13, 2/14, 09/15, 02/17	10/15	4/13;2/14; 10/15

v. No supplementation of formula unless ordered by provider, requested by mother or as per other procedures where supplementation is required.
vi. Obtain lactation consult as clinically indicated
1) Refer to WNS ~~p~~**P**olicy: Infant Feeding.

2. Bottle-feeding
a. Offer bottle with formula of mother's choice, ~~20 Kcal/ounce,~~ by 3 hours of age
i. Assess feeding status every 3-4 hours, offer formula PRN and on demand.
ii. Refer to WNS ~~p~~**P**rocedure: ~~Bottle~~**Formula** Feeding.

C. Procedures:
1. Newborn hearing screen
a. Ensure hearing screen is ordered per WNS ~~p~~**P**olicy: Hearing Screening **Program:** Newborn and Infant**s**.
2. Obtain Total Serum Bilirubin at approximately 24 hours of age or sooner if baby visually appears to have jaundice.
a. If greater than or equal to 95th percentile (high risk zone) on Bhutani's curve (per hours of age**)** notify provider.
b. Notify provider of Total Serum Bilirubin prior to discharge if he/she is not already aware of the result and the baby will not be rounded on/seen again by a pediatrician prior to discharge.
3. If infant Coombs positive, order CBC with manual differential, retic count, and total serum bilirubin STAT and call provider with results.
a. Contact physician immediately upon return of test results.
4. All infants meeting criteria will have a car seat challenge performed prior to discharge as per WNS/Neonatal Intensive Care Unit (NICU) ~~p~~**P**rocedure: Car Seat Challenge Test.
5. All infants meeting criteria will have neonatal abstinence scoring performed as per WNS/NICU ~~p~~**P**rocedure: Neonatal Abstinence Scoring.
6. All infants will have pulse oximetry done after 24 hours of life or prior to discharge per PCS SP**:** Universal Blood Saturation Screening for Critical Congenital Heart Disease (CCHD).

D. Laboratory tests:
1. Point of care glucose testing
a. Perform per PCS **SP:** Blood Glucose Newborn Monitoring ~~Standardized Procedure~~.
2. Toxicology
a. Obtain a urine specimen if mother has a positive toxicology screen, a positive history of substance use, is suspected of substance use or with diagnosis, has had less than or equal to three prenatal visits, or suspicion of placental abruption.
i. If positive for cocaine, amphetamines and or opiates, lab will perform a confirmation.
b. Obtain a urine specimen on all babies assigned to Neonatology.
3. Cord blood screen (Direct Coombs and blood typing) ASAP
4. Newborn metabolic screen prior to discharge but at least 24 hours following delivery.
a. Refer to PCS ~~p~~**P**rocedure: Newborn Screen**ing**, Collection of Specimen.
5. Perform CBC with manual differential and blood culture on newborn between 6 - 12 hours of age if:
a. If Mother is GBS positive, ~~and~~ received no treatment or **received a dose** ~~1 dose only~~ of antibiotics less than 4 hours prior to delivery
i. Infant is either less than 37 weeks estimated gestational age (EGA)
~~5.~~**ii. Infant is greater than 37 weeks EGA , but mother had a rupture of membranes greater than 18 hours:**
~~a. Perform CBC with manual differential and blood culture on newborn between 6 - 12 hours of age~~
~~i.~~**6.** Notify provider of CBC with manual differential results if abnormal
~~1)~~**a.** Abnormal CBC for infant, at least one of the following:
~~a)~~**i.** WBC greater than 35,000 or less than 9,000
~~b)~~**ii.** ANC less than 1500

~~c)~~**iii.** Platelet Count less than 120,000

E. Call provider immediately for maternal/infant signs of chorioamnionitis/infection or the following symptoms ~~:prior to delivery~~
   1. Maternal temperature greater than or equal to 100.4 degrees Fahrenheit plus two or more of the following:
      a. Maternal tachycardia (greater than 100bpm)
      b. Fetal tachycardia (greater than 160bpm)
      c. Uterine tenderness
      d. Foul smelling amniotic fluid
      e. Maternal leukocytosis (greater than 15,000 WBC)

III. DOCUMENTATION:

A. Document assessment, actions and provider notification/response in electronic health record (EHR) as appropriate.
B. When administering medications or implementing orders from a standardized procedure, the Registered Nurse shall enter the medication/order into the **(EHR)**~~electronic health record~~ as Standardized Procedure.
   1. Not required if a screening process triggers the order.
   2. Utilizing **Computerized Physician Order Entry** (CPOE), select the Standardized Procedure (SP) power plan **PCS** SP**:** Newborn Admit.
   3. Type in provider's name and select "Standardized Procedure" as the order communication type.
C. Initiate, sign and refresh Newborn Medications power plan prior to birth in order to readily access medications in Pyxis.
D. Prior to administration of vaccines **see PCS Policy: Vaccination Administration**~~provide a copy of the Center for Disease Control (CDC) Vaccine Information Statements (VIS) to the newborn's mother/legal guardian and document in Cerner. Document the name and edition date of the VIS in the "comments" section of the e-mar and in care plan.~~
~~E. Document administration and injection sites of medications on the Cerner electronic Medication Administration Record (eMAR). Including: manufacturer, lot number and expiration date for all vaccines administered.~~
~~F. Document administration of vaccine on the yellow California Immunization Record card. Give this record to the mother/legal guardian with instructions to take the card with her/him to all infant healthcare provider visits at discharge.~~
~~G.~~**E.** Document patient (mother/legal guardian) teaching in the education section of the EHR.
~~H.~~**F.** Total serum bilirubin will be documented in the EHR.
~~I. Document newborn screen specimen collection in EHR.~~
~~J. Document newborn hearing screen in EHR.~~
~~K. Document car seat challenge, if appropriate, in EHR.~~
~~L. Document neonatal abstinence score, if appropriate in EHR~~
~~M. Document the universal blood saturation screening in the EHR.~~

IV. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. Current California RN license working in Women's and Children's Services
B. Education: Register Nurse
C. Initial Evaluation: Orientation
D. Ongoing Evaluation: Annual

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
B. Review: Every two (2) years.

VI. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform "Care of the Newborn" Standardized Procedure.

VII. **RELATED DOCUMENTS:**

A. PCS Policy: Vaccination Administration
~~A.~~**B.** PCS Procedure: Newborn Screen**ing**, Collection of Specimen
~~B.~~**C.** PCS Standardized Procedure: Administration of Vitamin K Injection and Erythromycin Ophthalmic Ointment to Newborns
~~C.~~**D.** PCS Standardized Procedure: Administration of **Pediatric** Hepatitis B Vaccine and **Hepatitis B** Immunoglobulin (HBIG) **(Hyper B Sd®)** to Newborns
~~D. PCS Standardized Procedure - Erythromycin Ophthalmic Ointment to the Newborns~~
~~E. PCS Standardized Procedure - Hepatitis B Immunoglobulin (Hbig) (Hyper B Sd®) to Newborns~~
~~F.~~**E.** PCS Standardized Procedure: Blood Glucose Newborn Monitoring
~~G.~~**F.** PCS Standardized Procedure: Universal Blood Saturation Screening for Critical Congenital Heart Disease (CCHD)
G. WNS Policy: Infant Feeding
H. **WNS Policy: Hearing Screening Program: Newborn and Infants**
I. WNS Procedure: ~~Bottle-Feeding~~**Formula Feeding**
J. WNS Procedure: Breast **Milk,** Pumping**, Handling** and ~~Milk~~ Storage **of**
K. WNS/NICU Procedure: Car Seat Challenge Test
L. WNS/NICU Procedure: Neonatal Abstinence Scoring

VIII. **REFERENCES:**

~~A. Thureen, Deacon, Hernandez, Hall. Assessment and care of the well newborn 2nd edition. St. Louis, Missouri: Elsevier Saunders 2005. pp 91-92.~~
~~B.~~**A.** AWHONN Core curriculum for Maternal-Newborn Nursing 4th edition. St Louis, Missouri: Elsevier Saunders 2007. pp 427- 429.
B. Gilstrap, L.C. ed., et al. Guidelines for Perinatal Care, 7th Edition. AAP & ACOG 2012.
C. Schrage, S. et al: Prevention of Perinatal Group B Streptococcal Disease: Revised Guidelines from CBC. MMWR, 2010; 59 (no. RR 10): November 19, 2010.
~~C.~~**D. Thureen, Deacon, Hernandez, Hall. Assessment and care of the well newborn 2nd edition. St. Louis, Missouri: Elsevier Saunders 2005. pp 91-92.**

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**PERINATAL DEATH~~DECEASED NEWBORN/~~ (MISCARRIAGE, STILLBIRTH~~BORN,~~ AND NEONATAL DEATH CARE ~~OF~~ AND DISPOSITION**
Purpose:	To assist the family in cope~~ing~~**ing** with **a perinatal death via miscarriage, stillbirth or neonatal** ~~the~~ death**, obtain mementos, if applicable** ~~of their newborn~~ and provide postmortem care. Families experiencing a Perinatal death ~~or miscarriage~~ shall be provided ~~a~~ support~~ive atmosphere~~ for grieving.
Supportive Data:	~~To facilitate bonding, separation, and loss of their newborn and provide time for expression of feelings, asking of questions in preparation for the grief process.~~**Data shows that assisting families ~~to make~~in making memories during a perinatal death helps ~~to~~ validate the lost life and can help facilitate an effective grieving process. Use of multidisciplinary resource support during this time also has a vital role in helping these grieving families~~families who are grieving~~.**
Equipment:	1. Personal protective equipment 2. Infant scale 3. Disposable measuring tape 4. ID bracelets**, if applicable** 5. **Disposition preparation items for transfer to the morgue** ~~Shroud —~~ (Chux, baby blanket, **instrument packing**~~disposable~~ drape, ~~and~~ tape **and 3x 5 card)** 6. Authority for Release of Deceased/ **Miscarriage** Form — triplicate**, if applicable** 7. Authorization for Autopsy form, if applicable 8. Camera 9. Grief packet, including: • Checklist for assisting parent experiencing neonatal death/stillborn • Mementos **folder**~~booklet~~ • Care Plan – Perinatal Loss • Discharge Instruction Form

A. **POLICY:**

1. **Families who experience ~~the~~a perinatal death during pregnancy or shortly after birth may grieve for their baby and the loss of an entire lifetime with that child. Caring, supportive people can help families move through the initial crisis toward re-establishing their lives without their babies.**
2. **It is important to meet the needs of bereaved parents and their family during the initial crisis of their perinatal loss by offering comprehensive care that includes compassion and an interdisciplinary perspective.**

~~1. Inform the necessary personnel, when a patient with a known perinatal loss is admitted.~~
~~2. The attending physician shall be notified of the perinatal loss.~~
~~3. If the patient has not been previously informed of the loss, the attending physician shall inform patient of miscarriage/perinatal death.~~
~~4. The attending physician shall diagnose/confirm fetal death with ultrasound.~~
~~5. The patient's response shall be documented in the medical record.~~
~~6. Contact the Women's & Children's Services Social Worker to provide support and supplies.~~
~~a. Psychological support and privacy shall be provided; Social Services to assist.~~
~~7. The plan of care shall be discussed with the patient. Encourage the mother to conduct labor as she originally planned.~~
~~8. The patient and her family shall be encouraged to express their thoughts and feelings.~~
~~a. Social Services shall be notified for consult.~~
~~9. The nurse shall verify the patient's blood type and notify physician if RhoGam is indicated.~~
~~10. The patient shall be recovered in an area away from other delivered patients, if possible.~~

Revision Date	Clinical Policies & Procedures	Nursing Executive Council	Department of OB/GYN	Division of Neonatology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
12/08; 6/11	04/11, 10/16	04/11, **10/16**	**12/16**	**01/17**	n/a	05/11, **02/17**	06/11	06/11

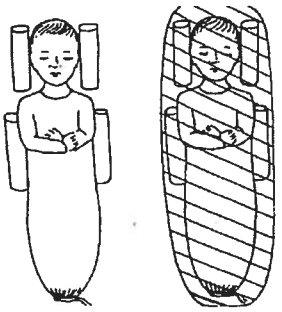
B. **PROCEDURE:**

1. **Miscarriage**
   a. **Assign patient to a room away from other patients and unit activity to promote a private and quite atmosphere free from chaos, laboring patients and crying babies if possible.**
      i. **If miscarriage greater than 16 weeks estimated gestational age (EGA),**
      ii. **occurs in the ED and the ED provider initiates an Obstetrical consult, arrangements may be made to transfer the patient to the labor and delivery (L&D) unit for admission and care coordination, as available.**
      iii. **Efforts shall be made to ensure the patient has necessary supports to assist her through this difficult time if not already present.**
2. **Newborn or stillbirth**
   a. **Complete the same patient admission requirements to the unit per standards of care for the patient and for the newborn if born alive. See Standards of Care for Intrapartum, Postpartum and Newborn Care.**
      i. **If the delivery is a stillbirth, there will NOT be a medical record created for baby. All of the delivery information is charted in the mother's chart.**
         1) **Identification band information shall be entered on the bands manually and include:**
            a) **Last name and baby's sex, if known**
            b) **Patient's first and last name**
            c) **Patient's medical record number**
         2) **Attach one band to the stillbirth's arm for identification for remains disposition.**
         3) **The other baby band/parent bands can be saved and included as a part of the memory making process.**
      ii. **If the delivery is a LIVE birth, but then later dies, the banding process for the baby is followed per unit routine and is usually computer generated.**
         1) **One band shall remain on the baby's arm for identification for remains disposition.**
         2) **The other baby band/parent bands can be saved and included as part of the memory making process.**
      iii. **The patient shall be included in the decision of where she would like to remain post delivery and for the remainder of her stay. Transfer off the unit may be coordinated with a providers order, once the patient is stable, and as indicated.**
3. **Staffing considerations should include recognition that this situation may require more intense psychosocial and emotional support and assignments adjusted, as indicated.**
4. **Post a special bereavement card outside the entrance to the patient to notify staff entering the space that a loss/ death has occurred to ensure sensitivity.**
5. **Inform Social Services and/or pastoral care of the perinatal death to ensure alternate support measures are offered to the family.**
   a. **Social Services can evaluate any psychosocial needs, provide bereavement support and discuss disposition options with the family if desired.**
      i. **For miscarriage see Patient Care Service Procedure: Miscarriage and Stillbirth Identification and Disposition Process ~~is usually disposed of by hospital regulations, but the family does have options if they would like the remains to be taken to a funeral home for processing instead~~.**
      ii. **A "Comfort Cub" may be given to the family to assist with bereavement support and shall be determined by the social worker.**

b. Pastoral care provides both spiritual comfort and support to families and can provide blessings, naming ceremony, baptism and/or a memorial service as indicated.

6. Discuss the anticipated plan of care with the patient including these options as appropriate: ~~Offer options to the parents, which can include these items:~~
   a. To see and hold their pregnancy, tissue, baby.
      i. The family may wish to hold the newborn/fetus immediately after delivery.
      ii. Care should be taken to treat anything that comes from the mother's body with respect.
      iii. It is helpful to prepare them for what they will see: color, shiny skin, fused eyes, translucency, tiny hands and feet, any defects, skin sluffage, ~~deformaties~~deformities, coloring, etc.
      iv. When handling the remains it is important to use gloves and complete good hand hygiene
      v. Ask the family if they have an outfit they want the baby to wear, a special blanket to wrap him/her, when appropriate
         1) If no outfit, staff can offer donated outfit layettes from the angel room. Have the family select one.
   b. Weigh and measure the length of the remains, if able.
   c. Obtain footprints, if able Or, if loss is small, can trace around the baby's hands, feet and/or body on paper background to represent size.
      i. The application of acetone to the surface of the foot and then use of a black marker (rather than an ink pad) will make prints clearer in this small gestation
   d. Complete newborn identification certificate/card with parent's name and birth information.
   e. Discuss naming the baby
   f. Cut locks of the baby's hair if available.
   g. Obtain photos upon verbal consent ~~Arrange for photos to be taken~~
      i. The parents may take their own photos on personal camera
      ii. A hospital camera may be used for non-medical photography after verbal consent is obtained from the parents.
      iii. When appropriate, attempt to capture candids with the baby and family interactions as well as posed positions to highlight some of the physical attributes of the newborn/stillbirth.
   h. Ask family if they want to bathe the baby and facilitate as indicated.
7. Collect all of the mementos and place them in the memory box including any photos, memento booklet, the outfit the baby was wearing, the blanket and hat and any other mementos.
   a. The Labor and Delivery unit has a dedicated room where the memento box and other memory making supplies are stored.
   b. If parents refuse mementos, they remain in a locked file in Women's & Newborn Services Department.
8. If the family desires to make arrangements for the miscarriage disposition, ensure the Authority for Miscarriage Remains Release form is completed.
      i. Staff should move the remains to an appropriate and private room to prepare for transport.
      ii. It is important that placement of the remains for transport not be done in the parent's presence to ensure dignity is maintained.
      iii. Send remains to the Laboratory using the corresponding tissue requisition and per PCS Procedure: Miscarriage and Stillbirth Identification and Disposition Process.

9. When the family is ready for the stillbirth/newborn remains (baby) to be brought to the morgue, it is important that the preparation and positioning of the baby be performed in a way that combats the combined effects of rigor mortis, algormortis (cooling of the body), and permanent discoloration in case the parents wish to view the baby at another time.
   a. The baby should be unclothed except for a diaper in place, if desired and have an identification band located on its arm.
   b. Place on a chucks pad first, the body supine.
      i. Care should be taken to not place any textured blankets or towels on exposed skin because it may leave permanent impressions.
   c. Support the head in position, by having two rolled towels/chux pads positioned at each side of the head to keep it upright.
      i. If the head is left unsupported, it may fall to one side and blood may collect in the soft facial tissues, leaving permanent discolorations.



   d. Fold the arms with a towel roll inserted under the arms at the side of the body to support the position.
      i. Place the hands crossed or next to each other on the chest.
   e. Wrap the body in the chux and baby blanket mummy-fashion to secure positioning, followed by an instrument packing drape which shall be taped in place.
   f. Complete an index card with the following information and tape it to the outside of the baby's wrap:
      i. Baby's last name and gender (baby girl/baby boy)
      ii. Mother's name and medical record number
         1) May use an admission sticker
         2) Newborn's medical record number if a newborn death
      iii. Date and time of delivery
      iv. Weight (gms) and length (cm)
      v. Attending provider
   g. Coordinate transfer to the morgue per PCS: Release of the Deceased Procedure.
      i. Ensure the morgue log book is completed when bringing baby to and from the morgue for family viewing.
10. Give the family bereavement support material to review as indicated and discharge instructions for follow-up:
   a. Provide information about medical care options available to them by their provider depending on their perinatal loss diagnosis
   b. Include in the plan of care regarding post procedure and/or post delivery options, and disposition options.
   c. For a miscarriage please review the "Authority for Miscarriage Remains Release form" with the family, per Patient Care Services (PCS) procedure: Miscarriage and Stillbirth identification and disposition process.
   d. For a stillbirth or neonatal death, please review the "Release of the Deceased form" with the family per PCS procedure: Miscarriage and Stillbirth identification and disposition process.
11. A grief checklist should be completed to provide information on what has been done.

~~1. Perform hand hygiene and don gloves.~~
~~2. Offer viewing of newborn/fetus to parents before removing infant. The family may wish to hold the newborn/fetus immediately after delivery.~~

~~3. Baptize "conditionally" (refer to Patient Care Services, *Infant Baptism* procedure).~~
~~4. Weigh and measure newborn (refer to Patient Care Services, *Differentiating Intrauterine Fetal Demises from Miscarriages* procedure).~~
~~5. Complete Newborn identification certificate with parent's name and birth information.~~
~~a. Apply footprints of the newborn/fetus.~~
~~b. Save as a memento for the family.~~
~~6. Complete the identification bracelets as follows:~~
~~a. Last name and sex of newborn~~
~~b. Mother's first and last name~~
~~c. Mother's medical record number~~
~~d. Newborn's medical record number~~
~~i. Only newborns born alive will have medical record numbers. Stillborns are not assigned a medical record number.~~
~~7. Attach identification bracelet to arm of newborn. This allows correct identification for mortuary or correct disposition of fetal remains.~~
~~8. Prepare the newborn for viewing as follows:~~
~~a. Groom and clean newborn~~
~~b. Wrap in receiving blankets (place on Chux as a fluid barrier)~~
~~9. Provide privacy for mourning. Allow parents and family to hold newborn if desired.~~
~~10. Complete the following after the family viewing (preparation for the morgue):~~
~~a. Take photos~~
~~b. Place newborn on Chux and wrap in receiving blanket and disposable drape and secure with tape~~
~~11. Complete an index card with the following information:~~
~~a. Newborn's name and gender~~
~~b. Mother's name and medical record number~~
~~c. Newborn's medical record number, if applicable~~
~~d. Date and time of delivery~~
~~e. Weight and length~~
~~f. Attending physician~~
~~12. Prepare mementos for parents and place in envelope:~~
~~a. Pictures of newborn/fetus~~
~~b. Footprint ID Certificate~~
~~c. ID bracelet~~
~~d. Lock of hair, if applicable~~
~~e. Name band with newborn's statistics~~
~~f. Blanket and hat, if applicable~~
~~13. The parents shall be given grief support material, memento booklet, and other mementos including any photos taken by hospital staff for the parents. If parents refuse mementos, they remain on file in Women's & Children's Services.~~
~~14. Complete grief checklist to provide information for others.~~
~~15. Arrange for body to be taken to the morgue.~~

C. **DOCUMENTATION:**

1. Document the **miscarriage and/or delivery information and other interventions in the Perinatal Death Ad Hoc form, including the disposition ~~of the~~with fetal remains**~~following on the Delivery Summary Sheet:~~**.**
~~a. Date and time of stillbirth/fetal demise~~
~~b. Weight and length of newborn~~
~~c. Disposition of newborn/fetal remains~~
~~2. Document all required birth and physical information on Patient Care Record.~~
~~3.~~**2. If born alive, ~~D~~**document **admission items per standards of care in the Electronic Medical Record~~on the Newborn Patient Care Record, if the newborn was born alive:~~, complete Perinatal Death Ad Hoc form, including the disposition of the newborn.**

~~a. Date and time of death~~
~~b. Name of attending physician who pronounced death of newborn~~
~~c. Disposition of newborn~~

~~D. **TECHNICAL NOTES:**~~

~~1. **Health and Safety Code 7054** states that, "(a) Except as authorized pursuant to the sections referred to in subdivision (b), every person who deposits or disposes of any human remains in any place, except in a cemetery, is guilty of a misdemeanor.~~

~~2. **Health and Safety Code 7054.3** states that, "Notwithstanding any other provision of law, a recognizable dead human fetus of less than 20 weeks uterogestation not disposed of by interment shall be disposed of by incineration."~~

~~3. **Penal Code 643** states that "No person knowingly shall dispose of fetal remains in a public or private dump, refuse, or disposal site or place open to public view. For the purposes of this section, 'fetal remains' means the lifeless product of conception regardless of the duration of the pregnancy. Any violation of this section is a misdemeanor."~~

D. RELATED DOCUMENTS:

1. **Patient Care Service Procedure: Miscarriage and Stillbirth Identification and Disposition Process**
2. **Women and Newborn Services Standards of Care for Intrapartum**
3. **Women and Newborn Services Standards of Care Postpartum**
4. **Women and Newborn Services Standards of Care Newborn Care**
5. **Authority for Miscarriage Remains Release Form**
~~5.~~6. **Authority for Release of the Deceased Form**

E. **REFERENCES:**

1. **Wilke, J. & Limbo, R. (2012) *Bereavement training in perinatal death (8th ed.)*. La Crosse: Gunderson Lutheran Medical Foundation, Inc.**
2. **Simpson, K. & Creehan, P. (2014) *AWHONN Perinatal nursing (4th ed.)*. Philadelphia: Lippincott, Williams & Wilkins.**
3. **Rosenbaum, J., Renaud-Smith, J., & Zollfrank, R. (2011) Neonatal end-of-life spiritual support care. The Journal of Perinatal and Neonatal Nursing 25(1), 61-69.**
~~1. TCMC Pathology Department – Histology Policy and Procedure Manual.~~
~~2.~~4. Mattson, S., & Smith, J.E. (2011). *Core-curriculum to maternal-newborn nursing.(4th Ed.)*. Philadelphia: Saunders.
~~3. Besuner, P. (2007). *AWHONN Templates for Protocols and Procedures for Maternity Services, (2nd Ed.).*~~
~~California Penal Code Section 643~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 2/94

SUBJECT: Enteral Feeding Preparation, Storage, Distribution, and Administration

REVISION DATE: 4/00; 10/02, 6/03, 7/05, 8/07, 5/10, 3/13

POLICY NUMBER: IV.AA.3

Department Approval:	01/17
Clinical Policies & Procedures Committee Approval:	~~03/13~~02/17
Nurse Executive~~Patient Care Quality~~ Committee Approval:	~~03/13~~02/17
Medical Staff Department/Division Approval Date(s):	n/a
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	n/a
Professional Affairs Committee Approval:	05/13
Board of Directors Approval:	05/13

A. **PURPOSE:**

1. To assure proper preparation, storage, distribution, and administration of enteral feedings.

B. **POLICY:**

1. Food & Nutrition Services is responsible for preparation, storage and distribution of enteral feedings.
2. Nursing shall administer enteral feedings to patients.
3. Most enteral formulas utilized shall be prepared and packaged by various medical nutritional companies and shall be available in cans or closed system liter bottles.
4. Homemade, blenderized formulas shall not be processed at Tri-City Medical Center.
5. Canned or bottled enteral formulas shall be stored in the nursing pantry areas.
   a. Opened cans of formula shall be labeled with the date and time of expiration, and refrigerated and discarded if not used within 24 hours.
   b. Unopened cans of formula shall be discarded on manufacturer's expiration date.
6. Nursing and Food & Nutrition shall process orders for enteral feedings. Food & Nutrition Service workers shall process and gather product for delivery to nursing station via food carts after the tube feedings are verified for accuracy by the Food & Nutrition supervisor.
7. Closed feeding system hang times shall be according to the labeled manufacturer's recommendation. Document the date and time the container is opened on the container. Attach new tubing with each container.
   a. ~~Closed feeding systems, bags, and tubing are good for forty-eight (48) hours.~~ Label feeding system tubing with *change day sticker* indicating date tubing is to be changed using numerical day and month.
8. Formula used in an open system should be changed every **eight hours for adult patient and every** four hours **for neonates**, the tubing and the bag shall be flushed thoroughly with tap water; any existing formula shall be discarded and new formula should be added.
   a. Open system bags and tubing should be changed every 24 hours. Label the open system bag with date and time formula is first placed in the bag. Label feeding system tubing with change day sticker indicating date tubing is to be changed using numerical day and month.

C. **REFERENCES:**

~~a.~~**1. ASPEN Guidelines (2012)**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 5/78	**SUBJECT:** Food Brought in from Outside the Hospital
REVISION DATE: 4/00, 6/03, 7/05, 4/08, 03/11	**POLICY NUMBER:** IV.AA.1

Department Approval:	**02/17**
Clinical Policies & Procedures Committee Approval:	**~~01/11~~05/~~15~~10/~~15~~02/17**
Nursing Executive Council Approval:	**~~01/11~~02/17**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**02/11**
Professional Affairs Committee Approval:	**03/11**
Board of Directors Approval:	**03/11**

A. Food brought from outside for patient:

~~1. The use of food prepared or brought in by an individual outside the hospital is discouraged.~~

~~a.~~**1.** Food shall not be contraindicated on the patient's diet.

2. Food is to be eaten immediately and not stored.

~~b.~~**a. Food prepared outside of the hospital shall not be stored in the patient food refrigerators.**

~~c. Food prepared from milk or eggs are not permitted because of bacterial contamination risks.~~

3. ~~While food brought in from the outside for patients is discouraged, a~~**A**ny such occurrence will be documented in the patient's medical record.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 8/02	**SUBJECT:** Food Storage on Nursing Units~~Expiration Dates~~
REVISION DATE: 6/03, 7/05, 03/11	**POLICY NUMBER:** XI.D

Department Approval:	**02/17**
Clinical Policies & Procedures Committee Approval:	**~~01/11~~10/~~15~~02/17**
Nursing Executive Council Approval:	**~~01/11~~10/~~15~~02/17**
Medical Executive Committee Approval:	**02/11**
Professional Affairs Committee Approval:	**03/11**
Board of Directors Approval:	**03/11**

A. **POLICY:**

~~1. Food Storage on the Nursing Units:~~

~~a.~~**1.** Food shall not be stored in a refrigerator used to store medicines, chemicals, or specimens.

~~b.~~**2.** Food items shall not be removed from the patient trays and placed in the patient nutrition refrigerators.

~~c.~~**3.** Refrigerators designated for food are used for food and food products only.

~~i.~~**a.** All foods without manufacturer's expiration dates shall be dated with an expiration date 3 days from date placed in refrigerator.

~~ii.~~**b.** Upon opening any item, it shall be re-dated for 24 hours from opening and discarded on new expiration date.

~~iii.~~**c.** All foods shall be covered or protected during transit.

Tri-City Medical Center
Oceanside, California

~~STANDARDIZED PROCEDURES MANUAL~~PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: NEEDLE ~~ASPIRATION~~ THORACENTESIS OF CHEST FOR PNEUMOTHORAX IN NEONATES

I. **POLICY:**

A. Function: To **outline the procedure**~~provide guidelines~~ for the Neonatal Intensive Care Unit (NICU) **registered** nurse **(RN)** to perform thoracentesis on a neonate.

1. The NICU RN must adhere to the policies of the institution and remain within the scope of practice as stated by the Nurse Practice Act of the State of California.

B. Circumstances **under which the NICU RN may perform function**:

1. Setting: ~~Labor & Delivery, Newborn Nursery, NICU, and/or Emergency Department.~~

a. Inpatient neonatal patients

~~a.~~b. ~~-~~Neonates being admitted or transferred to and from Tri-City Medical Center (TCMC) NICU.

2. Supervision:

a. The necessity of the procedure will be determined by the RN in verbal collaboration with the attending ~~neonatologist~~ **physician**. Ideally the procedure will first be discussed with the **physician**~~attending~~, but if time does not permit for that, then the attending ~~neonatologist~~**physician** is to be notified as soon as possible after the procedure. Direct supervision will not be necessary once competency is determined as provided for in this standardized procedure.

3. Patient Conditions/Indications (Subjective/Objective):

a. Suspicion of a pneumothorax as evidence by:

i. Respiratory distress
ii. Unstable vital signs
iii. Abnormal pulse oximetry
iv. Abnormal blood gas
v. Cyanosis
vi. Shifted cardiac impulse
vii. Tracheal shift
viii. Asymmetrical/absent breath sounds

b. Chest X-ray interpreted as showing

i. Mediastinal shift
ii. Pneumothorax
iii. Pleural fluid collection (effusion, hemothorax, empyema, and/or chylothorax)

c. High intensity transillumination is interpreted as showing a pneumothorax

~~b.~~i.

~~2.~~4. Contraindications:

a. ~~If there is a s~~**S**uspected diaphragmatic hernia

~~When the air collection is likely to resolve spontaneously without patient compromise.~~

b. Current thrombolytic therapy

~~b.~~c. History of known bleeding disorder

~~c.~~d. When the vital signs are stable enough to allow for the placement of a thoracotomy tube instead.

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Department of Neonatology	Pharmacy & Therapeutics Committee	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
11/12, **5/16**	11/12, **6/16**	12/12, **7/16**	**08/16**	1/13, **11/16**	1/13, **01/17**	3/13, **02/17**		3/13

~~C. Indications: Decompression of tension pneumothorax or fluid accumulation (pleural effusions, chylothorax, empyema) in order to allow adequate lung expansion for ventilation. In an acute emergency, needle aspiration should be performed if the baby's cardiopulmonary status is unstable.~~

~~D.~~**C.** Definitions:

1. Neonate: Any infant **less than 30 days old.**~~in the NICU, delivery room, newborn nursery or emergency department.~~
2. Pneumothorax: The presence of free air or gas in the pleural cavity.
   a. May be produced by the application of positive pressure to the airway and lung tissue. With ventilation pressures greater than 30 cm water, there is significant rise in risk.

~~3. Symptoms: May vary from irritability and restlessness to apneic spells, tachypnea, grunting, retractions, and in severe cases bradycardia, cyanosis, and shock. A tension pneumothorax must be diagnosed and treated promptly. Clinical signs of a tension pneumothorax include:~~

~~a. Abrupt and dramatic worsening of respiratory or circulatory status~~
~~b. Hypotension with narrowed pulse pressure~~
~~c. Bradycardia and severe cyanosis in association with absent or decreased breath sounds on the affected side.~~

~~E. Database:~~

~~1. Subjective – Any of the following: irritability, restlessness, apneic spells, tachypnea, grunting, and retractions.~~
~~2. Objective – Abrupt worsening of respiratory and circulatory status; bradycardia, hypotension, cyanosis.~~
~~3. Diagnosis – Tension pneumothorax~~
~~4. Plan – Evacuate air from pleural space by needle aspiration.~~

~~F. Transillumination of the chest with a fiberoptic light source can help to determine the affected side. Definitive diagnosis should be made by x-ray.~~

II. PROCEDURE:

A. Equipment:

1. Cardiac monitor, oximeter and/or bedside nurse to monitor apical pulse
2. Transilluminator
3. Needle Aspiration Kit:
   a. **2% chlorhexidine gluconate**~~Povidone-iodine swab sticks~~
   ~~b. Sterile saline pads~~
   ~~c.~~**b.** 2x2 gauze sponges
   ~~d.~~**c.** 23 or 25 gauge butterfly needle**, or 23 or 25-gauge angiocatheter.**
   d. Three-way stopcock
   e. **T-connector (if using an angiocatheter)**
   f. Transparent Dressing
   g. ~~10/20~~ **20 or 35** mL syringe

B. Pre-treatment evaluation:

1. Notify attending physician of sudden onset of symptoms
~~1.~~**2.** Obtain chest x-ray if possible. If chest x-ray cannot be obtained promptly, transilluminate before placement if pneumothorax is life-threatening, to confirm affected side.
3. Ensure that the neonate is pre-medicated for the procedure and that a plan for pain control and developmental management is in place.

~~2. If time permits pre-medicate infant for pain control and or sedation. Assess need for further medication throughout the procedure. Offer oral sucrose with a pacifier.~~

~~a. Morphine~~
~~b. Pacifier~~
~~c. Oral Sucrose~~

~~3.~~**4.** Monitor the patient's cardiorespiratory status and oxygen status throughout the procedure.

~~4.~~**5.** If time permits inform the family of the treatment plan, otherwise notify them after the procedure is complete.

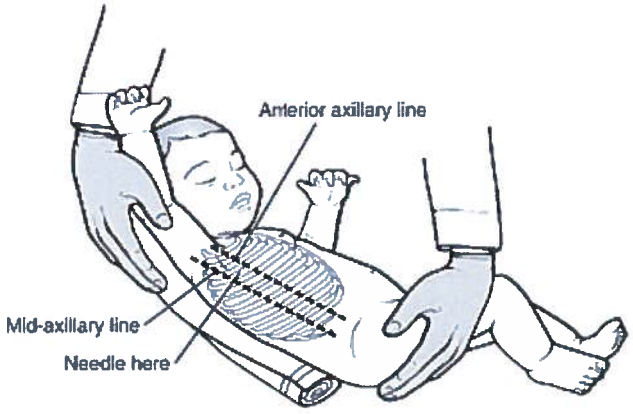
C. Set-up

1. The equipment is assembled as follows:
   a. Connect the 3-way stopcock to the syringe.
   b. If using a butterfly needle, c~~C~~onnect the tubing of the butterfly needle to the 3 way stopcock~~. May instead connect the angiocath to a T-connector and connect that to the 3-way stopcock~~.
   ~~b.~~**c. If using an angiocatheter, connect stopcock and syringe assembly to a t-connector.**

~~D. Notify attending/neonatologist of sudden onset of symptoms~~
~~Obtain chest x-ray if possible. If chest x-ray cannot be obtained promptly, transilluminate before placement if pneumothorax is life-threatening, to confirm affected side.~~

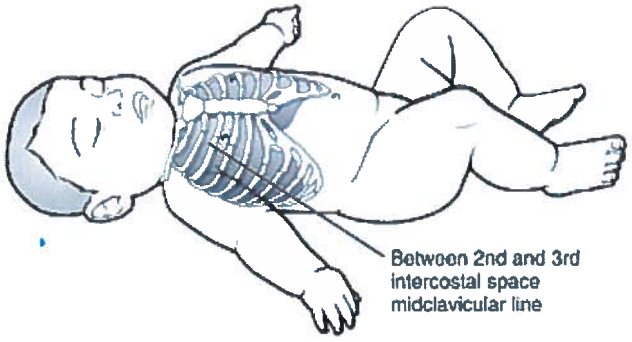
D. Plan:

1. Perform a time out ~~with all the appropriate steps~~**per Patient Care Services (PCS): Universal Protocol**.
2. **Positioning of Infant:**
   a. **For the lateral approach position the neonate with a blanket roll behind the back, the affected side slightly above the mattress, and the arm of the affected side restrained above the head. The needle or catheter will be inserted into the 4th intercostals space in the mid-axillary or anterior axillary line.**



Needle aspiration procedure option 1: Lateral approach.

   b. **For the anterior approach position the neonate supine for needle insertion into the second -intercostal space in the midclavicular line.**



Needle aspiration procedure option 2: Anterior approach.

c. ~~Position the infant supine position. Remember that air rises. For lateral approach position neonate with blanket roll behind back, affected (side with pnemothroax) elevated approximately 45° above the mattress, and arm of the affected side restrained about the head..~~

d. ~~The second inter space is used in the midclavicular line (MCL). Confirm site of insertion with another nurse and mark area.~~

~~2.~~**3.** Prep this area with **2% chlorhexidine gluconate,**~~povidone-iodine~~ allowing it to dry a minimum of ~~30 seconds~~**1 minute.**.. ~~Wipe povidone-iodine away with sterile saline pads.~~

~~3.~~**4.** Have assistant hold infant's legs and arms.

~~4.~~**5.** **Puncture the skin at a 45-degree angle, angling over the top of the 3rd rib (5th rib for lateral approach) to avoid the artery and nerve located on the inferior surface of the rib. The distance required for needle insertion varies with the neonate's size but is usually less than 15 mm. Avoid trauma to breast tissue. Insert the needle only once, and do not move it back and forth.**~~Enter the pleural cavity through the second interspace in the MCL just above the third rib. This is to avoid damage to the intercostals vessels which run immediately beneath each rib. Angle the needle at 45° and direct toward the medastium.~~ On entry into the pleural cavity, a slight "pop" is often felt The needle is steadied in this position.. ~~Gently aspirate the syringe to see if air is present. If no air is obtained, advance needle slightly and repeat the procedure.~~

a. **If using an over-the-needle catheter, remove the needle from the catheter while sliding the catheter into the pleural space. Attach the catheter hub to the pre-assembled T-connector, stopcock, and syringe setup.**

b. **If using a butterfly needle,** have **an assistant gently aspirate the syringe as the needle is inserted into the pleural space. Stop advancing the needle when air is obtained.**

6. **Stabilize the catheter or butterfly needle, and slowly aspirate the air or fluid. Continue withdrawing until no fluid is aspirated.**

~~**If the plunger is withdrawn to its fullest extent, turn the stopcock off to the neonate and atmosphere.**~~

~~**Attach a new syringe, turn the stopcock open to the neonate, and continue aspirating air or fluid.**~~

~~5.~~**7.** ~~**If the purpose of the thoracentesis is to remove fluid, and laboratory tests are ordered, have the assistant place the aspirated fluid in specimen collection tubes.**~~ If air is present, there is free withdrawal. Withdrawal continues until resistance is met.

~~6.~~**8.** If plunger is withdrawn to its fullest extent (~~10~~/20/**35**ml), turn the stopcock off to the patient**, then rapidly pushing air out of the syringe from the side port.**~~.~~

~~7.~~**9.** Repeat this process until all of the air is evacuated.

~~8.~~**10.** Observe the infant's ~~heart rate~~**vital signs** and listen for breath sound improvement. ~~Usually eliminating the air from the pleural space will improve the infant's condition immediately.~~

~~9. Transilluminate and obtain an order for a chest x-ray to assess adequacy of air removal and catheter placement.~~

11. Remove the catheter or butterfly needle when no more air or fluid can be obtained.

12. Apply pressure with a folded 2 × 2 sterile gauze until any oozing or bleeding has stopped. Cover the site with a dry, sterile, and occlusive dressing.

~~10. Follow-up treatment~~

~~11.~~**13. Obtain a** ~~C~~chest X-ray to determine continued presence of air or fluid.

~~12. Termination of Treatment~~

~~a. Needle throacostomy discontinued when:~~

~~i. Chest tube is placed~~

~~ii. Air or fluid is evacuated and does not reaccumulate.~~

~~13.~~**14.** Potential Complication

a. Lung puncture
b. Pneumothorax
c. Bleeding
d. Liver puncture
e. Infection
f. Hypovolemia if draining a large amount of fluid.

~~14.~~**15.** Documentation
a. Document the following:
i. Time procedure started
ii. Reason for thoracentesis
iii. Infant's status before and after procedure including heart rate, respiratory rate, degree of respiratory effort and blood pressure, Fio2, O2 saturations and pain management.
iv. Results of chest x-ray or transillumination
v. Size of needle used, and location of insertion
vi. Amount of air or drainage obtained
vii. Infant's tolerance of procedure
viii. Any complication

III. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. Current California RN license.
B. Education: The RN shall attend the required TCMC didactic class on Needle Aspiration for Pneumothorax, and pass all written and performance tests. The RN shall demonstrate proper procedure and technique for thoracentesis on a training mannequin or **simulation**~~skills~~ labs.
C. Initial Evaluation: The NICU Clinical Nurse Specialist **or designee** in collaboration with **a Division of** Neonatology **representative** shall validate initial competency. The initial competency shall be completed in a **simulation**~~skills~~ lab.
D. Ongoing Evaluation: The RN shall exhibit knowledge and skills to perform thoracentesis during annual competency testing on the training mannequin or **simulation**~~skills~~ lab.

IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: This Standardized Procedure was developed through collaboration with an authorized representative from Nursing Administration, Administration and Medical Staff.
~~B. Review: Bi-Annually~~**~~Every two years.~~**
~~Nursing Administration~~
~~1. **Division of Neonatology**~~
~~2. Interdisciplinary Practice Committee~~
~~3. Medical Executive Committee~~
~~4. Board of Directors~~

V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All NICU Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform Neonatal Thoracentesis -Standardized Procedure.

VI. RELATED DOCUMENTS:

A. **PCS: Universal Protocol**

VII. REFERENCES:

A. Karlsen, K. (2013). Procedures: Pneumothorax Evacuaiton: Needle Aspiration of the Chest. The S.T.A.B.L.E. Program, 6th edition.
B. Mosby's Nursing Skills. (2016). Needle Thoracostomy. Elsevier, Inc.

~~A.~~**C. National Association of Neonatal Nurses. (2011). Procedure: Chest-tube Management: Placement, Needle Aspiration, and Maintenance. Policies, Procedures, and Competencies for Neonatal Nursing Care.** ~~The S.T.A.B.L.E. Program, 5th edition (2013)~~

~~B. Neonatal Resuscitation Program, 6th edition (2012)~~

~~C. University of California San Francisco, Standardized Procedure (2008)~~

D. ~~Neonatal Handbook, Neonatal handbook Editorial Board, (2011)~~

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**PERTUSSIS NASOPHARYNGEAL (NP) SWAB, ADULT**
Purpose:	To identify the process for obtaining a nasopharyngeal swab for *Bordetella petussis.*
Supportive Data:	Proper technique for obtaining a nasopharyngeal specimen for isolation of *Bordetella pertussis* is essential for optimal results. Once a NP swab has been collected it should be placed into a collection container and transported immediately to the lab.
Equipment:	Nasopharyngeal Swab with flexible wire handle Transport Container Personal Protective Equipment (i.e. Mask, Gloves, Face Shield) Tissue Nurse Collectable Requisition Patient Label

A. **ORDERING A PERTUSSIS SWAB**

1. Place patient in droplet isolation until an order is obtained to discontinue isolation.
2. Ensure a physician order is obtained prior to collecting a NP swab
3. Ensure a ~~**STAT**~~ order is **entered**~~placed~~ in Cerner **as Bordetella Pertussis by PCR** ~~for a~~ Nurse Collectable ~~Pertussis Nasal Swab~~ and notify the laboratory.
4. Obtain the following equipment from the Microbiology laboratory department:
   a. Nasopharyngeal swab with flexible wire handle (blue top).
   b. Specimen collection container (blue top).

B. LABELING

~~B.~~**1. Refer to Patient Care Services Specimen Labeling Procedure**

C. **OBTAINING SPECIMEN**

1. Perform hand hygiene
2. Don personal protective equipment.
3. Identify patient per TCMC policy.
4. Place supplies on clean surface.
5. Open Culture Swab Collection and Transport package.
6. Remove nasopharyngeal swab with flexible wire handle (blue-top) from package.
7. Remove the collection and transport culture from the package and discharge (white top).
8. Have patient sit up in bed, place pillow behind shoulders to assist in maintaining an upright position.
9. Insert swab into one nostril **straight back** (not upwards) along the floor of the nasal passage for several centimeters until reaching the posterior wall of the nasopharynx (resistance will be met). See diagram below.
   a. The distance from the nose to the ear gives an estimate of the distance the swab should be inserted. Do not force the swab, if obstruction is encountered before reaching the nasopharynx, remove swab and try the other side.

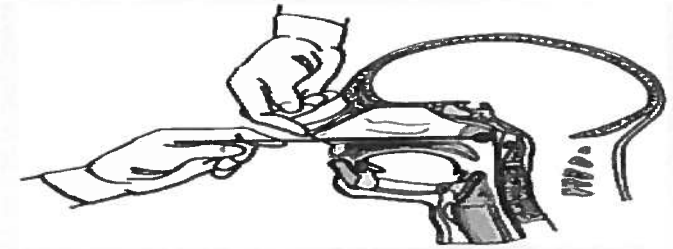


Image: Manual for the Surveillance of Vaccine-Preventable Diseases, 4th ed, 2008

Department Review	Clinical Policies & Procedures	Nurse Executive Council	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
10/10; 09/14, **11/16**	12/10;10/14, **01/17**	12/10;10/14, 02/17	n/a	01/11; 10/14	02/11;11/14	02/11;12/14

10. Rotate the swab gently for 5-10 seconds to loosen the epithelial cells.
11. Remove swab without touching sides of speculum or nose.
12. Remove the cap from blue-capped specimen container and insert wire swab.
13. Break or cut wire swab handle with clean scissors to fit the specimen container and reattach cap securely.
14. Offer patient facial tissue or using a tissue, wipe any residual nasal secretions from patient's nose.
15. Discard used supplies, remove gloves, and perform hand hygiene.
16. **C**~~Label specimen and c~~omplete the **nurse collectable**~~NC~~ requisition.
17. Send specimen to the laboratory immediately.
18. Perform hand hygiene.
19. Document collection of specimen in the medical record.

D. **REFERENCES:**

1. California Department of Public Health. (2010, March). Pertussis: laboratory testing. Retrieved October 26, 2010 from http://www.cdph.ca.gov/programs/immunize/Documents/CDPH_Pertussis
2. Centers for Disease Control and Prevention (CDC). (2009, August 10). Manual for the surveillance of vaccine-prevention disease. (4th e.d.). Chapter 10 pertussis. Retrieved October 26, 2010 from http://www.cdc.gov/vaccines/pubs/surv-manual/chpt10-pertussis.htm
3. Centers for Disease Control and Prevention (CDC). (2010, August 26). Pertussis (whooping cough) diagnostic testing. Retrieved October 26, 2010 from http://www.cdc.gov/pertussis/clinical/diagnostic.html
4. Mosby's Nursing Skills. (2006-2010). Specimen collection: nose throat specimens for culture. Retrieved October 27, 2010 from TCMC intranet.

Tri-City Medical Center
Oceanside, California

~~**Administrative Policy Manual**~~**PATIENT CARE SERVICES**

ISSUE DATE: **12/09**

SUBJECT: **Physicians Orders for Life Sustaining Treatment (POLST)**

REVISION DATE: **05/10**

~~**POLICY NUMBER: 8610- 393**~~

Department Approval:	**08/16**
Clinical Policies and Procedure Committee Approval:	~~**09/15**~~**09/16**
~~**Administrative Policies & Procedures Committee Approval:**~~	~~**01/10**~~
Nurse Executive ~~Operations Team~~ Committee Approval:	~~**04/1009/15**~~**09/16**
Critical Care Committee Approval:	**10/16**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**02/17**
Professional Affairs Committee Approval:	**05/10**
Board of Directors Approval:	**05/10**

A. **DEFINITIONS:**

1. Physicians Orders for Life Sustaining Treatment (POLST): A standardized form that complements an advance directive by taking the individual's wishes regarding life-sustaining treatment, and converting them into a physician order.
   a. The POLST document is a statewide mechanism for seriously ill individuals or those in very poor health to communicate his or her wishes about a range of life-sustaining or resuscitative measures. It is portable, authoritative, and immediately actionable physician order consistent with the patient's wishes, which shall be honored across treatment settings.
   b. Pink paper is the recognized and recommended color of the form; however, the form remains valid on any color paper including facsimiles and photocopies.

B. **POLICY:**

1. Tri-City Medical Center shall honor Physicians Orders for Life Sustaining Treatment (POLST). This policy outlines appropriate actions when a patient enters the hospital with a POLST form.
2. A health care provider is not required to initiate a POLST form, but is required to treat a patient in accordance with the POLST form.
3. A legally recognized health care decision maker may execute, revise, or revoke the POLST form for a patient only if the patient lacks decision making capacity.
4. If the POLST form conflicts with the patient's previously-expressed health care instructions or advance directive, then the most recent expression of the patient's wishes govern.
5. For any conflicts or ethical concerns about the POLST orders, appropriate hospital resources (e.g., ethics committees, care conference, legal, risk management, or other administrative and medical staff resources) may be utilized to resolve the conflict.
6. Patient presents with a completed POLST form:
   a. The RN shall confirm with the patient, or the patient's legally recognized health care decision maker that the POLST form is valid.
   b. The RN shall communicate to the treating physician **or Allied Health Professional** the existence of the POLST form.
   c. A copy of the POLST form shall be placed in the medical record under the Orders tab. The original POLST form shall be returned to the patient.
      i. Enter POLST orders in Cerner.
7. Reviewing/Revising a POLST form:
   a. The POLST form may be revised at any time by the patient or the patient's legally recognized healthcare decision maker. Initiate a referral to Social Services for assistance in revising the form.

i. Discussions about revising or revoking the POLST shall be documented in the medical record, and dated and timed. This documentation shall include the essence of the conversation and the parties involved in the discussion.

ii. To void the POLST form, draw a line through sections A through D and write "VOID" in large letters. Sign and date this line.

1. If a new POLST form is completed, a copy of the original POLST marked "VOID" shall be kept in the medical record directly behind the current POLST.

C. **FORMS/RELATED DOCUMENTS~~ATTACHMENT~~:**

1. Physicians Orders for Life Sustaining Treatment (POLST) **sample** form

D. REFERENCES:

1. **California Hospital Association Consent Manual (2015)**

California POLST Form

In order to maintain continuity throughout California, please follow these instructions:

****** Copy or print POLST form on 65# Cover Pulsar Pink card stock. ******

Wausau Pulsar Pink card stock is available online and at some office supply stores.

Pulsar pink paper is used to distinguish the form from other forms in the patient's record; however, the form will be honored on any color paper. Faxed copies and photocopies are also valid POLST forms.

Physician Orders for Life-Sustaining Treatment (POLST) Sample

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2009)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name	
First /Middle Name	
Date of Birth	Date Form Prepared

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): ***Person has no pulse and is not breathing.***

☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)
(Section B: Full Treatment required)

When not in cardiopulmonary arrest, follow orders in **B** and **C**.

B *Check One*

MEDICAL INTERVENTIONS: ***Person has pulse and/or is breathing.***

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Antibiotics only to promote comfort. ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Do Not Transfer to hospital for medical interventions. Transfer*** if comfort needs cannot be met in current location.

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes in*

Additiona

DELETE – old form

C *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: ***Offer food by mouth if feasible and desired.***

☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube.

☐ Long-term artificial nutrition by tube.

Additional Orders:_____

D

SIGNATURES AND SUMMARY OF MEDICAL CONDITION:

Discussed with:

☐ Patient ☐ Health Care Decisionmaker ☐ Parent of Minor ☐ Court Appointed Conservator ☐ Other:

Signature of Physician

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Physician Name	Physician Phone Number	Date
Physician Signature (required)	Physician License #	

Signature of Patient, Decisionmaker, Parent of Minor or Conservator

By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Signature (required)	Name (print)	Relationship (write self if patient)
Summary of Medical Condition	Office Use Only	

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY			
Patient Name (last, first, middle)		Date of Birth	Gender: M F
Patient Address			
Contact Information			
Health Care Decisionmaker	Address		Phone Number
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professional

Completing POLST

- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by a physician and the patient/decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Certain medical conditions or medical treatments may prohibit a person from residing in a residential care facility for the elderly.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- No defibrillator (including automated external defibrillators) should be used on a person who has chosen "Do Not Attempt Resuscitation"

DELETE – old form

Section B:

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- Treatment of dehydration prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

Modifying and Voiding POLST

- A person with capacity can, at any time, void the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or a new POLST form.
- To void POLST, draw a line through Sections A through D and write "VOID" in large letters. Sign and date this line.
- A health care decisionmaker may request to modify the orders based on the known desires of the individual or, if unknown, the individual's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.

For more information or a copy of the form, visit **www.capolst.org**.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2016)*

First follow these orders, then contact **Physician/NP/PA**. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): ***If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.***

- ☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)
- ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — *Check One*

MEDICAL INTERVENTIONS: ***If patient is found with a pulse and/or is breathing.***

- ☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
  In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
  - ☐ ***Trial Period of Full Treatment.***
- ☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
  In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
  - ☐ ***Request transfer to hospital only** if comfort needs cannot be met in current location.*
- ☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
  Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

C — *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: ***Offer food by mouth if feasible and desired.***

- ☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____
- ☐ Trial period of artificial nutrition, including feeding tubes. _____
- ☐ No artificial means of nutrition, including feeding tubes. _____

D

INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

- ☐ Advance Directive dated _____, available and reviewed →
- ☐ Advance Directive not available
- ☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	FOR REGISTRY USE ONLY
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

NP/PA's Supervising Physician	**Preparer Name** (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None

Name:	Relationship to Patient:	Phone #:

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary**. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive**. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen 'Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit www.caPOLST.org.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 10/06	**SUBJECT:** Rapid Response Team Activation and Condition Help (H)
REVISION DATE: 3/07, 10/07, 9/08, 6/11, 3/12	**POLICY NUMBER:** IV.L

Department Approval:	~~04/16~~07/16
Clinical Policies & Procedures Committee Approval:	~~03/12~~05/16~~09~~/16
Nursing Executive Council Approval:	~~03/12~~05/16~~09~~/16
Critical Care Committee Approval:	10/16
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~05/12~~02/17
Professional Affairs Committee Approval:	06/12
Board of Directors Approval:	06/12

A. **DEFINITIONS:**

1. Bipap (NIPPV): A type of mechanical ventilation which provides inspiratory and/or expiratory positive pressure ventilation via nasal, full face or total face mask in order to improve hypoxemia, reduce ventilatory muscle fatigue, and to support ventilation.
2. Condition Help (H): A program that enables patients and family members to call for immediate help if they feel the patient is not receiving adequate medical attention.
3. Multidisciplinary Medical Team: A team consisting of multiple members with varying medical education backgrounds such as an ICU Nurse, an RCP, Patient's Primary Nurse and the Administrative Supervisor if duties/time permits. For Condition H, a social worker and a chaplain also will respond.
4. Rapid Response Team (RRT): A multidisciplinary team that responds to urgent patient situations throughout the hospital.

B. **PURPOSE:**

1. To provide, within minutes a multidisciplinary medical team approach using a formalized process, to assess and treat a patient, whose condition is deteriorating or when nursing staff on the floors has concerns related to patient's condition.
2. To provide support when a patient/family recognizes a noticeable medical change in condition and feels they are not receiving the appropriate response from the healthcare team.
3. Tri-City Medical Center (TCMC) will plan for, support, and coordinate a systematic approach to complex patients such as the implementation of the Rapid Response Team (RRT) to respond to deterioration in patient status outside the critical care setting.
4. The role of the Rapid Response Team is to:
   a. Assess
   b. Stabilize
   c. Assist with communication
   d. Educate and support
   e. Assist with transfer to a higher level of care if necessary

C. **POLICY:**

1. The goal of the team is to provide early and rapid intervention in order to promote better outcomes such as:
   a. Reduced cardiac and/or respiratory arrests in the hospital;

b. Reduced or more timely transfers to the Intensive Care Unit (ICU) or a higher level of care;
c. Reduced patient intubations; and
d. Reduced number of hospital deaths.

2. The RRT Nurse provides clinical expertise, advanced assessment skills and support for the patient's primary nurse, patient and patient's family, as well as facilitates a more timely transfer to a higher level of care when needed.
3. The Primary Nurse is a critical member of the team who shall provide report, remain in room to collaborate with the RRT Nurse, and assist in the care of the patient.
4. The Respiratory Care Practitioner (RCP) provides advanced respiratory assessment, immediate oxygen therapy, delivery of aerosolized medications, and assistance in delivering mechanical ventilation, through Non-Invasive Positive Pressure Ventilation (NIPPV) if required.

D. **PROCEDURE:**

1. When a nurse is concerned about the condition of a patient or feels that a patient needs immediate intervention, they will:
   a. Contact the operator by dialing "66." The operator will announce "Rapid Response Team to Room -----", three times overhead.
      i. Once notified, the RRT members will simultaneously respond to that room/location within 5 minutes.
   b. **Call RRT cell phone.**
2. When a caregiver/family member is concerned about the condition of a patient or feels that a patient needs immediate intervention, they will contact the operator by dialing "66." The operator will announce "Condition H" and the RRT members will respond.
3. Criteria to call the Rapid Response Team:
   a. Staff member is concerned/worried about the patient
   b. Acute change in:
      i. Heart rate (less than 50 or greater than 130 beats per minute)
      ii. Systolic blood pressure (less than 90 mm/Hg or greater than 180 mm/Hg)
      iii. Respiratory rate (less than 8 or greater than 28 breaths per minute) or threatened airway
      iv. Oxygen saturation, which reflects the percentage of red blood cells, saturated with oxygen (level is less than 92% despite oxygen therapy)
      v. Level of consciousness, sudden unexplained agitation and confusion.
      vi. Urine output (less than 50 mL in 4 hours)
   c. ~~Other neurological changes such as n~~**N**ew onset unilateral motor weakness, sensory loss, and/or aphasia ~~warrant a Code Stroke call~~**or other neurological changes suggestive of stroke**.
   d. Patient complains of new onset chest pain or any other symptoms suggestive of Acute Coronary Syndrome (ACS)
   e. Acute significant bleed
   f. New, repeated, or prolonged seizures
   g. Failure to respond to treatment for an acute problem/symptom
   h. Change in skin tone (pale, dusky, gray or blue)
   i. The patient must be stabilized or a decision to transfer to a higher level of care must be made within 30 minutes.
4. Criteria to Call a Condition H Rapid Response:
   a. A caregiver or family member is worried about the patient's condition and feels it is not receiving appropriate response from the healthcare team.
   b. Noticeable medical changes:
      i. Shortness of breath or barely breathing
      ii. Severe pain not resolved after treatment
      iii. Feels as though heart is beating too fast
      iv. Difficulty speaking or moving arms or legs

v. Confusion, agitation, or other mental changes
vi. Difficulty waking up when aroused
vii. Using the bathroom less or more frequently

5. RRT Nurse Responsibilities:
   a. Takes emergency cart to room.
   b. Speak with the primary nurse to get the situation, background, assessment and recommend (SBAR) of the patient.
   c. Assist with further assessment of the patient.
   d. Speak with the physician/family/patient about the situation.
   e. Assist with/facilitate transfer to higher level of care if indicated.
   f. **Provides necessary treatment and obtains pertinent diagnostic tests per Rapid Response Standardized Procedure.**
   g. In emergency situations implements current standards of care by following ACLS protocols.
   h. Functions as role model.
   i. Provides education pertinent to event and general clinical education as time allows.
   j. Follows up on patients maintained on the floor within 4 hours of the call.
   k. **Completes a RRT Cart check at least daily and documents the following on the RRT Cart Checklist located inside the RRT Cart:**
      i. **Presence of**:
         1) **RRT cellular telephone and charging cable.**
         2) **Cart keys**
         3) **Manual blood pressure cuff**
         4) **Emergency supplies, including**
            a) **Three sets of gel defibrillation pads**
            b) **Three sets of multifunction defibrillator pads**
            c) **Resuscitation bag (Ambu).**
            d) **Restock any missing supplies**
      ii. **Verifies contents of Respiratory bag and tool box**
         1) **Restock any missing supplies**
      iii. **Expiration dates of all supplies completed on the first day of each month**
         1) **Replace any expired supplies**
      iv. **Proper functioning of defibrillator**
         1) **Verify adult paddles are installed and are pushed all the away into their holders on the side of the M series unit**
         2) **Ensure the Multi-Function Cable is plugged into the unit**
            a) **The Multi-Cable Function should not be plugged into the test connector**
         3) **Switch unit to *DEFIB* and set energy to 30 joules**
            a) **The messages *CHECK PADS* and *POOR PAD CONTACTS* will alternately display**
         4) **Plug the Multi-Function Cable into its test connector**
            a) **The message *DEFIB PAD SHORT* will display**
         5) **Press the *CHARGE* button on the front panel or on the apex paddle handle**
         6) **Wait for the charge read tone to sound and verify that the energy ready value displayed on the monitor registers 30 joules**
            a) **The message will read *DEFIB 30J READY***
            b) **The strip chart recorder will print a short strip indicating *TEST OK* energy delivered if the unit delivered energy within specifications**
               i) **During the Energy Delivery Test, unit will only discharge when energy level is set to 30 joules**

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

7) Defibrillator battery change performed

~~ii.~~**v. Sign your name in the signature box of the Cart Checklist**

6. Respiratory Care Practitioner Responsibilities:
   a. Assesses and provides treatment.
   b. Assists in managing airway and providing ventilatory support.
   c. Assists with and provides treatment as necessary to facilitate transfer to higher level of care.
   d. Functions as role model.
7. Primary Care Nurse Responsibilities:
   a. Briefs the team on patient history, current assessment, and identified concerns.
   b. Ensures patient's chart, all labs and diagnostic test results are available for the team.
   c. Remains with patient as a vital member of the team, repeats vital signs and other assessments as needed.
   d. Contacts ~~P~~physician if asked by RRT Nurse and give information as needed, using SBAR communication.
   e. ~~Responsible for following~~ **Follows** through with determined plan of action and ongoing patient assessment.
8. Administrative Supervisor Responsibilities:
   a. ~~May r~~Responds and assists as needed if duties/time permits.
   b. Provides necessary resources.
   c. Facilitates efficiency of the team.
   d. Recognizes and utilizes the chain of command to obtain appropriate medical care when necessary to ensure patient's well-being.
   e. Facilitates transfer and bed assignment if a higher level of care is indicated.
   f. Responds to Condition H on nights, weekends, and holidays in place of social worker to address patient/family non-medical concerns.
9. Social Worker Responsibilities:
   a. Responds to Condition H to address patient/family non-medical concerns.
10. Chaplain:
    a. Responds to Condition H to provide spiritual and emotional support to patient/family.
11. **In the event the ICU is unable to provide a RRT RN (such as in times of unanticipated low staffing), the following steps will occur:**
    a. **The ICU Charge Nurse will notify the AS when there is no RRT; the ICU Charge Nurse will notify the AS when the RRT becomes available.**
    b. **The AS will notify each unit's Assistant Nurse Managers (ANMs)/Charge Nurses that the RRT has been pulled to patient care.**
       i. **Each unit's ANM/Charge Nurse will ensure their immediate staff is aware of the lack of RRT coverage.**
       ii. **Each unit's ANM/Charge Nurse will be available to all immediate staff to address patient concerns prior to calling a Rapid Response event.**
    c. **The ICU Charge Nurse (or other designated ICU RN) will be available for telephone consults.**
       i. **Call forwarding from the RRT phone to the Charge Nurse phone *may* be done to avoid carrying more than one cell phone (optional).**
          1) Dial *72 760 802 1939 and press *CALL* from the RRT phone to forward calls to the charge nurse phone (you will hear 3 beeps when the task is complete).
          2) Dial *720 and press *CALL* from the RRT phone to cancel call forwarding (you will hear 3 beeps when the task is complete).
    d. **The ICU Charge Nurse (or other designated ICU RN) will respond to overhead RRT pages and/or provide bedside support to floor nurses when necessary.**

i. **If a designated ICU RN other than the Charge Nurse will respond to a Rapid Response call, the Charge Nurse will ensure adequate coverage of that RN's patient assignment.**

E. **DOCUMENTATION:**

1. The Emergency Event Record will be used to document the RRT and Condition H activation and interventions performed.
2. An evaluation tool (Form# 6010-1006) ~~will~~**may** be completed by the primary nurse on the floor.

F. **RELATED DOCUMENTS:**

1. **PCS SP: Rapid Response**

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**STROKE CODE, EMERGENCY DEPARTMENT**
Purpose:	To outline the procedure for prompt recognition of a patient with signs and symptoms of stroke or worsening stroke and to outline appropriate interventions.
Supportive Data:	Rapid response is critical to obtain required data for a prompt diagnosis and appropriate intervention.
Equipment:	Stroke Admission Packet

A. **POLICY:**

1. A Stroke Code shall be initiated if a patient presents to the Emergency Department (ED) experiencing "stroke-like" symptoms of less than eight (8) hours duration.

B. **PROCEDURE:**

1. **Stroke Code Activation:**
   a. Patient with "stroke-like" symptoms who are en route to **Tri-City Medical Center (TCMC)** by **Emergency Medical Service (EMS)** providers will have a Stroke Code activated by the **Mobile Intensive Care Nurse (MICN)** prior to arrival by dialing 66 and notifying the operator.
      i. The MICN will notify the ANM/Charge RN as well as the **ED**~~Emergency Department~~ Physician.
   b. Patients with "stroke-like" symptoms who present through triage should be immediately placed in an emergency department bed and notify the ~~Emergency Department~~ **ED** ANM/Charge RN and ~~Emergency Room~~ **ED** physician.
      i. The Registered Nurse or Unit Secretary will activate a Stroke Code at the direction of the ~~Emergency Department~~ **ED** Physician by dialing 66 and notifying the operator.
   c. The operator will page the Stroke Team consisting of:
      i. **Computed Tomography (CT)** Technologist
      ii. Lab Phlebotomist
      iii. Stroke Coordinator
      iv. Radiology Technologist
      v. Lab Technologist
2. **Notification of Neurologist:**
   ~~a. When a Stroke Code is initiated by the MICN for patients arriving by EMS providers, the operator will notify the Neurologist on call.~~
   ~~b.~~**a.** ~~When a Stroke Code is initiated by the Emergency Department ED Physician, t~~The Neurologist on call will be notified by the ~~Emergency Department~~ **ED** Physician.
3. **Initial Care of the Stroke Patient:**
   a. Initial care of the stroke patient should include immediate stabilization of the airway, breathing, and circulation (ABC's). This is quickly followed an assessment using the NIHSS (National Institute Health Stroke Scale).
   b. The ~~Emergency Department~~ **ED** Physician serves as the Stroke Team Leader and is responsible for initial evaluation and stabilizing treatment, as well as determining eligibility for thrombolytics in collaboration with the Neurologist.
      ~~i. **Emergency Medical Technician (EMT) to stay with patient and complete all items on stroke checklist form and hand form to secretary when released by ED physician.**~~
   c. Determine time of symptom onset.
      i. This is defined as when the patient was at his or her previous baseline or symptom-free state. For patients unable to provide this information or who awaken

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
4/09; 11/1101/17	12/11, 4/15, 02/17	12/11; 4/15, 02/17	02/17	1/12, 02/17	2/12	2/12

with stroke symptoms, the time of onset is defined as when the patient was last awake and symptom-free or known to be "normal".

~~d. Obtain finger stick blood sugar.~~
~~i. Notify Emergency Department **ED** Physician of result.~~

~~e.~~**d.** Initiate continuous cardiac monitoring

~~f.~~**e.** Monitor blood pressure ~~Q~~ **every** 15 minutes until thrombolytic eligibility is determined.

~~g.~~**f.** Obtain vital signs including: heart rate, blood pressure, respiratory rate, oxygen saturation, and actual weight.

~~h.~~**g.** Obtain 12 lead **Electrocardiogram** (ECG).

~~i.~~**h.** Obtain **Intravenous** (IV) access.
i. Place 18 or 20 gauge IV in **antecubital** (AC) or forearm.

~~j.~~**i.** Initiate supplemental oxygen as ordered.

~~k.~~**j.** Perform NIHSS assessment and Swallow Screen prior to any oral intake.
i. Notify ~~Emergency Department~~ **ED** Physician of results.

4. **Time Parameter goal is to maintain the best practice times listed below:**
a. Draw STAT labs to include **prothrombin time** (PT)**/international normalized ratio** (INR), **partial thromboplastin time** (PTT), Glucose, and Creatinine –complete within 45 minutes of arrival but not to delay ~~r~~TPA**rtPA** administration.
i. Draw labs prior to CT scan.
b. Obtain STAT CT scan – completed within 25 minutes of arrival.
i. The Emergency Department RN accompanies all Stroke Code patients to CT scan.
ii. CT Technologist will notify Radiologist of the Stroke Code CT for STAT read.
iii. Radiologist will notify the Emergency Department Physician of CT results within 20 minutes of completion.
c. Obtain portable chest x-ray and ECG – complete within 45minutes of arrival but not to delay ~~r~~TPA**rtPA** administration.

~~5. Care of Stroke Patients Not Eligible for Thrombolytics:~~
~~a.~~**d.** ~~Care should be provided according to the Emergency Department Standard of Nursing Care~~.

~~6.~~**5. Care of the Patients Eligible for Thrombolytics:**
a. Continuous cardiac monitoring
b. Place second peripheral IV.
c. Place Foley Catheter prior to ~~r~~TPA**rtPA** administration if ordered by the ~~Emergency Department~~ **ED** Physician.
d. Monitor blood pressure Q 15 minutes.
i. Blood pressure obtained prior to administration of ~~r~~TPA**rtPA** is a systolic blood pressure < 185 and diastolic blood pressure of <110.
e. ~~Consider reconstituting rTPA in patients eligible for thrombolytic intervention early to prevent delays in administration. If rTPA is reconstituted and not used, return to pharmacy~~.
f. If patient is eligible for ~~r~~TPA**rtPA** treatment informed consent will be obtained by ~~Emergency Department~~ **ED** Physician and/or Neurologist.
i. Signed consent~~r~~ is not required for administration of ~~r~~TPA**rtPA**.

~~7.~~**6. Administer rtPA per Physician Order:**
a. Recommended TOTAL dose of ~~r~~TPA**rtPA** is 0.9 mg/kg, not to exceed 90 mg.
b. Reconstitute and administer ~~r~~TPA**rtPA** as follows:
i. **Reconstitute**~~10% of the total dose of r~~TPA ~~-~~**rtPA** with 100 ml of sterile water for injection utilizing the transfer device to create a solution with a concentration of 1 mg/mL.
ii. With a second Registered Nurse, calculate the weight based dose of ~~r~~TPA**rtPA**.
iii. Remove from the vial any quantity drug in excess of that specified for patient treatment~~. To do this~~, calculate the excess dose and discard 10 ml less than that dose. This will allow for the complete dose of ~~r~~TPA**rtPA** to be infused.

iv. Withdraw the bolus amount **(bolus dose is 10% of total dose)** and administer IVP over 1 minute.
v. Program the infusion pump to deliver the remaining dose over 60 minutes.
vi. ~~rTPA~~**rtPA** must be double checked by two Registered Nurses and documented in the Medication Administration Record.

~~8.~~**7. Monitoring During and Post Thrombolytic Administration:**

a. Continuous cardiac monitoring.
b. Monitor blood pressure **every**~~Q~~ 15 minutes ~~X~~ **times** 2 hours, then ~~Q~~ **every** 30 minutes for 6 hours, then ~~Q~~**every** 1 hour ~~X~~ **times** 16 hours.
   i. Notify Emergency Department Physician immediately for systolic blood pressure > 185 and/or diastolic blood pressure > 110.
c. Monitor neurological status ~~Q~~ **every** 15 minutes ~~X~~ **times** 2 hours, then ~~Q~~ **every** 30 minutes for 6 hours, then ~~Q~~**every** 1 hour ~~X~~ **times** 16 hours.
   i. Neurological assessment should include: level of consciousness, orientation, response to commands, motor scoring of upper and lower extremities, language, dysarthria, and pupillary response.
   ii. If the patient develops a severe headache, acute hypertension, nausea, vomiting or has worsening neurological examination notify Emergency Department Physician immediately.
   iii. Monitor temperature and maintain normothermia.
   iv. Monitor blood sugar and maintain euglycemia.
d. Continue monitoring patient upon transport and during diagnostic tests. If unable to perform assessment/vital signs during test, document reason and resume assessment/vital signs as soon as test is completed.
   ~~d.~~**i. Note: most diagnostic areas have vital sign monitoring capability but staff may not be able to perform assessment during test**
e. Disposition of Stroke Patient:
   i. Stroke patients who have received thrombolytics are admitted to the Intensive Care Unit.
   ii. Stroke patients who do not meet the criteria for admission to the Intensive Care Unit should be admitted to 4 Pavilion or Telemetry.

~~Most diagnostic areas have vital sign monitoring capability, but staff may not be able to perform assessment during diagnostic test.~~

C. **RELATED DOCUMENTS/FORMS:**
1. 24 hour **rt**PA Flow Sheet. Form # 6010-1010

D. **REFERENCES:**
1. Guidelines for the Early Management of Adults with Ischemic Stroke. Stroke, Journal of the American Heart Association, 2007: 1655-1708
2. **Guidelines for the early management of patients with acute ischemic stroke: a guideline for healthcare professionals from the American Heart Association/American Stroke Association. Stroke. Volume 44 pages 870-947 (2013)**
3. ~~The National Institute of Neurological Disorders and Stroke tPA Stroke Study Group. N Engl J Med 1995;333:1581-7.~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 3/65

SUBJECT: Telephone Service for Patient Rooms

REVISION DATE: 5/88, 9/91, 10/96, 3/00, 11/00, 6/03, 8/05, 7/07, 4/10,7/136

POLICY NUMBER: II.G

Department Approval:	**12/16**
Clinical Policies & Procedures Committee Approval:	**~~04/10~~07/~~13~~01/17**
Nurse Executive ~~Patient Care Quality~~ Council Approval:	**~~05/10~~07/~~13~~02/17**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**05/10**
Board of Directors Approval:	**05/10**

A. **POLICY:**

1. Tri-City Medical Center (TCMC) shall allow telephone access to and from patient rooms while providing adequate amounts of rest for both patients in the room.
   ~~1.~~**a. Behavioral Health Services – Public phones are available for patients.**
2. All telephones in patient rooms have the capability for direct dialing. Patients can initiate and receive phone calls on a twenty-four hour basis.
3. Incoming calls to the P.B.X. operator shall not be connected to the patient rooms between the hours of 2200 and 0700 but shall be referred to the Nursing Unit.
4. If telephone communications need to be limited based on nursing assessment or patient behaviors, the process shall be verbally explained to the patient and/or family. Restrictions shall be evaluated by nursing for their effectiveness, so that at the earliest possible time the restriction may be lifted.
5. At the patient's request, phone service may be blocked.
6. Accommodations shall be made for patients requesting a private area for telephone usage. The Assistant Nurse Manager or the Administrative Supervisor may be contacted for assistance.

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	~~**THERAPEUTIC HYPOTHERMIA**~~ **TARGETED TEMPERATURE MANAGEMENT AFTER CARDIAC ARREST**
Purpose:	To manage comatose patients after cardiac arrest using cooling methods to induce hypothermia in order to improve neurological outcomes.
Supportive Data:	In studies of cardiac arrest, induced hypothermia protocols have contributed to improved neurological outcomes. This procedure is done in the Emergency Department (ED) and Intensive Care Unit (ICU).
Equipment:	~~Arctic Sun~~ Temperature Management System ~~or alternate system~~ Ice packs Core body temperature monitoring system (bladder, rectal, esophageal, or pulmonary artery) Refrigerated (4°C) normal saline

A. **POLICY:**

1. Patient Indications:
   a. Adults age 14 years and older.
   b. Cardiac arrest followed by return of spontaneous circulation.
   c. Persistent coma after cardiac arrest as evidenced by no eye opening, no speech, no purposeful response to noxious stimuli (Glasgow Coma Scale 8 or lower).
   d. Those able to maintain a systolic blood pressure greater than 90mmHg, with or without vasopressor agents after return of spontaneous circulation.
2. Absolute Contraindications:
   a. Active bleeding
   b. Severe sepsis
3. Relative Contraindications:
   a. Pregnancy (women < 50 years old must have a negative pregnancy test prior to initiating the protocol)
   b. Major head trauma
   c. Other causes of coma, ie. drug overdose, pre-existing coma)
   d. Recent major surgery within 14 days
   e. Greater than 6 hours from return of spontaneous circulation
   f. **Preexisting** DNR status

B. **DEFINITIONS:**

1. Cardiac Arrest – When the heart stops pumping blood effectively due to a lethal arrhythmia such as ventricular fibrillation or asystole, or due to mechanical failure such as in pulseless electrical activity (PEA).
2. Hypothermia – Core body temperature less than 35°C3. Severe hypothermia – Core body temperature less than 30° C

C. **PROCEDURE:**

1. Assessment:
   a. Confirm that patient meets eligibility criteria for ~~therapeutic hypothermia~~**targeted temperature management**.
   b. Obtain physician orders.
   c. Verify that patient will not be going for immediate cardiac catheterization. If immediate cardiac catheterization is planned, ~~therapeutic hypothermia~~**targeted temperature management** may be started after catheterization is complete.

Department Review	Clinical Policies & Procedures	Nursing Executive Committee	Critical Care Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
10/12, **08/16**	10/12, **09/16**	10/12, **09/16**	**10/16**	**n/a**	01/13, **02/17**	02/13	02/13

d. Perform neurological assessment, including Glasgow Coma Scale, before initiating therapy and at the end of therapy.
e. Assess pupil response every hour if paralytics are used.
f. Assess **and document** vital signs, including core body temperature, every 15 minutes during therapy.
i. Assess core body temperature **using** one of the following methods, listed in order of preference:
1) ~~(1)~~ Pulmonary artery catheter~~,~~
2) ~~(2)~~ Esophageal catheter~~,~~
~~i.~~**3)** ~~(3)~~ Bladder or rectal probe.
~~g. Assess skin condition every two hours during therapy.~~
~~h.~~**g.** Draw labs frequently, as ordered, to monitor patient for electrolyte abnormalities, coagulopathy, and infection.

2. Patient/Family Education:
a. Explain the purpose of ~~therapeutic hypothermia~~**targeted temperature management** and goals of treatment to family.
b. Assure family that appropriate comfort measures will be taken (i.e. sedation and analgesia).
~~b.~~**c. Provide hypothermia teaching handout.**

3. Initiation of hypothermia using the ~~Arctic Sun~~ temperature management system:
a. Artic Sun (topical cooling device)
i. Artic Sun Instructions for Use
b. Zoll Thermogard Intravascular System (intravascular device)
i. Zoll Thermogard XP Instructions for Use
c. Gaymar Cooling Blanket (topical device)
i. Gaymar Cooling Blanket Instructions for Use
~~a. Use the sizing chart to determine the appropriate size gel pads for the patient.~~
~~b. Apply gel pads to the patient.~~
~~i. Gel pads must be placed only on intact skin.~~
~~ii. Gel pads may be placed over top of defibrillation pads.~~
~~c. Connect the gel pads and temperature probe to the machine's console.~~
~~d. Set the patient's target temperature to 33°C.~~
~~i. Goal temperature is 32 - 34°C.~~
~~e. Ensure the Arctic Sun is in "automatic mode" (can only be used with attached temperature probe.)~~
~~f. Time to target should be at MAX.~~
~~g. Document time of initiation of patient cooling and 24-hour point of therapy on the order sheet and flow sheet.~~
~~h. Administer cold intravenous saline, per physician's order, if no evidence of pulmonary edema on chest x-ray.~~
~~i. If core temperature is NOT decreasing by at least 1°C per hour, see the Arctic Sun troubleshooting guide.~~
~~j. Notify the physician if unable to reach target temperature within 4 – 6 hours.~~
~~k. Monitor the patient for shivering during cooling using the Bedside Shivering Assessment Scale (BSAS) and notify physician if shivering cannot be controlled with the medications ordered.~~
~~l. Monitor the patient for hypokalemia during cooling.~~
~~m. Avoid severe hypothermia.~~

~~4. Maintenance phase:~~
~~a. Once the target temperature has been achieved, the patient will be maintained at 32 – 34 °C for 24-hours from the initiation of cooling.~~
~~b. Monitor the Arctic Sun water temperature hourly. A decrease in water temperature may indicate increased resistance to cooling, such as with shivering or fever from an infectious source.~~

~~c. If the water temperature remains less than 10°C for more than 8 hours, refer to the Arctic Sun troubleshooting guide.~~

~~5. Rewarming phase:~~

~~a. Begin rewarming the patient 24-hours after the initiation of hypothermia.~~

~~b. Set the patient's target temperature to 37°C.~~

~~c. Set the rate of rewarming to 0.3°C per hour. (Please note that the default setting is to "warm – MAX." The rewarming rate must be changed in order to achieve slow, controlled rewarming over 12 hours.)~~

~~d. Monitor the patient for hypotension related to rewarming, secondary to vasodilation.~~

~~e. Potassium replacement should be conservative 8 hours prior to rewarming and during rewarming.~~

~~f. Monitor for hyperkalemia during rewarming.~~

~~g. After rewarming is complete the Arctic Sun pads may be left in place for a total of 5 days. Monitor for rebound hyperthermia and reinitiate cooling if necessary to maintain the patient's core body temperature less than 37.5°C.~~

~~6. Therapeutic hypothermia with the Gaymar cooling blanket:~~

~~a. Therapeutic hypothermia may be performed without the use of the Arctic Sun temperature management system only if all of the Arctic Sun machines are unavailable.~~

~~b. Apply ice packs to the groin, sides of chest, axillae, neck and limbs to initiate cooling.~~

~~c. Cold IV saline may also be administered, as ordered, to facilitate rapid cooling.~~

~~d. The Gaymar cooling blankets should be placed beneath and on top of the patient, with a sheet between the patient and the blanket to protect the skin.~~

~~e. The water temperature in the Gaymar system is adjusted manually to achieve the desired rate of cooling.~~

~~f. Ice packs can be removed during the maintenance phase.~~

~~g. After 24-hours, the water temperature must again be manually readjusted to achieve slow, controlled rewarming at a rate no faster than 0.5°C per hour.~~

~~7.~~**4.** Communication:

a. Notify the physician of any changes in patient condition, complications of treatment or if unable to reach target temperature within specified time frame.

~~8.~~**5.** Documentation:

a. Time of initiation of hypothermia shall be documented in the medical record.

b. Patient assessments and communication with the physician shall be documented in the medical record.

D. RELATED DOCUMENTS:

1. **Artic Sun Instructions for Use**
2. **Zoll Thermogard XP Instructions for Use**
3. **Gaymar Cooling Blanket Instructions for Use**

~~D.~~E. REFERENCES:

1. Geocadin, R.G., Koenig, M.A., Stevens, R.D., Peberdy, M.A. (2007). Intensive Care for Brain Injury after Cardiac Arrest: Therapeutic Hypothermia and Related Neuroprotective Strategies. Crit Care Clin; 22: 619-636.
2. Bernard, S. (2006). Therapeutic Hypothermia after Cardiac Arrest. Neurol Clin.; 24:61-71.
3. J.P. Nolan, et.al. (2003). Therapeutic hypothermia after Cardiac Arrest: An Advisory Statement by the Advanced Life Support Task Force of the International Liaison Committee on Resuscitation. Circulation. 108: 118-121.
4. **Palmer, S. J. (2015). Nursing the Out-of-Hospital Cardiac Arrest Patient: Use of Targeted Temperature Management. British Journal of Cardiac Nursing, 10(7), 335-344 10p.**
5. **Mathiesen, C., McPherson, D., Ordway, C., & Smith, M. (2015). Caring for Patients Treated with Targeted Temperature Management. Critical Care Nurse, 35(5) e-1-e13 13p. doi;10.4037/ccn2015168.**

Artic Sun Instructions for Use

1. Use the sizing chart to determine the appropriate size gel pads for the patient.
   a. Apply gel pads to the patient.
      i. Gel pads must be placed only on intact skin.
      ii. Gel pads may be placed over top of defibrillation pads.
   b. Connect the gel pads and temperature probe to the machine's console.
   c. Set the patient's target temperature to 33°C.
      i. Goal temperature is 32 - 34°C.
   d. Ensure the Arctic Sun is in "automatic mode" (can only be used with attached temperature probe.)
   e. Time to target should be at MAX.
   f. Document time of initiation of patient cooling in the electronic health record (EHR).
   g. Administer cold intravenous saline as necessary to facilitate patient cooling, per physician's order, if no evidence of pulmonary edema on chest x-ray.
   h. If core temperature is NOT decreasing by at least 1°C per hour, see the Arctic Sun troubleshooting guide.
   i. Notify the physician if unable to reach target temperature within 4 – 6 hours.
   j. Monitor the patient for shivering during cooling using the Bedside Shivering Assessment Scale (BSAS) and notify physician if shivering cannot be controlled with the medications ordered.
   k. Monitor the patient for hypokalemia during cooling.
   l. Avoid severe hypothermia.
   m. Assess and document skin condition every two hours during therapy.
2. Maintenance phase:
   a. Once the target temperature has been achieved, the patient will be maintained at 32 – 34 °C for 24-hours from the initiation of cooling.
   b. Monitor the Arctic Sun water temperature and flow rate hourly in the EHR. A decrease in water temperature may indicate increased resistance to cooling, such as with shivering or fever from an infectious source.
   c. If the water temperature remains less than 10°C for more than 8 hours, refer to the Arctic Sun troubleshooting guide.
3. Rewarming phase:
   a. Begin rewarming the patient 24-hours after the initiation of hypothermia.
   b. Set the patient's target temperature to 37°C.
   c. Set the rate of rewarming to 0.3°C per hour. (Please note that the default setting is to "warm – MAX." The rewarming rate must be changed in order to achieve slow, controlled rewarming over 12 hours.)
   d. Monitor the patient for hypotension related to rewarming, secondary to vasodilation.
   e. Potassium replacement should be conservative 8 hours prior to rewarming and during rewarming.
   f. Monitor for hyperkalemia during rewarming.
   g. After rewarming is complete the Arctic Sun pads may be left in place for a total of 5 days. Monitor for rebound hyperthermia and reinitiate cooling if necessary to maintain the patient's core body temperature less than 37.5°C.

Zoll Thermogard XP Instructions for Use

Insertion of Zoll Quattro Catheter (note insertion procedure same as with central venous catheter insertion).

1. **Assemble Supplies:**
   - a. **Full body sterile drape**
   - b. **Sterile gown for physician**
   - c. **Sterile gloves for assistant and physician**
   - d. **Mask with face shield for physician**
   - e. **Full face shield for physician**
   - f. **Caps for assistant and physician**
   - g. **Gel hand hygiene solution**
   - h. **Zoll Intravascular Temperature Management Catheter**
     - i. **Each catheter insertion kits contain all the necessary line insertion equipment**
     - ii. **The "Quattro" heat exchange catheter is a 4 balloon femoral venous catheter preferred for post cardiac arrest patients who need cooling (orange and white package). This is a 9.3 French 45 cm catheter . Catheter should be positioned so that the distal tip is in the inferior vena cava below its junction with the right atrium and parallel to the vessel wall. All balloons should reside within the vessel.**
   - i. **Zoll Start Up Kit for the Thermogard**
   - j. **500 ml. IV bag of normal saline . Note: takes about 250 ml of normal saline to prime the Thermogard.**
   - k. **Temperature probe connector for "T1" temperature from Foley catheter ; & secondary temperature monitoring source with temperature probe**
2. **Ensure physician/designated healthcare provider (HCP) has performed chlorhexidine skin antisepsis**
3. **Provide maximal barrier precautions for the inserting and assisting personnel (i.e., cap, mask, sterile gown, sterile gloves, and full body sterile drape)**
4. **Ensure "time out" is performed per Patient Care Standards (PCS) Universal Protocol procedure.**
5. **Ensure Central Line Insertion Procedure Checklist is completed in Cerner.**
6. **Confirmation of Line Placement:**
   - a. **After insertion of the line by the physician, confirm placement with KUB or CXR but do not delay initiation of cooling while waiting for this to be done.**
   - b. **Ensure line confirmation is documented in Cerner .**
7. **After femoral insertion keep patient's HOB at a 30 degree angle or less).**
8. **For ongoing maintenance and care of femoral catheter, refer to Central Venous Access Devices, Adults .**
9. **Machine set-up and connection to the patient**
   - a. **The Zoll Thermogard consists of three major components: a recirculating chiller, a sterile fluid roller pump, and a temperature control system.**
   - b. **The Thermogard is connected to a ZOLL catheter (a temperature-controlled central line catheter) by two small-bore plastic tubes (orange luers).**
   - c. **Steps for Machine Set Up:**
     - i. **Check the level of the coolant in the coolant well, add more sterile or distilled water if necessary to ensure fluid is filled to just below the indicated "Max" coolant line (note: clinical engineering will add to the coolant chamber propylene glycol as part of routine machine maintenance). Place a "do not discard" sticker on the round plastic coolant cap and be sure to return it to the top of the coolant chamber.**

ii. Plug in the power cord and turn the power switch on. The machine will go through a self-test.
iii. Make the following selections on the system set-up display screens:
  1) When asked if it is new patient, select "no" for the TCMC Thermogard Trial. This will allow all data to be stored.
  2) Bath Pre-Set: Choose Precool and Enter
  3) Set Target Temperature: Turn the knob and select 33.0 C degrees for Hypothermia post-cardiac arrest with ROSC patients and then push "Enter".
  4) For Normothermia patients select 36.0 C degrees as target temperature.
  5) Set low temperature alarm at 32.5 when using hypothermia.
  6) Max Power, Control Rate or Fever: Turn the knob to select MAX Power and Enter
iv. Install the start-up kit tubing set.
  1) Insert the heat exchange coil into the coolant well.
  2) Insert the air trap into the air trap holder.
  3) Open lid of roller pump. The large section of tubing goes into the roller pump.
  4) Manually rotate the pump to facilitate loading of tubing (see quick reference guide attached to machine).
v. Load the pump tubing into the pump, following the tubing circuit diagram printed on the inside of the machine's top cover. The side of tubing with flange fits into the slot on the right side of the roller pump house.
vi. Firmly close the top cover of the pump.
vii. Hang 500 ml of sterile normal saline on the hook.
viii. Using aseptic technique, connect the tubing to the 500ml normal saline using the spike connector. Ensure that spike is all the way to the hub but be very careful that you do not puncture the bag as the spike is exceptionally long.
ix. Lift out the air trap from its holder and turn it upside down. Press and continuously hold the PRIME switch down until the air trap and tubing are completely flushed with saline (approx. 2 minutes).
x. Turn the filled air trap right side up and place it in the holder.
xi. Slip the insulating jacket over the saline container. Note: When you use this insulating jacket you will not be able to view the amount of fluid in the saline bag. Therefore, when using the insulating bag be sure to regularly check the fluid level in the saline bag. Normally there should be about 250 ml. in the 500 ml bag. If the saline bag level is decreasing in volume assess it for a leak.
xii. Route the tubing out of the machine through notches in the front of the console and through the channel at the rear of the console.
xiii. Close the top cover making sure the tubing is not kinked.

d. Connection to The Patient
i. Position the Thermogard near the patient's bed and lock the casters.
ii. Place the primary and secondary patient temperature probes in the patient.
  1) Plug the cable from the primary temperature probe into T1.
  2) Note: T2 will not display on the Thermogard.
iii. The supply and return connectors of the tubing are connected to each other. Use aseptic technique to disconnect the two catheters.
iv. Connect the male tubing connector to the female connector on the patient's ZOLL catheter.
v. Connect the female tubing connector to the male connector on the patient's ZOLL catheter (orange-to-orange connection).

vi. Position the tubing so that it is not kinked, obstructed, or cannot be dislodged by the patient's movement.
vii. Press the STANDBY/RUN button to place the Thermogard in the Run mode.

10. Disconnection / reconnection procedures:
    a. The Thermogard does not have a battery and will have to be disconnected if a patient needs to be transported.
    b. Temporary Disconnection From The Patient:
        i. Press the STANDBY/RUN button to place the Thermogard in standby mode. Do not turn the machine off.
        ii. Disconnect the temperature probes from their cables. Leave the temperature probes in the patient.
        iii. Using aseptic technique, disconnect Start up Kit tubing from the ZOLL catheter. Do not cap the orange ports, simply connect the two ends of the catheter to each other. Do the same with the start up kit tubing to ensure the ends stay clean. ** The product used for the evaluation has ORANGE luers. This is the updated product that was released in April. The orange luers are custom luers, which provide an additional safety feature and will not be able to connect to a luer lock syringe or IV tubing, thus preventing the possibility of a misconnection.
    c. Reconnection After a Temporary Disconnection:
        i. Using aseptic technique, reconnect the Start up Kit tubing to the ZOLL catheter.
        ii. Reconnect the temperature probes to their cables.
        iii. Restart the Thermogard by pressing the STANDBY/RUN button.
    d. Thermogard Rewarming & Normothermia
        i. This machine will not automatically switch from cooling to rewarming.
        ii. RN will note time that rewarming is set to occur.
        iii. Place Thermogard in STANDBY mode.
        iv. Push TARGET TEMPERATURE button and use the dial to change setting to desired temperature 36.5 degree Centigrade and then push "enter".
        v. Push Rate Degree Per Hour Button and dial in Controlled Rate. Turn to desired rate of .25 degrees Centigrade per hour and Enter. It will take about 12 hours to go from 33 degrees to 36.5 degrees.
        vi. Place Thermogard back in RUN mode.
11. Line maintenance
    a. Catheter stabilization & Protection of the Patient's Skin: Once catheter is verified to be properly positioned utilize standard Central Venous Catheter care for the site.
    b. Recommended length of time for line use:
        i. Quattro (four balloons) and ICY (three balloons) femoral lines are good for up to 4 days
        ii. The Cool-line inserted via internal jugular or subclavian is good for 7 days
        iii. Triple Lumen ports are not power ports.
        iv. If continued temperature management is desired after dwell time of catheter is up, simply replace catheter with new catheter kit over the wire.
        v. Replace Start up Kit tubing at 7 days or when changing out femoral line.
12. Ending Treatment
    a. Press the STANDY/RUN button. The pump stops turning and the Standby screen appear.
    b. Using aseptic technique, disconnect both tubing connectors from the ZOLL catheter.
    c. Disconnect the primary and secondary patient temperature probes.
    d. Press the knob and, select END PROCEDURE, then choose "download data later" and press knob once to confirm. Or simply turn off system. Patient data will be saved for 21 days.

e. **Prior to catheter removal, uncap and leave uncapped the inflow and outflow lumen. This will allow residual saline within the circuit to be expressed. Use a 20 ml slip-tip syringe from the start up kit to aspirate from the balloons to ensure all the saline is removed prior to the line being removed (optional with the Quattro catheter, as long as the orange luers are open to air).**

f. **The RN or physician can remove the line. It is normal to feel slight resistance as each balloon on the catheter passes out of the patient.**

13. **Troubleshooting & other key points:**
14. **Refer to the Thermogard User's Manual attached to each machine.**
15. **Use FICK cardiac output rather than thermodilution cardiac output on these patients.**
16. **The catheters are MRI compatible.**
17. **The catheters are NOT power injectable.**
18. **Mannitol may run through the ZOLL catheter, however the machine must be put on STANDBY for two minutes and the lumen must be flushed after the Mannitol has infused. This is to ensure the medication has not crystallized**
19. **Check the coolant level each time the machine is initially started. The coolant contains propylene glycol and distilled water. Engineering will replace the propylene glycol annually. The nurse will only need to add distilled water, if needed.**

REFERENCES:

1. **Zoll Thermogard Operator's Manual 2015**

Gaymar Cooling Blanket Instructions for Use

1. **Targeted temperature management may be performed without the use of the Arctic Sun or Zoll Thermogard temperature management systems only if all of the Arctic Sun and Zoll temperature management machines are unavailable.**
   a. **Apply ice packs to the groin, sides of chest, axillae, neck and limbs to initiate cooling.**
   b. **Cold IV saline may also be administered, as ordered, to facilitate rapid cooling.**
   c. **The Gaymar cooling blankets should be placed beneath and on top of the patient, with a sheet between the patient and the blanket to protect the skin.**
   d. **The water temperature in the Gaymar system is adjusted manually to achieve the desired rate of cooling.**
   e. **Ice packs can be removed during the maintenance phase.**
   f. **After 24-hours, the water temperature must again be manually readjusted to achieve slow, controlled rewarming at a rate no faster than 0.5°C per hour.**

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES ~~Policy Manual~~

ISSUE DATE:	**6/08**	**SUBJECT:**	**Visiting Guidelines**
REVISION DATE:	**5/92, 9/94, 10/96, 1/99, 5/02, 5/03, 12/03, 12/05, 7/07; 02/09; 03/11; 6/14**	**POLICY NUMBER:**	**8610 – 301**

Department Approval:	**12/16**
Clinical Policy & Procedures Committee Approval:	**~~06/14~~01/17**
Nurse Executive Council Approval:	**~~06/14~~02/17**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/14**
Board of Directors Approval:	**07/14**

A. **PURPOSE:**

1. To promote patient and family focused care in a healing environment while maintaining patient and staff safety, privacy and infection control measures.

B. **POLICY:**

1. Visiting is determined by the healthcare needs of the patient.
   a. Family members/significant others are encouraged to participate in care planning through regular interaction with the patient and the health care team.
   b. Limitations may need to be made due to the clinical condition of the patient or at the patient's request.
2. Recognizing the positive contribution made by patients' family/significant others; the Medical Center is open for visiting 24 hours a day.
3. Special Considerations: Visiting hours may be restricted for medical or emergency situations. All exceptions or restrictions are at the discretion of the Chief Nurse Executive or designee.
   a. Adult supervision is required for children in all areas of the facility. Visitors under the age of 14 must be accompanied at all times by an adult other than the patient when visiting a patient unit.
   b. To provide privacy and confidentiality, visitors may be requested to wait in designated waiting areas during physician examinations, nursing care, and the performance of tests or procedures.
   c. In order to allow opportunity for medical care to be provided and to ensure adequate rest and privacy for patients.
      i. In rooms with adjoining beds (semi-private), 2 visitors per patient at a time are allowed.
   d. To ensure patient safety and infection control, family members/significant others and visitors are not allowed in the bed with a patient; nor allowed in an unoccupied patient care bed.
4. The following areas have special visiting policies. Visitors must check in at the nursing station in the following departments:
   a. Intensive Care Unite
   b. Women's & Children's Services
   c. Neonatal Intensive Care Unit
   d. Emergency Department
   e. **Inpatient** Behavioral Health ~~Unit~~
   f. Surgical Services

5. Visitor responsibilities include but are not limited to:
   a. Observing the visiting hours for the area that they are visiting and leaving the patient room or care area when asked by hospital staff.
   b. Refraining from behavior that may cause annoyance, inconvenience and/or lack of consideration and assisting with the control of noise and the number of visitors.
   c. Consideration of the rights of patients and hospital staff by treating them with courtesy and respect.
   d. Maintenance of patient confidentiality and privacy.
   e. Refrain from damaging or removing any article or property belonging to TCMC.
   f. Refrain from bringing any food, alcohol or medications to the patient without prior approval from the physician.
   g. Reporting any concerns or complaints to the Assistant Nurse Manager, Manager or designee.
   h. Use hand sanitizer or soap and water to wash hands.
6. Violent or aggressive behavior by visitors:
   a. The hospital will not tolerate violence or aggression by visitors towards staff, patients or other visitors.
   b. The following items and behaviors are prohibited at TCMC:
      i. Alcoholic beverages ~~(unless ordered by physician)~~
      ii. Disruptive or violent behavior
      iii. Smoking**/electronic smoking devices**
      iv. Street drugs
      v. Weapons (see Administrative Policy # 284)
   c. For the safety of our patients, visitors and staff - visitors who do not comply with safe conduct regulations may be asked to leave or will be escorted off hospital grounds.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
District Operations

ISSUE DATE: 5/91 **SUBJECT:** CODE GRAY: HOSTAGE RESPONSE PLAN

REVISION DATE: 12/03; 9/05; 9/10 **POLICY NUMBER:** 8610-283

Department Approval:	02/17
Administrative Policies & Procedures Committee Approval:	~~01/14~~ 2/17
Medical Executive Committee Approval:	
Professional Affairs Committee Approval:	02/14
Board of Directors Approval:	02/14

A. **PURPOSE:**

1. **To provide a rapid, organized and thorough response at Tri-City Healthcare District (TCHD) to an incident where there is an individual being held against their will or in a hostage situation while in the facility or in the immediate surrounding parking areas.**~~To assure the proper implementation of a first response Medical Center procedure that will result in the successful resolution of any hostage situation that may emerge. To outline a process that will prepare each involved individual to maintain discipline, determination, and the proper utilization of sound judgment under stressful conditions.~~

B. **POLICY:**

1. **It is the policy of TCHD while responding to a hostage or barricaded suspect situation that the primary aim of personnel is to ensure the safety of all people on the premises, as well as, preserve life and protect property**~~While each and every hostage incident will vary in both complexity and locality within the Medical Center, to assist all involved personnel, the following guidelines should always be considered~~.
2. ~~Contain the movements of both the hostage and the hostage taker in order to keep the situation from further escalating. This guideline should only be safely attempted unless the incident factors force the utilization of another action.~~
3. ~~Control the immediate and orderly removal of all patients, visitors, and staff members from the incident area or department if safely possible to do so.~~
4. ~~Communicate with all involved personnel all the available pertinent facts regarding the hostage incident. Before any action is taken, all personnel must be properly briefed and continually updated on all available information.~~

C. **PROCEDURES ~~CESS~~:**

1. **The TCHD personnel who witnesses or comes upon a hostage situation within the facility shall:**
   - **a. Warn others of the situation by calling out for everyone to "take cover" and also take cover as well.**
   - **b. If a landline is available dial "66" and report "Code Gray" to the PBX Operator,** ~~Whoever first discovers an apparent hostage incident immediately notifies the Medical Center PBX/Operator of a Code Gray,~~ **and advise of** the incident location, and any other pertinent information, such as the number of hostages, a complete description of the hostage taker(s), and the description of any weapons.
     - ~~a.~~**i. The PBX/Operator will announce "Code Gray" three (3) times overhead, followed by the unit, department or location.**
     - ~~b.~~**ii.** The PBX/Operator will immediately notify the Security Department of the Code Gray and the location of the incident.

~~i.~~**iii. The PBX/Operator will also notify Oceanside Police Department via "911" and advise of the current situation.**

c. **TCHD Security Personnel will respond to the incident location and** ~~It~~ **it** will be the responsibility of the ~~Lead~~ Security **Supervisor or designee**~~Officer or Senior Officer~~ to ~~respond to the incident location and~~ assume the primary Officer designation.

i. The**is Security Supervisor** ~~Officer will~~ **shall** remain in this capacity until such time that **they are relieved of command by Oceanside Police Department personnel.**~~the Security Supervisor or Designee relieves the Officer~~.

ii. **The Security Supervisor will be responsible to brief Oceanside Police Department personnel of the hostage situation and will supply any requested support or additional personnel.**

iii. **The Security Supervisor will also advise for the facility to be placed into a security lockdown mode until further orders.**

d. ~~The primary Security Officer will ensure that the Oceanside Police Department and the Security Supervisor or Designee is immediately notified and informed of the incident. The Officer will also be responsible for insuring that he/she or the~~ **The** PBX/Operator **will** initiate~~s~~ the following call-out process.

i. The on-duty Administrator / Administrative Supervisor.
ii. The Environment of Care/Safety Officer.
iii. The on-call Administrator if after hours.
iv. The Public Information Officer.
v. The Director of Risk Management.

e. Security Department personnel will proceed to the incident location and **begin to safely** ~~orderly~~ remove all patients, visitors, and staff members to a safe location and properly **ensure that** ~~secure~~ all approaches into and exits out of the **immediate situation** area **are secured**.

f. The Emergency ~~Room~~ **Department and Surgery staff shall be advised of the hostage situation and prepare for possible trauma patients.**

~~e.~~**g.** During or after the evacuation processes any **capable** witnesses will be interviewed **by Security personnel for** ~~regarding~~ pertinent information regarding the **hostage situation**~~incident~~.

~~f.~~**h.** A secure area will be established for use as a command center and central location for the hostage negotiation team. A floor plan of the incident area will be obtained from the **Facilities** ~~Engineering~~ Department and a secured communications system will be established.

i. The Administrator or Designee **along with Oceanside Police Department** will obtain any pertinent information from the unit Manager or Designee of the affected area or department, regarding the hostage and hostage taker.~~, and~~

~~g.~~**j. TCHD medical personnel will be** reassign**ed as** needed ~~additional personnel~~ to this area in order to ensure proper staffing and continuance of the necessary medical services **if possible.**~~.~~

~~h.~~**k.** At no time during the hostage situation will any **TCHD** ~~Medical Center~~ personnel attempt to rescue a hostage or disarm a hostage taker. Open communications with the hostage taker can be attempted to deescalate the incident or obtain information, but at no time will any **TCHD** ~~Medical Center~~ personnel offer any promises or concessions to the hostage taker.

~~i.~~**l.** It will be the responsibility of the primary Security Officer to ~~assign the chronological~~ documentation ~~of~~ all pertinent circumstances related to the hostage situation. This documentation should include but not limited to the date, time, location, actions taken and personnel involved.

~~a. Upon the arrival of the law enforcement personnel, the Security Department will be responsible to supply any requested support or additional personnel.~~

m. At the completion of the **Hostage situation**~~incident~~, all involved personnel will remain available for interviewing by local law enforcement personnel and will only return to

normal operations after first receiving authorization to do so from the Security Supervisor or Designee.

D. RELATED DOCUMENTS:

~~j.~~**1. Emergency Operations Procedure: Code Silver Person with Weapon or Active Shooter**

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 6/94 **SUBJECT: CONTROL OF LOCKS AND KEYS**

REVISION DATE: 5/03; 2/06; 01/09; 02/11; 04/14 **POLICY NUMBER:** 8610-243

Department Approval:	**02/17**
Administrative Policies & Procedures Committee Approval:	**~~04/14~~ 2/17**
Professional Affairs Committee Approval:	**06/14**
Board of Directors Approval:	**06/14**

A. **PURPOSE:**

1. To set forth a uniform and systematic control for locks and keys at Tri-City **Health Care District (TCHD)**~~Medical Center (TCMC)~~.

B. **POLICY:**

1. All locks and keys at **Tri-City Medical Center** (TCMC) are the responsibility of the Director of Facilities.
2. Locks:
   a. All door locks in TCMC shall be keyed to the same master keyed system and shall comply with all applicable codes and standards.
   b. Door locks are to be keyed or re-keyed only by approval of the Department Director, Director of Facilities, or area Executive.
   c. Offsite door locks are managed through the Engineering Department.
   d. Any lock that is removed from the Master Key MUST- be approved by the Chief Executive **Officer** or Area Vice President.
3. Keypad combination locks are to be used only where absolutely necessary such as the number of keys to be issued would be impractical. All applicable codes and standards shall be adhered to for installation of keypad combination locks.
   a. Keypad combinations for door locks will be coordinated whenever possible provided hospital security is not compromised.
   ~~a.~~**b. Department Directors or Managers shall be responsible to ensure the integrity of the door code, and to change/update the code whenever there is a potential security risk.**
4. Keys:
   a. Keys will be issued to employees on an as needed basis upon approval of the Key Request form by Department Director or Manager, ~~and~~ Director of Facilities, ~~or~~ **A**~~a~~rea ~~Administrator~~ **Vice President** or CEO.
   b. Keypad combinations and keys for medical staff will be distributed through the Medical Staff Office.
   c. All keys and **k**~~K~~eypad combinations issued to **p**~~P~~hysicians and employees are to remain **protected/confidential** with the **p**~~P~~hysician/employee and are not to be ~~given~~ **shared with**~~to~~ anyone else.
   d. Any employee who terminates **employment** or transfers to another Department ~~will~~ **shall** ~~leave~~ **turn-in the** keys with exiting Department Director or Manager who will notify Engineering Department. ~~Keys will be issued to employee of new Department through a Key Request Process.~~
5. Electronic access control systems: The proximity card readers can only be installed with the approval of the CEO or COO.~~.~~

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 1/81 **SUBJECT:** HELICOPTERS ON DISTRICT PROPERTY

REVISION DATE: 5/89; 8/93; 10/97; 10/99; 5/03; 01/09 9/10; 04/14 **POLICY NUMBER:** 8610-207

Department Approval:	**02/17**
Administrative Policies & Procedures Committee Approval:	**~~04/12~~ 2/17**
Professional Affairs Committee Approval:	**06/14**
Board of Directors Approval:	**06/14**

A. **PURPOSE**

1. To maintain a safe environment for all personnel on the helipad.

B. **POLICY**

1. The patient's physician shall request helicopter transport.
2. Departments requesting helicopter transport shall notify the Emergency Department (ED) as to the estimated time of arrival.
3. The Emergency Department (ED) Mobile Intensive Care Nurse (MICN) shall make appropriate in-house arrangements for landing and take off.
4. The ED MICN shall be notified by the Aeromedical Dispatcher of helicopter landing.
   a. The ED MICN shall notify Security via the radio in radio room of estimated time of arrival of helicopter.
   b. The Security Department will respond to the elevator alcove (and must turn off air handlers temporarily by pushing red button) to standby in case the fire suppression system needs to be activated. The elevator shall be kept in the locked position, available to the flight crew.
      i. If the patient is incoming, an ED technician shall meet the helicopter with a gurney, oxygen tank and I.V. pole and, when directed, assist the flight crew in the transfer of the patient and equipment.
5. The following safety rules shall be followed at all times.
   a. No running on the helipad.
   b. Doors to the helipad shall remain closed at all times **(except during patient transfers to or from the helicopter)**.
   c. Visitors are not allowed on the helipad unless accompanied by the flight crew or TCMC Security personnel.
   d. Gurneys with mattresses, linens, or IV poles are not permitted within 50 feet of the aircraft when the blades are turning. Make sure all loose objects (i.e., MAST suits; debris) are secured on the helipad.
   e. ~~Unsecured oxygen cylinders shall not be left unsupported in the upright position.~~**Oxygen cylinders must be properly secured at all times (designated cylinder cart or underneath the gurney in the cylinder slot). At no time may cylinders be left unsecured.**
   f. Wait for the pilot's approval before approaching or exiting the aircraft. Approach or exit the aircraft from the front in view of the pilot.
   g. Do not approach the helipad until the aircraft has landed on or lifted off the pad.
   h. Do not approach or exit the aircraft when the blades are turning. Do not allow ancillary personnel to approach the aircraft until the rotors have stopped turning.
   i. Tri City Medical Center heliport weight restriction for all medical air transportation is 10k lbs. maximum with a blade diameter of no more than 36 feet.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 7/91

SUBJECT: MANDATORY REPORTING REQUIREMENTS

REVISION DATE: 12/91; 11/94; 2/95; 3/96; 4/97; 7/99; 6/02; 5/03; 7/09; 06/11

POLICY NUMBER: 8610-236

Department Approval:	**12/16**
Administrative Policies & Procedures Committee Approval:	**~~02/15~~02/17**
Medical Executive Committee Approval:	
Professional Affairs Committee Approval:	**03/15**
Board of Directors Approval:	**03/15**

A. **PURPOSE:**

1. To objectively and systematically monitor and evaluate quality and appropriateness of patient care, pursue opportunities to improve patient care, assure patient safety and resolve identified quality/risk issues on an ongoing basis. To identify and prevent serious injury, actual or potential, harm to a patient or visitor of Tri-City Health Care District (TCHD). Incident reporting enhances the quality of patient care and reduces healthcare and medical liability.
2. This policy/procedure consists of the following areas for reporting:
   a. Sentinel Events
   b. Unusual Occurrences (Title 22)
   c. Adverse Unexpected Events
   d. **Serious Reportable Events**

B. **SENTINEL EVENTS:**

1. **PURPOSE:** The purpose of this section is to describe the nature of a sentinel event and to provide a process for identifying, investigating, and reporting sentinel events.
2. **DEFINITIONS:**
   a. Sentinel Event: is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation that for which a recurrence would carry a significant chance of a serious adverse outcome [sometimes referred to as a "near miss"].
      i. The sentinel event definition includes any occurrence that meets any of the following criteria:
         1) The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition, or;
         2) The event is one of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition):
            a) Suicide of any patient receiving care, treatment or services in a staffed around-the-clock care setting or within 72 hours of discharge
            b) Unanticipated death of a full-term infant
            c) Abduction of any patient receiving care, treatment or services
            d) Discharge of an infant to the wrong family
            e) Sexual abuse, including rape
            f) Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
            g) Invasive procedure or surgery on the wrong patient, wrong

procedure, or wrong site.

h) Unintended retention of a foreign object in a patient after surgery or other invasive procedure

i) Severe neonatal hyperbilirubinemia (bilirubin greater than 30 mg/dL)

j) Prolonged fluoroscopy with cumulative dose greater than 1500 rads to a single field, or any delivery of radiotherapy to the wrong body region or greater than 25% above the planned radiotherapy dose.

b. Near Miss is a term used to describe any process variation which did not affect the outcome but for which a recurrence carries a significant chance of serious adverse outcome.

c. Root Cause Analysis - is a process for identifying the basic or causal factor(s) that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event **or serious reportable event which will include human factors related to the occurrence**.

d. **Serious Reportable Event — as developed by the National Quality Forum see National Quality Forum List of Serious Reportable Events 2011.**

3. **POLICY:**

a. It is the District's policy to investigate any sentinel event, serious adverse event, or serious "near miss" from an interdisciplinary perspective and take action to reduce the risk of recurrence. Each serious adverse event will be intensively assessed through the use of the Root Cause Analysis (RCA) process. An action plan, based on the RCA is developed to implement improvements to reduce risk; the action plan is implemented and the effectiveness monitored.

b. The Risk Manager or Senior Administrative Designee shall coordinate the implementation of the improvement or correction plan, the monitoring of the effectiveness of the plan and reporting of progress to the Executive Council.

c. A report of each RCA shall be communicated to the Quality Assurance/Performance Improvement/Patient Safety Committee (QA/PI/PS) of the Medical Staff, for periodic reporting to the Board of Directors via the Professional Affairs Committee (PAC).

d. RCAs shall not be reported to the Joint Commission, nor to any external agency or organization, except upon specific, written advice of legal counsel. The Sentinel Event investigation and reporting process, including development of the RCA, is intended to remain within the bounds of Medical Staff Peer Review, subject to all applicable protections from discovery, including Evidence Code § 1157 and Attorney-Client and Attorney Work Product privileges.

4. **PROCESS:**

a. Each potential sentinel event will be investigated to the extent necessary to determine all the relevant facts and circumstances. The Risk Manager or Senior Administrative Designee shall compare the facts and circumstances to the Sentinel Event definition, and make a preliminary determination whether the potential event appears to qualify as a sentinel event. In order to make this determination, the Risk Manager or Senior Administrative Designee has the discretion to convene an Ad Hoc committee, composed of physicians, hospital staff and consultants, if necessary, to assist in determining if a sentinel event has occurred.

b. If the potential event is determined to qualify as a sentinel event, the RCA process commences immediately and shall be completed within 45 days of notification of the event.

c. If the potential event fails to qualify as a sentinel event, the matter may be closed or referred for additional study using performance improvement methods.

d. The RCA shall be documented on a "Root Cause Analysis" form and made part of a permanent file to be maintained by the Risk Manager. The RCA shall not be filed in the Medical Record.

e. The RCA report's conclusions and recommendations, if any, shall be communicated to the involved departments/services for development of a plan of action or plan of correction.

f. The Director of Risk Management and/or the Director of Regulatory Compliance, or Senior Administrative Designee shall coordinate the implementation of the improvement or

correction plan, the monitoring of the effectiveness of the plan and reporting of progress to the Administrative Team Meeting.

5. **REPORTING TIMEFRAMES:**
   a. The first person to identify an adverse event will notify his/her supervisor as soon as it is safe to do so.
   b. The supervisor must assure that serious adverse events are reported the Director of Risk Management, Chief Nurse Executive, and the Director of Regulatory Compliance. These will assure that the event is then reported to the Chief Executive Officer, Chief Operating Officer, etc as appropriate.
   c. Based on the circumstances, a decision will be made to report the event to the appropriate regulatory agencies.
   d. All events requiring notification of regulatory agencies, such as the California Department of Public Health, will be completed in a timely manner.
   e. The patient's primary and/or involved physician is notified.
   f. The appropriate Medical Staff Leader for the department is notified.
6. **COMMUNICATION:**
   a. Information related to the reportable event is communicated to the physician and staff involved in the care of the patient as soon as possible.
   b. Physicians and staff involved in the reportable event may be included in the RCA and Action Plan.
   c. The appropriate Medical Staff Leader will be notified prior to reporting the event whenever possible.
   d. Reported events are communicated to the appropriate medical staff Quality Review committees, the Medical Executive Committee, and the Board of Directors.
   e. Critical events may be reported in an expedited manner by Administration via verbal or electronic methods.
   f. A report of each RCA shall be communicated to the QA/PI/PS of the Medical Staff, for periodic reporting to the Board of Directors via the Professional Affairs Committee (PAC).

C. **UNUSUAL OCCURRENCES (TITLE 22)**
1. **DEFINITIONS:**
   a. Unusual Occurrence: (Title 22, Section 70736) – any condition or event which has jeopardized, or could jeopardize, the health, safety, security or well being of any patient, employee or any other person while in the facility. These shall include, but not be limited to the following:
      i. An epidemic outbreak of any disease, prevalence of communicable disease, whether or not such disease is required to be reported by Title 17, California Administrative Code, Section 2500, or epidemic infestation by parasites or vectors
      ii. Poisonings
      iii. Fires
      iv. Physical injury to any person, which would require treatment by a physician
      v. Death of a patient, employee or visitor from unnatural causes
      vi. Sexual acts involving patients who are non-consenting
      vii. Physical assaults on patients, employees or visitors
      viii. All instances of patient abuse
      ix. Actual or threatened walkout, or other curtailment of services or interruption of essential services provided by the facility
2. **PROCEDURE:**
   a. In accordance with State of California standards, the following provisions have been established. An occurrence such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety or health of patients, personnel or visitors, shall be reported as soon as reasonably practical, either by telephone or by any other practical means to the local health officer and to the California Department of Public Health (CDPH) and as applicable to county of San Diego Behavioral Health Services or the Department of Health Care Services.
   b. The District shall furnish other pertinent information related to such occurrences as may be

required by CDPH or health officers.

c. In the event of a disruption of services, the Administrator or designee shall be responsible for immediate reporting.

D. **ADVERSE UNEXPECTED EVENTS:**

1. **PURPOSE:** This section complies with the requirements of SB 1301 (CA Health & Safety Code §§ 1279.1, 1279.2, 1279.3, and 1280.4) mandating the reporting of "adverse events" to the California Department of Public Health (CDPH).

2. **POLICY:**

a. It shall be the policy of Tri-City Medical Center (TCMC) to report an adverse event, as defined in Health & Safety Code § 1279.1, to the CDPH and as applicable to county of San Diego Behavioral Health Services or the Department of Health Care Services not later than 5 days after the adverse event has been detected; or, in the event of an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel or visitors, not later than twenty-four (24) hours after the adverse event has been detected. TCMC shall inform the patient or the party responsible for the patient of the adverse event by the time the report to CDPH is made.

3. **PROCESS:**

a. All adverse events shall be reported without delay to the Director of Risk Management and to the Director of Regulatory Compliance, or in their absence, to the COO, CNE, or in his/her absence, to the CEO for analysis and determination if such adverse event needs to be reported to CDPH and as applicable to county of San Diego Behavioral Health Services or the Department of Health Care Services. The Director of Risk Management shall notify the attending physician(s) and the Chief of Staff, or his designee, that a report of a potential adverse event has been received. These physicians and the CEO, CNE,COO or their designees shall be consulted and provide input regarding the report ability of the event, so long as such consultation and input does not prevent timely reporting to CDPH and as applicable to county of San Diego Behavioral Health Services or the Department of Health Care Services. In the event that an adverse event qualifies for reporting to CDPH, the report shall be made on a form, specifically designed for such reporting and individually identifiable patient information shall be safeguarded, in terms of privacy and confidentiality, consistent with applicable law.

b. In every situation, the attending physician shall be the preferred individual to disclose the adverse event to the patient/family. Only where the attending physician is unable to or unwilling to make this disclosure will a Medical Staff Officer, or some other designee, disclose the event to the patient/family. The date, time, and circumstances of disclosure shall be recorded in the patient's permanent medical record.

c. The Department Director/Manager/designee shall be notified of the event. In addition, if the patient is a research patient, the Director of Clinical Research shall be notified.

d. The Director of Risk Management is responsible for ensuring that a thorough investigation of the adverse event is completed, which may include a root cause analysis.

e. The adverse significant event shall be reported in the in the RL Solutions Incident Report.

E. **CALIFORNIA STATE REPORTABLE ADVERSE EVENTS:**

1. Surgical events, including the following:

a. Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.

b. Surgery performed on the wrong patient.

c. The wrong surgical procedure performed on a patient, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.

d. Retention of a foreign object in a patient after surgery or other procedure, excluding

objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.

e. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

2. Product or device events, including the following:
   a. Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.
   b. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.
   c. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.
3. Patient protection events, including the following:
   a. An infant discharged to the wrong person.
   b. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision-making capacity.
   c. A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.
4. Care management events, including the following:
   a. A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.
   b. A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
   c. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.
   d. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.
   e. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. For purposes of this subparagraph, "hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.
   f. A Stage 3 or 4 ulcers, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.
   g. A patient death or serious disability due to spinal manipulative therapy performed at the health facility.
5. Environmental events, including the following:
   a. A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric counter shock.
   b. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.
   c. A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.

d. A patient death associated with a fall while being cared for in a health facility.
e. A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.

6. Criminal events, including the following:
   a. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
   b. The abduction of a patient of any age.
   c. The sexual assault on a patient within or on the grounds of a health facility.
   d. The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.
7. An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.
   a. Serious Disability means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than 7 days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

F. **ATTACHMENTS:**
1. Reporting Grid

G. RELATED DOCUMENTS:
~~2.~~**1. National Quality Forum List of Serious Reportable Events 2011**

~~G.~~**H. REFERENCES:**
1. CA Health & Safety Code §§ 1279.1, 1279.2, 1279.3, and 1280.4
~~1.~~**2. California Code of Evidence Section 1157**
3. California Hospital Association Consent Manual 2016~~14~~
4. Title 17
5. Title 22, Section 70736

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Adverse Drug Reaction (ADR)	ICH guidance for Clinical Safety Data Management: Definitions and Standards for Expedited Reporting	Attending Physician/Investigational Drug Pharmacists/Principal Investigator of Clinical Trial/ Sub Investigator of Clinical Trial/Clinical Research Coordinator	Clinical Trial Site/Principal Investigator of Clinical Trial, Sub Investigator of Clinical Trial/Clinical Research Coordinator	All ADRs must be documented in the research participants medical and research record.	Policy:Clinical Research Subject Safety & AE/SAE/Incident Reporting Policy; Policy number #010
Adverse Event (AE)	ICH guidance for Clinical Safety Data Management: Definitions and Standards for Expedited Reporting	Attending Physician/Principal Investigator of Clinical Trial/ Sub Investigator of Clinical Trial/Clinical Research Coordinator	Clinical Trial Site/Principal Investigator of Clinical Trial, Sub Investigator of Clinical Trial/Clinical Research Coordinator	Aes are to be captured in the case report forms and as part of the medical records. There are no special reporting requirements for AEs at TCMC.	Policy:Clinical Research Subject Safety & AE/SAE/Incident Reporting Policy; Policy number #010
Animal Bites		Emergency Department, Business Office	Humane Society	Phone Call	Emergency Dept.
Assault & Battery to On-Duty Health Care Personnel	A.B. #508 CA Penal Code # 240,242	Security Department	Local Law Enforcement Professional & Regulatory Services (P&RS), Employee Health, Dept. of Health	Phone Call within 72 hours of occurrence. Employee Injury Report	Admin. Policy #241
Assault Victims Domestic Violence	CA Penal Code 11160/11161 CCR Title 11, Section 920	Emergency Department, Business Office Registrars, Social Service Department, Nursing Staff, Security, Risk Management	Local Law Enforcement	Phone police immediately and written report - 2 working days	Admin. Policy #310
Cancer/Reportable Neoplasms	Title 17, California Code of Regulations, Section 2593	Oncology Data Registrar	California Department of Public Health (CDPH) Cancer Prevention Section	Within six months of diagnosis	Oncology Registry/CNE
Certification of Birth	Health and Safety Code Section 10101	Birth Certificate Clerk Medical Records Department	San Diego County Registrar	Within 10 days of birth	Medical Records Dept.
(Suspected) Child Abuse	Penal Code: 11164-11174.3	Social Service Department Health Practitioner, Child Care Custodian	Child Protective Services or Local Law Enforcement	Immediately by Phone-And Within 36 Hours in Writing	Admin. Policy #308 Social Service Dept. #308

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Chromosomal Defects in Fetus or Infant	Title 17 CCR 6532	Lab performing the analysis or physician making diagnosis	CDPH	Within 30 days of diagnosis using form provided by CDPH	Women's & Children's Services
(Illegal) Drug Use - non employee	CA Penal Code, Section 11-160	Security Dept.	Oceanside Police	Telephone and written report	Admin. Policy #236
(Suspected) Elder and Dependent Adult Abuse	Penal Code: Section 368 Welfare & Institution Code #15600–15637	Social Service Department Health Practitioner, Care Custodian	Occurring in a LTC Facility report to Long Term Care Ombudsman or Local Law Enforcement; All others to County Adult Protective Services	Telephone Report-Immediately Written Report-Within 2 Working Days	Admin. Policy #309 Social Service Dept. #309
Infectious Diseases (Reportable *) (See Reporting Responsibility Table)	Title 17, Chapter 4, CCR 2500 Health & Safety Code 3125	Nursing Staff Emergency Department, Infection Control Practitioner, Laboratory - Microbiology & Chemistry	Infection Control Practitioner Public Health Department	Phone immediately to Public Health depending on disease. Fax information to Public Health using PM 110.	Infection Control #110
Lapses in Consciousness/Seizures	Health & Safety Code 3125 Section 410 Title 17, CCR 2500	Physician	Local Health Officer who reports to DMV	Fax information to Public Health using PM 110.	Physician Protocol
Mental Health holds beyond 24 hours (ED) (Unusual Occurrence)	Title 22 Section 70737, 71535	Health Care Practitioner Administration Manager Emergency Department	CDPH	Phone after 24 hour mark followed by letter to CDPH	Emergency Dept., Mental Health Unit
Missing Patient		Security Department	Local Law Enforcement Agencies	Telephone immediately within reasonable time frame (given situation)	Admin. Policy #305
Multiple bee stings (Unusual occurrence)	Title 22 CCR 70737	Emergency Department Nursing Staff	County of San Diego, CDPH	Phone call immediately to CDPH written report	Admin. Policy #228
Needle stick injury/BS Exposure	Fed and Cal OSHA Rec. Blood borne Path.	Supervisor	Employee Health or ED	Immediate Supervisor Investigative Report. Employee Health uses separate injury log for needle sticks.	Employee Health Services/ Infection Control
Neural Tube Defects in a Fetus	Title 17, California Code of Regulations, Section 6531	Medical Records Department	CDPH Alpha-Feto Protein Screening Program	Within 30 days of initial diagnosis	Women's & Children's Services

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Newborn Abandonment: Voluntary surrender (abandonment of newborns up to 72 hours old)	SB 1368	Health Care Practitioner	Child Protective Services	As soon as possible; no later than 48 hours	Admin. Policy #380
Newborn Screening Test refusal (PKU)		Women's & Children's Services Representative	CDPH Genetic Disease Branch	Prior to infant discharge Fill out form #NBS-PR	Women's & Services
Occupational Injuries/Illnesses	Labor Code 3209.3 CCR Title 8 S - 14003	Physician	Employer & Employees Insurer	Written Report within 5 working days	Physician Protocol Employee Health Services
Outbreaks or undue prevalence of infectious or parasitic disorder	Title 17, Chapter 4 CCR 2502	Any healthcare provider (physicians, PA, RN, nurse midwife, or Infection Control Practitioner)	Local Health Officer	Phone, fax or mail information to Public Health using the CMR form found in the IC Manual.	Infection Control #IC.12
Patient Death	Title 22 72549 HSC 10250	Health Care Practitioner; Physician	Medical Examiner CDPH at a time and manner as requested, Pt. Reps – TCMC	Phone immediately Complete form 8720-37	PCS Policy IV.Z , PCS Procedure
Patient death due to unusual circumstances, i.e. suicide	Title 22 Section 70737, 71535	Health Care Practitioner Administration	Local law enforcement officer, medical examiner and CDPH. CMS and regional CDPH	Local law enforcement contacted prior to medical examiner. CDPH as soon as practical confirmed in writing. Incident report on file by facility for 1 year.	Admin Policy #228 PCS Policy IV.Z , PCS Procedure
Patient death while patient in seclusion or restraint for behavior management	42 CFR Section 482.13(f)(f) Reporting is required whether or not R/S was the cause of death Title 22, CCR Section 70737(a) Section 71535	Director of Regulatory Compliance	Centers for Medicare and Medicaid Services (CMS) CDPH	As soon as aware. By telephone: (415) 744-3726 or fax (415) 744-2692	Admin Policy #228 PCS Policy IV.Z , PCS Procedure

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Patient death while in medical surgical restraint	Title 22, CCR, Section 70737(a) Section 71535	Director of Regulatory Compliance	CDPH	As soon as reasonably practical, by phone: (800) 824-0613 Followed by letter: 7575 Metropolitan Drive Suite 104 San Diego, CA 92108	PCS Policy IV.Q
Patient Injury/Death due to Device Malfunction	Safe Medical Device Act 21 CFR 803	Health Practitioner Director of Risk Management	–MFR-Serious Injury FDA&MFR-Death or FDA if MFR is unknown	Within 24 hours via form FDA3500A and phone 301-796-6670. E-mail: MDRPOLICY@FDA.HHS.GOV. Annual Summary of Medical Device Related Death and Serious Injury Report to FDA on Form FDA 3419 by January 1st of each year as described in 803.33	Admin. Policy #201
Patient Transfer Violation	(COBRA) Health and Safety Code 1317 through 1317.99 Title 42 U.S.C. Section 139 dd	Director of Regulatory Compliance	CDPH HCFA	7 days 72 hours	Admin. Policies 228, 506; PCS Policy VI.D
Pesticide Poisoning	Title 8 CCR 14003	Emergency Department Health Care Practitioner	Emergency Department Mgr. Local Health Officer Co. Dept. of Agric. Deputy Agricultural Commissioner	Phone call within 24 hours	Emergency Dept.
PKU Specimen not obtained		Unit Representative where infant was a patient	California Department of Public Health Genetic Disease Branch	When patient transferred, expires Fill out form # (BS - No - 90)	Women's & Children's Services
Rhesus Hemolytic (RH) Disease – Newborn	Title 17 CCR Section 6510 Title 22 CCR 70737	Health Care Practitioner	CDPH - Women's & Children's Services Office physician who made diagnosis	Use reporting form "A case report of RH Disease of Newborn"	Women's & Children's Services
Reye Syndrome	HSC Section 304.5	Attending Physician	CDPH	Within 7 days of diagnosis using reporting form "CBC Reye Syndrome..."	Physician Protocol

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Serious Adverse Event (SAE) as related to Clinical Research	ICH guidance for Clinical Safety Data Management: Definitions and Standards for Expedited Reporting	Attending Physician/Principal Investigator of Clinical Trial/ Sub Investigator of Clinical Trial	Clinical Trial Site/Principal Investigator/Sub Investigator/Clinical Research Coordinator	Report Immediately to Attending Physician and Clinical Trial Site personnel. All SAEs must be documented in the research participants medical and research record.	**Policy: Clinical** Research Subject Safety & AE/SAE/Incident Reporting Policy; Policy number #010
Threat to kill	Tarasoff	Psychotherapist/Health Care Practitioner	Intended victim and local law enforcement	Immediately by telephone	Behavioral Health Unit, Social Service Dept.
Unusual occurrences that threaten the welfare of the patient, staff or visitors (i.e., allegation of staff sexual misconduct)	Title 22 Section 70737, 71535	Health Care Practitioner Administration Director of Regulatory Compliance	CDPH Local law enforcement as appropriate	As soon as reasonably practical - confirmed in writing Occurrence on file by facility for 1 year	Admin. Policy #228
Adverse effect of a vaccine	National Childhood Vaccine Injury Act	Health Care Provider	VAERS Hotline 800-822-7967	After administration by telephone	Infection Control

National Quality Forum
List of Serious Reportable Events - 2011

1. SURGICAL OR INVASIVE PROCEDURE EVENTS

1A. Surgery or other invasive procedure performed on the wrong site (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1B. Surgery or other invasive procedure performed on the wrong patient (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1C. Wrong surgical or other invasive procedure performed on a patient (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

2. PRODUCT OR DEVICE EVENTS

2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

3. PATIENT PROTECTION EVENTS

3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3B. Patient death or serious injury associated with patient elopement (disappearance) (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4. CARE MANAGEMENT EVENTS

4A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4B. Patient death or serious injury associated with unsafe administration of blood products (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers

4D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy (new)
Applicable in: hospitals, outpatient/office-based surgery centers

4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

4G. Artificial insemination with the wrong donor sperm or wrong egg (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5. ENVIRONMENTAL EVENTS

5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

6. RADIOLOGIC EVENTS

6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

7. POTENTIAL CRIMINAL EVENTS

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7B. Abduction of a patient/resident of any age (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

SUBJECT: AHA ~~/ AWHONN~~: COURSE CARD ACCEPTANCE

ISSUE DATE: 8/07;
REVISION DATE(S): 3/10; 12/11; 4/13

Department Approval Date(s): **12/16**
Medical Executive Committee Approval Date(s): **n/a**
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s): 8/07, 4/10, 3/12; 7/13

A. **PURPOSE:**

1. To ensure the appropriate documentation is current and valid for all TCMC employees, Contract Employees, Registry Employees requiring AHA Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), and Pediatric Life Support (PALS) course completion.

B. **POLICY:**

1. **American Heart Association**
   a. Course Completion must follow the established guidelines per American Heart Association (AHA) Emergency Cardiac Care (ECC) Course Matrix **2015**~~2010~~.
   b. TCMC Training Center (TC) maintains authorization to review and approve all Basic Life Support (BLS)/Advanced Cardiac Life Support (ACLS)/ Pediatric Advanced Life Support (PALS) Provider and Instructor cards from outside Training Centers (TC) and Training Sites (TS). **Military Training Network cards are accepted.**
   c. Employees must present a current AHA BLS/ACLS/PALS Provider and/or Instructor card from an approved AHA Training Center or Training Site that is current and in good standing utilizing the AHA guidelines and curriculum.
   ~~d. TCMC TC will accept cards only from the American Heart Association's Healthcare Provider Online Renewal course if it included a complete Part II skills checklist from an authorized AHA Training Center.~~
   ~~e.~~**d.** TCMC TC will utilize the Course Card Reference Guide for surveillance of AHA provider cards.
   ~~f.~~**e.** Contact Education department for most current list of Training Centers in good standing with the AHA or log onto www.americanheart.org.

~~2. **Associated of Women's Health Obstetric and Neonatal Nurses (AWHONN) Fetal Heart Monitoring:**~~
   ~~a. Course completion must follow the established guidelines in a workshop focusing on application of essential fetal heart monitoring (FHM) knowledge and skill set required to work in Labor and Delivery unit~~
   ~~b. This AWHONN course endorses and encompasses the updated National Institute of Child Health and Human Development (NICHD) nomenclature that the American College of Obstetricians and Gynecology (ACOG) has endorsed and recommends in clinical practice for common terminology and collaboration.~~
   ~~c. Courses for fetal monitoring certification must be AWHONN approved or sponsored courses.~~
   ~~d. Intermediate or advanced fetal monitoring courses are acceptable for meeting either initial certification or recertification.~~

C. **REFERENCE LIST:**

1. American Heart Association Program Administration Manual, 201~~208~~

~~2. Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), (2009). Fetal Heart Monitoring Principles and Practices, 4th Edition. Kendal/Hunt Publishing Company: Dubuque, Iowa~~

~~D. **APPROVAL PROCESS**~~

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

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT MANUAL

SUBJECT: AHA: CARE AND DECONTAMINATION OF AHA EQUIPMENT

ISSUE DATE: 7/05
REVISION DATE(S): 08/07, 04/10, 07/13

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

A. **POLICY**

1. To ensure the safety, comfort and health of all participates during AHA courses held in connection with the TCMC AHA Training Center (TC), all Instructors will follow current recommendations in the care and cleaning of equipment and other safety measures during and after all AHA courses.
2. Should a student be in an active state of an infectious disease, or share that they may have been exposed and are not sure, or have dermatologic lesions on their hands, mouth or face the Instructor must request that the student must return to class on another day after these situations have cleared or if possible, assign participant to own manikin to lessen the possibility of contamination and limiting exposure to other participants
3. Students may not eat, drink, smoke or chew gum during class.
4. ~~Before each course the AHA instructor will announce to participants that all equipment is decontaminated after each course and to encourage each participant to use hand sanitizer after each demonstration of skills using manikins and adjunct equipment~~
5. **Use of manikins during course**~~Checking out or up for a course with manikins~~:
   a. It is the responsibility of each Instructor to clean the manikins that are used for each class.
   b. ~~In some scenario a manikin may have been assemble but not used for practice in BLS skills and the manikin is still considered clean. If manikin(s) are not clean or there is a question, the Instructor responsible for the teaching station or checking out manikins must clean and obtain clean parts for manikin assembly before use. See below under the section "Cleaning of Manikins at end of Class."~~
   c. ~~Instructors will wash hands before handling manikins and not eat or drink during class.~~
6. During Class the following guidelines will be used:
   a. Each manikin station will have some type of antimicrobial cleaning agent; this may be alcohol wipes, Sani Cloths, or Gel and cloths. These are to be used by each instructor to wipe down manikin mouth, face and facemask after use.
   b. Each student will be given his or her own face shield or green one-way valve. Extra face shields will be available during class should a student misplace or lose theirs.
   c. Instruct students to use gel for hands in-between each manikin station.
   d. ~~During Obstructed-airway procedure demonstration request students only simulate the finger sweep to avoid contamination of rescuer's finger with any possible exhaled moisture and saliva from previous rescuers.~~
   e. ~~During 2-rescuer CPR training with mouth-to-mouth ventilation, there is no opportunity to disinfect the manikin between rescuers when switching positions. Thus, the second rescuer taking over ventilation will be instructed to simulate ventilations only.~~
   f. ~~Use plastic trash bags at each station for used cloths/wipes to be placed in.~~
   g. **d.** Used green one-way valves will be discarded at the end of each class. They can be offered to the students to take home. Only new green one-way valves will be used for each class.

~~7.~~**6.** Instructors responsibilities for cleaning manikins at end of class:
- a. Instructor should first apply gloves before dismantling manikins.
- b. Remove face and connectors and inspect for any damage. Should any parts be damaged, discard them; otherwise place them in a plastic bag. Report to TCC any equipment that need to be replaced and or ordered in a timely fashion
- c. Remove lungs and discard in trash.
- d. Clean face, internally and externally, jaw, neck and chest with Sani cloths or other cleaning solutions recommended on page 1-93 (chapter 6) in your Instructors manual. Let manikins dry thoroughly.
- e. Manikins deemed too dirty to be easily cleaned (manikin has had direct contact with a student's mouth, contaminates visible):
  - i. Instructor will utilize the manikin parts bag in the carrying case to replace all parts of the manikin with clean parts (lung bag, manikin face, and connector)

~~8.~~**7.** TC's responsibilities for cleaning and care of manikins:
- a. TC will take used parts to Sterile processing for sterilization.
- b. After sterilization, TC will inspect manikin parts for damage and toss if damage has occurred.
- c. The airway and face pieces will replaced after the last class of each month.
- d. These prepared bags of clean manikin parts will be placed in the clearly identified bin in the Manikin Care Station.
- e. TC will be responsible for periodical washing of manikins clothing at least monthly and if obviously soiled.
- f. TC will assume responsibility in caring for any manikins that fall under the situations mentioned in section G.8 above.
- g. The Equipment check-in and checkout log accuracy will be the responsibility of the Instructor.
- h. Any equipment missing from the Training Center and not logged is considered theft of TC property
- i. Reservation for equipment is on a first come first serve basis
- j. Equipment rental process may change periodically
- k. Late returns may result in loss of rental privileges
- l. Payment is expected when equipment is picked up

B. **FORMS**
1. BLS Manikin & Other Equipment Check Out

C. **REFERENCE LIST:**
1. Chapter 6 in BLS Instructor's Manual

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

AHA BLS MANIKIN & OTHER EQUIPMENT CHECK OUT

Date: Checked Out	Name/Contact #:	Video # Or Name	Manikins Checked out: A = adult/ C = child/ B = baby Also please identify by manikin number on bag Or write in other equipment	Manikins Cleaned/Restocked (Y/N)	Date: Checked In

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

SUBJECT: AHA CONTINUING EDUCATION STATEMENT

ISSUE DATE: 8/07
REVISION DATE(S): 04/10, 07/13

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

A. **POLICY**

1. Tri-City Medical Center AHA Training Center Continuing Education (CE) statement:
   - **a.** The AHA does not issue continuing medical education (CME), continuing education (CE or continuing education hours (CEH) for any AHA ECC courses. Instructors conducting courses for professional groups eligible to receive continuing education credits are encouraged to submit information to the appropriate professional organization.
   - ~~a.~~**b. The AHA does issue CE for their Heartcode ACLS and PALS online courses only. Any instructor led events are the responsibility of the Training Site or Center to maintain and issue CE or CME.**

B. **PROCEDURE:**

1. At the end of each ACLS or PALS course the Lead Instructor will calculate the total hours of Instruction and record the number of hours on the course roster.
2. TCMC Education Department issues the Continuing Education hours for participants.

~~C. APPROVAL PROCESS~~

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

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

SUBJECT: AHA: MISSION STATEMENT AND GOALS

ISSUE DATE: 8/07
REVISION DATE(S): 04/10, 07/13

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

A. **POLICY**

~~The American Heart Association's (AHA) mission is build healthier lives, free of cardiovascular diseases and stroke, that single purpose drives all we do.~~

1. **The American Heart Association's Emergency Cardiovascular Care (ECC) is inspiring the world to save lives through a dynamic message of hope. As the authority in resuscitation science, research and training, we publish the official AHA Guidelines for CPR and ECC. Because saving lives is why.**

~~1.~~**2.** Tri-City Medical Center's AHA Training Center supports the AHA mission and goals through administration, education, and quality assurance support of the AHA Instructor members and training sites. Our training center is committed to providing quality and current AHA courses to ~~HCPs~~ **Healthcare Providers and to the public** to provide them with the skills to promote excellence in the delivery of patient/family centered care.

~~2.~~**3.** Our goals are to provide AHA program to the community and support training courses to our community. We operate under a written agreement with the AHA and continue to build relationships with new members of the AHA community network.

~~B. APPROVAL PROCESS~~

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

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

SUBJECT: AHA: QUALITY ASSURANCE PROGRAM

ISSUE DATE: 7/05
REVISION DATE(S): 08/07, 04/10, 07/13

Department Approval Date(s):	**04/13**
Medical Executive Committee Approval Date(s):	**n/a**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(S):	**07/13**

A. **POLICY**

1. TCMC TC will have a Quality Assurance Plan integrated into the Education Departments Annual Operational Plan and update it annually. Indicators will be chosen that will reflect monitoring of course quality, instructor performance, and TC administrative operations.
2. TC Quality Assurance Monitoring Points to be considered in the annual Quality Assurance Plan and for the dash board are:
   a. Most Current AHA examinations used in all courses and student test scores
   b. Each student has the current appropriate provider textbook readily available for use before, during, and after the course.
   c. A mechanism exists for developing, monitoring, renewing status, and updating Instructors.
   d. AHA core content is taught in every course.
   e. Course completion cards and written exam answer sheets are kept secure.
   f. TC has adequate resources to complete the contracted program requirements, including staff, equipment, budget, etc.
   g. Appropriate cards are issued to each student who has successfully completed course requirements.
   h. A written internal dispute resolution policy is provided to all Instructors.
   i. Sufficient course materials and equipment is on hand to meet course and Instructors needs. That all equipment is clean and in good working order.
   j. All records are complete and filed properly.
   k. TC initiates a process that ensures all TCF, Lead Instructors, and Instructors are adequately trained to fill their roles and are actively involved in the Quality Assurance/Continuous Quality Improvement process.
   l. A mechanism exists to monitor courses taught by all Instructors and Training Centers.
   m. Courses, Instructors and program administration evaluation process are in place.
3. Additional monitoring of program growth and improvement in performance will be assessed through the following indicators:
   a. Increased training numbers
   b. Participation in chain of Survival activities in the community.
   c. Improved Course evaluations/summaries
   d. Expansion of the TC Training Network (e.g. new Instructors, new Training Sites)

~~B. APPROVAL PROCESS~~

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

Tri-City Medical Center
Oceanside, California

DELETE – combine with AHA Card Processing Procedure

EDUCATION DEPARTMENT MANUAL

SUBJECT: AHA TRAINING CENTER: COURSE CARD MANAGEMENT

ISSUE DATE: 7/05
REVISION DATE(S): 08/07; 04/10, 07/13

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

A. **POLICY**

1. TCMC Training Center (TC) has been issued a security code by the National Center ECC Department. This code is required to order AHA cards to be issued at the completion of each discipline. Only cards can be issued to the TC for those disciplines the TC has been approved to provide.
2. Only the TCC and his/her designee are authorized to use this security code.
3. TCC may delegate the issuance of cards to a Training Site; however, the TC remains responsible for the issuance of cards in accordance with AHA policies.
4. The AHA regional office may change this security code if deemed necessary to maintain the confidentiality of this code.
5. Each student who successfully completes an AHA ECC course will be issued the appropriate course card that bears the AHA logo.
6. TCMC TC will issue cards only to students of the TC, Aligned Training Sites, and/or Instructors who have met the requirements.
7. To maintain security and accountability for card issuance process only the TCMC TCC and Education Department Secretarial/Support staff will have access to AHA course cards.
8. TCMC TC will issue course cards within 30 days of receipt of paperwork.
9. Each card will be computer printed to reduce the risk of cards being altered and for legibility.
10. AHA Course Cards will be completed following the AHA course card reference guide to quality Control April 2010
    a. Front of Card (Provider and Instructor)
        i. Course Name
        ii. Student's name (first, middle initial, last)
        iii. Issue date (two-digit month and day, and four-digit year) (i.e. 01/03/2010)
        iv. Recommended renewal or expiration date (two years from date of issue) indicated by two-digit month and four-digit year only.
        v. TCMC will honor all AHA cards until the last day of the month of the recommended renewal or expiration date.
    b. Back of Card (Provider and Instructor)
        i.
        ii. Training Center name and ID number
        iii. Training Site if different from TC and address
        iv. First and last name of Course Director/Lead Instructor and instructor's ID #
    c. Student is to sign his/her card in ink upon receipt
11. It is the responsibility of the TC to issue a duplicate card if card is lost or mutilated. TCMC will charge $10 for replacement cards that is lost by the student. TC will verify course attendance before issuing a duplicate card.
12. AHA cards damaged during shipment must be returned to the distributor for replacements.

B. **APPROVAL PROCESS**

1. Clinical Policies & Procedures Committee

~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4.~~**1.** ~~Board of Directors~~

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

SUBJECT: COPYRIGHT POLICY

ISSUE DATE: 6/07
REVISION DATE: 8/07; 4/10; 7/13

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

A. **PURPOSE:**

~~A.~~**1.** Provides guidelines for duplicating or utilizing copyrighted material.

B. **POLICY:**

1. Tri-City Medical Center recognizes that federal law makes it illegal to duplicate copyrighted materials without authorization of the holder of the copyright, except for certain exempt purposes. Severe penalties may be imposed for unauthorized copying or using of audiovisual or electronic/printed materials and computer software, unless the copying or using conforms to the "fair use" doctrine. **The TCMC Staff Medical Library complies with Title 17 section 108 of the U.S. Code which provides specific guidelines for libraries and archives regarding the reproduction of copyrighted materials.**
2. Tri-City Medical Center requires its Staff to comply with the United States Copyright Act. The employees of Tri-City Medical Center are prohibited from reproducing materials not specifically allowed by fair use, copyright law, licenses or contractual agreements or permission. Staff shall download, possess, or store only lawfully acquired copyrighted materials and use, adapt, distribute, or perform them only in ways consistent with the Copyright act, associated case law, the Fair Use principle, and the intellectual property rights of others.
3. Under the "fair use" doctrine, unauthorized reproduction of copyrighted materials is permissible for such purposes as criticism, comment, news reporting, teaching, scholarship or research. If duplicating or changing a product is to fall within the bounds of fair use, these four standards must be met for any of the foregoing purposes:
    a. The purpose and character of the use.
        i. The use must be for such purposes as teaching or scholarship and must be nonprofit.
    b. The nature of the copyrighted work.
        i. Staff may make single copies of the following for use in research, instruction or preparation for teaching: book chapters; articles from periodicals or newspapers; short stories, essays or poems; and charts, graphs, diagrams, drawings, cartoons or pictures from books, periodicals, or newspapers in accordance with these guidelines.
    c. The amount and substantiality of the portion used.
        i. In most circumstances, copying the whole of a work cannot be considered fair use; copying a small portion may be if these guidelines are followed.
    d. The effect of the use upon the potential market for or value of the copyrighted work.
        i. If resulting economic loss to the copyright holder can be shown, even making a single copy of certain materials may be an infringement, and making multiple copies presents the danger of greater penalties.

4. Tri-City Medical Center disapproves of unauthorized duplication in any form. Employees who willfully disregard the copyright policy are in violation and do so at their own risk and assume all liability. Every attempt will be made to assist employees who need information so that they can perform their duties within the intent of the law.

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

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

Tri-City Health Care District
Oceanside, California

Infection Control Manual

ISSUE DATE: 1/1985

SUBJECT: Meningococcal Exposure

REVIEW DATE: 9/2007
REVISED: 9/2003, 10/2004, 07/2014

STANDARD NUMBER: IC. 6.2

Infection Control Department Approval:	**~~07/14~~01/17**
Infection Control Committee Approval:	**~~07/14~~01/17**
Medical Executive Committee Approval:	**~~07/14~~02/17**
Professional Affairs Committee Approval:	**08/14**
Board of Directors Approval:	**08/14**

A. **PURPOSE**:

1. To help prevent the transmission of disease to and colonization of healthcare workers (HCWs).
2. Health care workers may require prophylactic antibiotics after a significant exposure to a patient with an infection (meningitis, bacteremia, or pneumonia) due to *Neisseria* meningitidis Bacterial meningitis infection presents as a sudden onset of fever, headache, and stiff neck. The symptoms of bacterial meningitis can appear quickly or over several days. Typically they develop within 3 – 7 days after exposure.
3. Prophylaxis **is** most effective within the first 4 days post-exposure.
4. Patient is placed in Droplet Precautions if disease is known or suspected before lab confirmation.
5. Chemoprophylaxis is offered to HCWs if:
   a. the patient's CSF gram stain is positive *for* gram negative diplococci, or blood, sputum, or CSF is culture positive for Neisseria meningitis and
   b. (2) HCW had an "intimate exposure" as defined on the Meningococcal Meningitis worksheet (Appendix A), was not wearing appropriate PPE, and the patient was not receiving appropriate antibiotics for at least 24 hours.
   c. Staff Roles (See hyperlink for flow chart):
   d. Microbiology: report significant stains and cultures to patient's attending physician, public health and Infection Preventionist (M – F 8-am to 5pm) or the Administrative Supervisor after hours and weekends.
   e. Infection Preventionist or Administrative Supervisor: assist in identification of departments or units involved and report to San Diego County Health and Human Services~~.~~ **Epidemiology department: # (619) 692-8499 FAX # (858) 715-6458**~~Reference Infection Control Manual, IC 12 Required Reporting for forms and fax/phone numbers.~~
   f. Charge Nurse: review the patient's chart to identify **exposed** staff~~,. c~~**C**omplete and send attached Meningococcal Meningitis Worksheet (Appendix A) to Employee Health.
   g. ED **Base Coordinator to 1) fill out Communicable Disease Exposure Report Form (from County of San Diego Public Health Department: Division of Emergency Medical Services 2) send form to Infection Control staff for follow up 3) notify the EMS agency's Infection Control Officer of exposure.** ~~MICN: reference Patient Care Services manual, Policy X.B. Exposure to Communicable Diseases for questions related to pre-hospital personnel.~~

~~B.~~**6.** Exposed employee: complete an Injury/Illness Investigation Report and sign in to be seen in Emergency Department.

~~1.~~

B. RELATED DOCUMENTS:

~~C.~~**1. Meningococcal Meningitis Worksheet**

2. Neisseria Meningitis Exposure Flowchart

~~D.~~C. REFERENCES:

1. APIC, Ready Reference to Microbes, Washington DC: **3rd** Ed**ition**. Brooks, K, 201**2**~~07~~
2. APIC, APIC Text of Infection Control and Epidemiology, Washington, DC: **4th Edition.** Association for Professionals in Infection Control and Epidemiology, 201~~4~~**09**.
3. Gilmore A, Stuart J, Andrews N, Risk of secondary meningoccoccal disease in health-care workers. Lancet 2000, 11;356(9242): 1654-1655.
4. ~~4.~~ http://www.cdc.gov/meningitis/bacterial.html

~~Appendix A~~

Meningococcal Meningitis Worksheet

Charge Person/Department Manager: _____

Date:_____ Time:_____ Patient's MR#_____

Staff Involved:	Exposed	
1.	Y	N
2.	Y	N
3.	Y	N
4.	Y	N
5.	Y	N
6.	Y	N
7.	Y	N
8.	Y	N
9.	Y	N
10.	Y	N
11.	Y	N
12.	Y	N
13.	Y	N
14.	Y	N
15.	Y	N

Exposure is defined as intimate and unprotected (no mask or face shield) contact with a patient with meningococcal disease (*Neisseria meningitis*) prior to antibiotic administration for at least 24 hours. There is a negligible risk of disease following casual contact. The following are examples of an "exposure"

Mouth to mouth resuscitation
Suctioning without using personal protective equipment (mask and goggles or face shield)
Participation in intubation without using personal protective equipment (mask and goggles or face shield)
Oral or endoscopic examination without using personal protective equipment (mask and goggles or face shield)
Assisting with vomiting patient without using personal protective equipment (mask and goggles or face shield)
Other mucus-membrane contact with respiratory secretions.

All staff identified as "exposed" are directed to the Emergency Department for further evaluation and possible prophylactic treatment.

Please fax the completed form to Employee Health Services at (760) 940-4005.

Tri-City Health Care District
Oceanside, California

Infection Control Policy Manual

SUBJECT: Risk Assessment and Surveillance Plan

ISSUE DATE: 3/02
REVISION DATE: 7/13, 8/14

Department Approval Date(s):	**~~07/15~~01/17**
Infection Control Committee Approval:	**~~07/15~~01/17**
Medical Executive Committee Approval:	**~~04/16~~02/17**
Professional Affairs Committee Approval:	**05/16**
Board of Directors Approval:	**05/16**

A. **PURPOSE OF RISK ASSESSMENT**

1. Sound epidemiological principles must be considered in the formation of the surveillance program designed to provide maximum information and identify opportunities to reduce disease. Measures directed toward cost effective care must include best practice and technology to prevent infection. The economic impact of an efficient and flexible infection control plan is especially relevant in times of changing reimbursement and payment patterns. Tri-City Medical Center's plan outlines how this may be accomplished within the confines of resources, external regulatory guidelines, and medical staff requirements.

B. **PURPOSE OF SURVEILLANCE**

1. The foundation of and most important purpose of this program is to decrease the risk of infectious complications for all patients, healthcare workers, visitors and staff. Ongoing epidemiological information assists with identifying at risk populations and opportunities to interrupt prevent or reduce the occurrence of healthcare associated infections. Surveillance will be compared to nationally recognized benchmarks such as the National Healthcare Safety Network (NHSN) rates whenever possible.

C. **RESPONSIBILITY**

1. Successful creation of an organization-wide infection control program requires collaboration with all relevant components/functions. Individuals within the hospital who have the power to implement plans and make decisions related to prevention and control of risks related to infections are included in the design and coordination of processes. In consultation with the Medical Staff, Directors, Medical Director of Infection Control, Environmental Health and Safety Committee, Patient Safety Officer and the Infection Control Committee, the Infection Preventionist (IP) shall implement a systematic process for monitoring and evaluating the quality and effectiveness of the infection control program. Significant deviations are discussed in Infection Control Committee, Quality Improvement Medical Staff Committees, Environmental Health and Safety Committee and the Patient Safety Committee and referred to appropriate councils and committees for action.
2. Infection Prevention and Control Services are staffed with **2.0~~1.8~~** FTE (includes one FTE with certification in Infection Control). There are computer resources with Internet connection, Microsoft Office software, NHSN National internet based database and access to the hospital's electronic medical records (**Cerner~~Compass~~** and Affinity). Telephone with voice mail, and fax access is provided. The office is located within the Surgical Scheduling office.
3. Infection Control Services works in conjunction with others, as a consultant and resource for best practices. We support system changes and an interdisciplinary focus to improving care. We believe that all our employees, medical staff, and volunteers play an important role in preventing

and controlling infections. Ultimately, the leadership team within the district is responsible for adopting and ensuring compliance with appropriate policies and practices.

D. **LINKS WITH INTERNAL SOURCES**

1. On at least an annual basis, the IP department will meet with the affected departments (i.e. Medical Staff and Employee Health) to assess whether the goals and priorities have been achieved and what steps are required to implement any indicated changes. The goals are shared with and reviewed by the Infection Control Committee. Education on infection control goals and priorities will be included with quarterly reports and during individual meetings with the hospital leadership. The IP staff reports to Infection Control Committee quarterly and attends other medical staff and hospital committees as requested, regulatory requirements and department specific Quality Reports are reviewed.

E. **LINKS WITH EXTERNAL SOURCES**

1. The San Diego County Public Health Department, state health authorities, the Division of Occupational Safety and Health, and other recognized infection control specialists, for example, the Centers for Disease Control and Prevention (CDC), Association for Professionals in Infection Control and Epidemiology (APIC), Society for Healthcare Epidemiology of America (SHEA), and the California Healthcare Association (CHA) are important links between the district and outside resources. Infection Control department subscribes to automatic notifications available via email from the CDC, San Diego County Public Health (CAHAN) and California Department of Health and Human Services. Infection surveillance covers a broad range of processes and activities with potential for intervention and these organizations assist with the where, when, and how of targeting.
2. Healthcare associated infections (HAI) are reported by the IP staff to the external healthcare organizations when the infection was not known at the time of transfer. TCMC receives reports from outside organizations when a patient develops an infection that might meet criteria for a healthcare associated infection. Home Health/Hospice quality review staff report directly to Infection Control Committee.
3. The following conditions will be reported to external healthcare organizations with the intent to satisfy JCAHO IC 02.01.01(and recorded in the patient's chart using PowerForm). The Infection Surveillance Report will document notification to the referring healthcare organization within 7 days of discovery by the TCMC Infection Prevention and Control Staff:
   a. Positive culture from a surgical site and surgery performed at another facility.
   b. Influenza rapid test is positive and patient was discharged to another healthcare facility prior to results being known.
   c. Positive C difficile toxin test known after the patient was discharged to another healthcare facility.
   d. Positive MDRO culture known after the patient was discharged to another healthcare facility and the patient had no history of the same MDRO.
   e. Unusual occurrences based on the opinion of the Infection Prevention staff in consultation with the Infection Control Medical Director and Director of Regulatory Compliance.

F. **PERTINENT RISK FACTORS**

1. Each facility is unique and we considered the following factors in our planning.
   a. National and international published scientific studies, community standard of care, professional recommendations and regulatory requirements.
   b. A review of hospital specific surveillance data from years past.
   c. Medically fragile and at-risk populations such as newborns and those with invasive devices.
   d. The increasing antibiotic resistance in our facility and across the United States (as reported by the CDC in by NHSN).
   e. The vaccination/immunity rates of the community and employees.

G. EPIDEMIOLOGICAL FACTORS: INTERNAL AND EXTERNAL

1. Tri-City Medical Center is impacted by factors such as location, population served, community health, financial status, population age, clinical focus, and healthcare worker demographics and these were included in our planning.
2. The hospital's geographic location is in northern San Diego County. San Diego County is the second most populous of California's 58 counties, and the fifth largest county in the United States. San Diego is currently home to 3.~~2~~1 million residents, and is anticipated to grow to four million by 2020.
3. Located within the North County geographic region are 3 college campuses along with a Marine Corp Base (Camp Pendleton).
4. San Diego County is becoming increasingly bicultural due to its close proximity to Mexico. In addition, the county is already ethnically diverse, and will be increasingly so. **Of residents under 18,** 37~~2~~% are Hispanic, and the Hispanic population is expected to continue to grow at a rapid rate. Approximately 21.5% of the county's populations are immigrants, including refugees, who come from other countries, speak 68 different languages, and have a variety of needs as they assimilate into their new environment. The senior and disabled populations are growing disproportionately compared to the rest of the population.
5. Demographic information on the three cities most often served by Tri-City Medical Center is listed below.

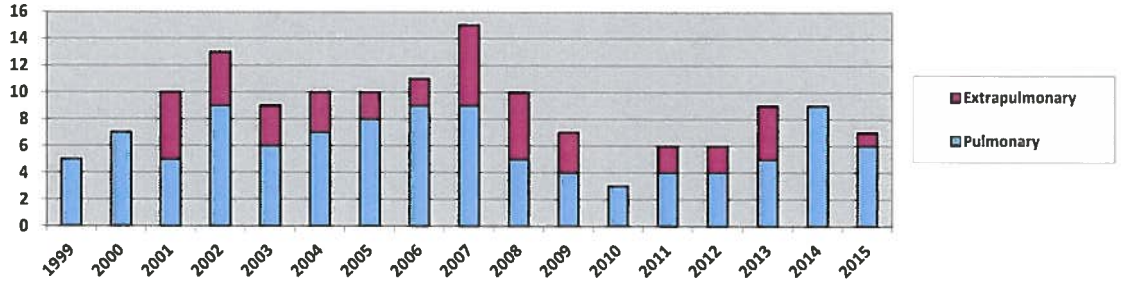
City	Median income	Total # residents	Percent increase since 2000	White	Hispanic	Asian & Pacific Islander
Oceanside	$ **48,375**~~59,640~~	161,029 (2000) 17~~42~~**,558**~~794~~ (201~~43~~)	**+8.**~~47.3~~%	4~~6.78.5~~ %	36.~~3~~0%	~~7.6~~**6.3**%
Vista	$ 45,322	89,857 (2000) **98,079**~~96,929~~ (201~~43~~)	**+9.**~~27.9~~%	**46.2**~~42.~~ ~~9~~%	**44.5**~~49.0~~ %	4.7~~2~~%
Carlsbad	$ **82,681**~~78,238~~	78,247 (2000) **112,299**~~110,972~~ (201~~43~~)	**+43.5**~~41.8~~%	7~~2.85.2~~ %	1~~4.53.6~~%	7.49~~4~~%

   a. http://www.city-data.com/city/Oceanside-California.html
   b. http://www.city-data.com/city/Vista-California.html
   c. http://www.city-data.com/city/Carlsbad-California.html
6. Enteric illness represents a significant burden of disease in the US and because of this the San Diego County Health and Human Services Agency conducts outbreak investigation and education to reduce the medical and cost-related impact of these diseases in the community. Food borne illnesses largely result from the ingestion of food or water contaminated by fecal matter or ingestion of infected animal products. Hospitals play an important role in early intervention by the identification and reporting of significant bacteria. The most common mandated reported enteric illnesses in SD County are Campylobacter, Giardia, Hepatitis A, Salmonella and Shigella.
7. In San Diego, overall rates for the three major reportable sexually transmitted diseases (Chlamydia, Gonorrhea & Syphilis) have increased from 201~~5~~1 to **2016**~~2012~~. National trends were reflective at the local level, including high rates of STD's among young women and MSM (men who have sex with men). San Diego County has the third largest number of HIV & AIDS cases in California. ~~The proportion of persons of color has increased over time among HIV & AIDS cases. Black cases have the highest rate of HIV & AIDS, followed by Hispanics and then Whites.~~
8. In 2014, San Diego County– reported 220 cases of active tuberculosis **while in 2015, 234 cases were reported.** ~~. In 2013, San Diego County reported 206 cases of active tuberculosis.~~ TB drug

susceptibility information was available for **100%**~~99%~~ of the culture proven cases for 201**5**~~4~~ in San Diego. Multidrug-resistant (MDR-TB) strains were found in **1**~~2~~ **(0.5%)** of the cases. **In 2015,** Tri City Medical Center **reported 1 case**~~reported both cases of~~ **of** MDR-TB.~~in our facility.~~ In SD County, Hispanics ~~-~~had the highest rates of TB at 5**3**~~2~~%, Asian/Pacific Islanders at 3**8**~~2~~%, non-Hispanic Whites at **7**~~1~~**9**% and non-Hispanic Blacks at **2**~~6~~%.TB cases born outside of the US compromised 7**4**~~0~~% of San Diego County's cases.(Source: ~~County of San Diego Health and Human Services Agency, Tuberculosis and refugee Health Branch~~ **County of San Diego Tuberculosis Control Program 2015 Fact Sheet Date March 18, 2016).**~~, April 20, 2015).).~~

9. At TCMC, most AFB positive smears and cultures grow organisms that are not communicable person to person. In 201**5**~~4~~, there were **6**~~9~~ patients with pulmonary TB and **1** ~~none~~ with extrapulmonary TB. An additional **27**~~34~~ cases were reported as rule out TB in 201**5**~~4~~. The number of active TB patients seen annually at Tri-City Medical Center varies from 5 –12.

TCMC Active TB Cases



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10. Tri City Medical Center Financial Characteristics for Fiscal Year 201**6**~~4~~

a. The top six insurance coverage seen the acute care setting are as follows: (Not including OB/Newborn, BHU and Rehab):

MEDICARE	**33.64%**~~36.03%~~
MEDICARE SR HMO	**15.69%**~~13.46%~~
MEDI-CAL HMO	**12.33%**~~7.85%~~
HMO	**6.91%**~~7.54%~~
Other Goverrnmental~~HMO Cap Sr~~	**7.00%**~~7.47%~~
Medi-Cal	**8.16%**~~6.98%~~

i. The majority of insurance coverage for our newborns (nursery and NICU) is funded by Medi-Cal or Medi-Cal HMO (**85.4**~~79.2~~% compared to HMO and PPO insurance (**8.5**~~12.3~~%) and other (**6.1**~~8.5~~%).

b. Patient census:

	Average. Daily Census	Average. Length of Stay*	Total Pt. Days
Acute Care (excludes all below)	**137.4**~~147.2~~	**3.89**~~4.04~~	**50,160**~~53,728~~
ICU*	**16.3**~~17.1~~	**3.38**~~2.83~~	**5,945**~~6,245~~
BHU	**17.0**~~23.8~~	6.76~~43~~	**6,209**~~8,703~~
NICU	**15.5**~~14.0~~	**6.81**~~9.81~~	5,660~~121~~
Rehab Serv.	6.2~~7~~	**13.70**~~15.49~~	2,275~~432~~

i. *ICU ALOS includes discharges, transfers out, and expirations. All other areas are based only on discharges.

c. In acute care FY 164, the three largest age groups are **56-65**~~76-85~~ year olds (19.**2**6%), **66-75**~~56-65~~ year olds (1**8.8**~~7.7~~%), and **76-85**~~66-75~~ year olds (**17.8**~~16.3~~%).

d. **Fourteen**~~Nineteen~~ percent (**9,386/65,828**~~10,745/ 57,193~~) of Emergency Department patients are admitted to the hospital.

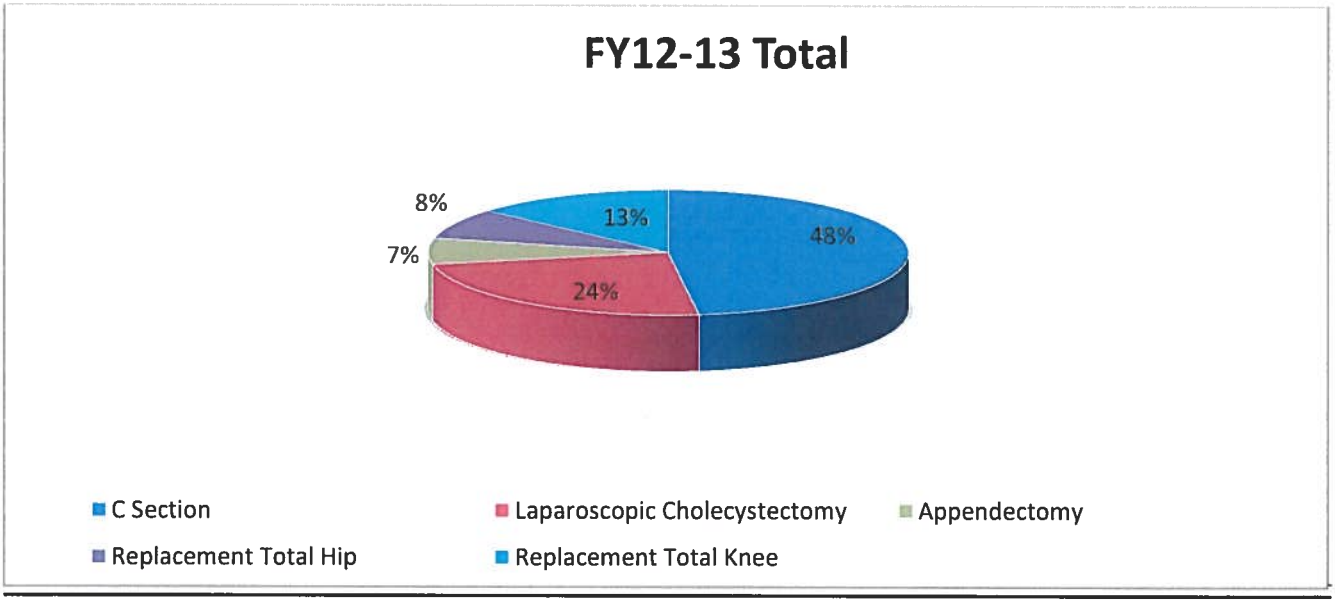
11. The total number of employees working at Tri-City Medical Center **FY 2016**~~(Fiscal Year 2014)~~ is approximately 2,**158**~~095~~ with **about**~~about~~ **1,403 (65%)**~~1,275~~ staff providing direct patient care.

12. Tri-City Medical Center's primary focus is on basic community services. ~~In fiscal year 2014, the~~ **The** top ten major **d**~~D~~iagnostic categories (DRGs) are the following:

a. Obstetrics
b. Newborns & Neonates
c. **Musculoskeletal & Connective Tissue**~~Circulatory System~~
d. **Circulatory System**~~Musculoskeletal & Connective Tissue~~
e. **Infectious & Parasitic Diseases**~~Mental diseases~~
f. Digestive System
g. Respiratory
h. **Nervous System** ~~Infectious & Parasitic Diseases~~
i. **Mental Diseases**~~Nervous System~~
j. Kidney & Urinary Tract

13. Top five Inpatient Surgical Procedures (Fiscal Year 201**6**~~3~~): **Cesarean section (CSEC), hip prosthesis (HPRO), knee prosthesis (KPRO), spinal fusion (FUSN), and open reduction of fracture (FX).**

~~13.~~**H.**



~~14.~~**1.** Home Care Services provides skilled, intermittent care to individuals in a home setting. The restorative, rehabilitative services are provided by Registered Nurses, Licensed Vocational Nurses, Masters of Social Work, Licensed Clinical Social Workers, Certified Home Health Aides, Physical Therapists, Occupational Therapists, Speech Therapists and/or Dietitians. For FY 201**6**~~4~~ in Home Care:

Average LOS	Top Payers	Top 4 Primary DX

33 days	Medicare- 531% HMO/PPO 309%	~~Aftercare Surgical/procedure~~ ~~Cardiovascular~~ **~~Malig. Neo-Lung~~** ~~Disease of Skin & Subcutaneous tissue~~ **-Other Health Services for Specific Procedures** **-Diseases of the Cardiovascular System** **-Diseases of the Respiratory System** **-Signs and Symptoms of Ill Defined Conditions**

~~15.~~**2.** General Process

a. Infection Prevention staff will regularly review, information from internal sources (case manager, RLs) or external sources (other IC practitioners, home health/hospice, or nursing homes) and the positive microbiology reports (furnished by the clinical laboratory). The following are some of the patterns or issues that are evaluated:
   i. Clusters of infections by the same organism, in the same ward or service or infections after undergoing the same procedure.
   ii. Infections due to unusual or highly resistant/significant organisms such as MRSA, VRE, ESBL, CRE, and/or C.difficile Infection.
   iii. All cases of reportable communicable diseases as mandated by Title 17. These shall be reported in accordance with the ordinances of the County of San Diego Department of Health.

b. Unusual or problem situations shall be brought to the Infection Control Committee for review and discussion. See Epidemiologic Investigation of a Suspected Outbreak policy.

c. In the absence of the Infection Prevention staff, hospital staff can direct questions to Employee Health Services, Director of Regulatory Compliance, Medical Director of Infection Control and/or Chair of the Infection Control Committee.

~~H.~~I. TARGETED AND FOCUSED SURVEILLANCE FOR FY 2017~~6 (Calendar Year 2015)~~

1. Infection control surveillance activities are systematic, active, concurrent, and require ongoing observation while meeting mandated reporting requirements. Our efforts are directed towards high risk, high volume and device/procedure associated infections. (such as urinary tract infections, selected surgical site infections, ventilator-associated events , and central line bacteremia) Goals will include limiting unprotected exposure to pathogens throughout the organization, Enhancing hand hygiene and limiting the risk of transmission of infections associated with procedures, medical equipment and supplies and medical devices.
2. Surgical Site Infections:
   a. Due to ever-decreasing lengths of stay, the majority of postoperative infections are not seen while the patient is in the hospital. Further, the increasing trend toward more outpatient surgery and shorter postoperative hospital stays limits the ability of infection control practitioners to detect infections.
   b. Surgical Site Infections that occur within 30 to 90 days (based upon the individual NHSN definitions). Surgical patients are risk stratified using the methods described in the CDC's NHSN surgical site component.
   c. Case finding methods include a review of all microbiology cultures, and ICD coding for post-operative infection. Potential cases have a chart review performed by Infection Prevention staff using the most recent NHSN definitions (-Centers for Disease Control and Prevention).

d. Infection rates are identified using the NHSN definitions and are reported to the California Department of Public Health through NHSN. In accordance with California senate bill requirements: facilities are required to report surgical site infections on 29 surgical procedures. Tri City Medical Center performs 25~~6~~ of the procedures, they are listed below:

AAA	Abdominal aortic aneurysm repair	Resection of abdominal aorta with anastomosis or replacement	
APPY	Appendix surgery	Operation of appendix (not incidental to another procedure)	
BILI	Bile duct, liver or pancreatic surgery	Excision of bile ducts or operative procedures on the biliary tract, liver or pancreas (does not include operations only on gallbladder)	
CARD	Cardiac surgery	Open chest procedures on the valves or septum of heart; does not include coronary artery bypass graft, surgery on vessels, heart transplantation, or pacemaker implantation	
CBGB	Coronary artery bypass graft with both chest and donor site incisions	Chest procedure to perform direct revascularization of the heart; includes obtaining suitable vein from donor site for grafting.	
CBGC	Coronary artery bypass graft with chest incision only	Chest procedure to perform direct vascularization of the heart using, for example, the internal mammary (thoracic) artery	
CHOL	Gallbladder surgery	Cholecystectomy and cholecystectomy	
COLO	Colon surgery	Incision, resection, or anastomosis of the large intestine; includes large-to-small and small-to-large bowel anastomosis; does not include rectal operations	
CSEC	Cesarean section	Obstetrical delivery by Cesarean section	
FUSN	Spinal fusion	Immobilization of spinal column	
FX	Open reduction of fracture	Open reduction of fracture or dislocation of long bones that requires internal or external fixation; does not include placement of joint prosthesis	
GAST	Gastric surgery	Incision or excision of stomach; includes subtotal or total gastrectomy; does not include vagotomy and fundoplication	
HPRO	Hip prosthesis	Arthroplasty of hip	
HYST	Abdominal hysterectomy	Removal of uterus through an abdominal incision	
KPRO	Knee prosthesis	Arthroplasty of knee	

LAM	Laminectomy	Exploration or decompression of spinal cord through excision or incision into vertebral structures	
NEPH	Kidney surgery	Resection or manipulation of the kidney with or without removal of related structures	
OVRY	Ovarian surgery	Operations on ovary and related structures	
PACE	Pacemaker surgery	Insertion, manipulation or replacement of pacemaker	
REC	Rectal surgery	Operations on rectum	
~~RFUSN~~	~~Refusion of spine~~	~~Refusion of spine~~	
SB	Small bowel surgery	Incision or resection of the small intestine; does not include small-to-large bowel anastomosis	
SPLE	Spleen surgery	Resection or manipulation of spleen	
THOR	Thoracic surgery	Non cardiac, nonvascular thoracic surgery; includes pneumonectomy and hiatal hernia repair or diaphragmatic hernia repair (except through abdominal approach.)	
VHYS	Vaginal hysterectomy	Removal of the uterus through vaginal or perineal incision	
XLAP	Abdominal surgery	Abdominal operations not involving the gastrointestinal tract or biliary system. Includes diaphragmatic hernia repair through abdominal approach.	

e. GOAL#1: The combined surgical site infection rate will not be statistically significantly higher than the most recent published NHSN rates, using the standardized infection ratio (SIR).

f. GOAL#2: Each individual surgical site infection rate (that is able to be calculated) will not be statistically significantly higher than the most recent published NHSN rates, using the standardized infection ratio (SIR).

3. Antibiotic Resistant Bacteria

a. Antibiotic resistance is an ongoing concern. Multiple studies have documented increased costs and mortality due to infections caused by multidrug resistant organisms. Data will be collected using positive cultures on patients with community acquired and hospital acquired methicillin resistant Staphylococcus aureus (MRSA), **V**~~v~~ancomycin resistant enterococci (VRE~~),~~ **), Extended spectrum-beta-lactamase** (ESBL)~~, Klebsella, and ESBL *E. coli,* and Carbapenem- resistant Enterobacteriaceae (CRE) CRE. A healthcare associated case is defined as a positive culture from any body site on or after the third hospital day, with no prior history of the organism.~~ MDRO and C.difficile **i**~~I~~nfection risk assessment is performed annually to determine need for additional interventions, resources, and surveillance. In addition, positive blood cultures with MRSA or VRE and positive C.difficile **i**~~I~~nfections are reported to CDPH through NHSN Multi-Resistant Organism & Clostridium difficile Infection Module (LabID Event Reporting).

b. GOA~~L~~#1: The number of healthcare associated MRSA infections ~~and colonization~~ will remain below the Institute for Healthcare Improvement's (IHI) published rate of 3.95 **hospital acquired**~~nosocomial~~ **infections**~~acquisitions~~ per 1000 **patient days**~~hospital discharges~~ for the calendar year.

Patients with + MRSA and/or VRE cultures
Hospital Discharges

c. GOAL#2: The MRSA and VRE Lab ID events (Blood culture specimen) rate will not be statistically higher than the most recent NHSN published rates (using the SIR).

4. Clostridium difficile (C. difficile) surveillance is performed utilizing the Multi-Resistant Organism & Clostridium difficile Infection Module (LabID Event Reporting).
   a. All positive C. difficile results are entered into NHSN.~~; reports are produced through NHSN.~~ Increases in hospital onset (HO) cases will be reviewed and action taken if they are epidemiologically associated.

   b. GOAL #1: The C. difficile hospital onset (HO) rate will not be more than expected based upon NHSN SIR Rates.
5. Ventilator Associated Event – Adult Critical Care Unit
   a. VAE is conducted on persons in the ICU who had a device to assist or control respiration continuously through a tracheostomy or by endotracheal tube within the 48 hour period before the onset of infection (inclusive of the weaning period). Current CDC/NHSN VAE definitions are followed.. The definition has three tiers: ventilator associated condition (VAC), infection related ventilator associated condition (IVAC), and possible ventilator associated pneumonia (PVAP). All three tiers will be reported and each PVAP case will be reviewed.
      i. GOAL: There will be seven consecutive months without a possible ventilator associated pneumonia (PVAP- Tier 3).

VAE cases in ICU x 1000
Total # ventilator days for the month

6. Central Line Associated Bloodstream Infection (CLABSI) ~~– Intensive Care Units~~
   a. Patients with a central line (defined by NHSN as a vascular access device that terminates at or close to the heart or one of the great vessels) and a primary bloodstream shall be counted. If a bloodstream infection occurs while a central line is in place or if a central line was inserted > than two calendar days before the onset of infection a chart review will be performed. **Current CDC/NHSN definitions are used to determine CLABSI events.**~~Current CDC/NHSN definitions are used to determine CLA-BSI events through culture review. Actual line-day information is available on-demand through the Compass Explorer program created by IT in 2005. NICU line day's data is collected by nursing services daily and reported to the Infection Prevention and Control Department at the end of each month. NICU rates are stratified by birth weight as per NHSN data comparison.~~
   b. GOAL #1: Using NHSN definitions for CLABSI, the CLABSI rate for ICU patients will not be statistically higher than the NHSN standardized infection ratio (SIR).
   c. GOAL #2: Using NHSN definitions for CLABSI, the CLABSI rate for non-ICU patients will not be statistically higher than the NHSN standardized infection ratio (SIR).
7. Catheter Associated Urinary Tract Infection (CAUTI)
   a. Symptomatic urinary tract infection – Patients with **positive urine cultures and indwelling foley catheters are reviewed.**~~an indwelling urinary catheter at the time of or within 7 days before the onset of a positive urine culture will have a chart review using~~ **Current CDC/NHSN definitions are used to determine CAUTI events.**~~current CDC/ NHSN definitions and methodology.~~

# of CAUTI cases x 1000
Estimation of urinary catheter days

b. GOAL #1: Using NHSN definitions for catheter associated urinary tract infection (CAUTI), the CAUTI rate for ICU patients will not be statistically higher than the NHSN standardized infection ratio (SIR).
c. GOAL #2: Using the NHSN definitions for CAUTI, the CAUTI rate for non ICU patients will not be more than expected based upon the NHSN standardized infection ratio (SIR).

8. Hand Hygiene
   a. Hand hygiene compliance rates are collected by manual observation performed by unit staff on a monthly basis. The Hand Hygiene compliance rates are reported to the **Managers,** Directors, **Regulatory Compliance**~~Joint Commission~~ Committee, and the Infection Control Committee**.** ~~Number of opportunities per~~ **Tri City Medical Center follows** the World Health Organization's 5 Moments **model for hand hygiene.**. ~~CDC) to perform hand hygiene compared to hand hygiene completed (% compliance) during care of patients.~~
   b. GOAL #1: Hand hygiene observations are performed in every patient care area at least once a month.
   c. GOAL #2: Overall hand hygiene compliance rate will be at least 90% per quarter.
9. Environmental and Patient Care Rounds
   a. Environment of Care rounds are performed monthly -and overseen by the Environmen**tal Health & Safety (EHSC)** ~~of Care~~ Committee. These rounds will identify risks associated with, but not limited to, medical equipment and supplies. In addition, tracers are performed monthly on a schedule throughout the patient care areas.
   b. GOAL #1: Infection Control assessments will be represented 90% of the time during scheduled environmental rounds.
   c. GOAL #2 Infection Control assessments will be represented 90% of the time during scheduled tracers.
   d. GOAL #3: Engineering staff in collaboration with Infection Control will complete an Infection Control Construction Permit 100% of the time for projects that require a Class III or higher containment.
10. Reportable Diseases
   a. Assisted by the Microbiology Laboratory and Emergency Department, required reporting to Public Health is performed by phone, fax or mail using the California Confidential Morbidity Report or other special form as directed by the County of San Diego Department of Health. Case finding is done through review of microbiology reports and calls from hospital staff (including physicians).
   b. GOAL: Required reportable disease will be sent to the local health department within the required time frame 100% of the time.
11. Employee Health collects and reports the following:
   a. GOAL#1: There will be 10% less needle stick injuries from the previous calendar year
      i. Number of needle sticks injuries and details of department involved, device, and cause.
   b. GOAL#2: 100% of employees will complete the annual tuberculosis screen
      i. # Staff completing annual TB screening (PPD, blood test or survey)/ # Employees in whom compliance is required.
   c. GOAL #3: Greater than 90% of Tri City Medical Center staff (per NHSN definition) will receive influenza vaccine.
      i. # Employees and who received influenza vaccine/# employees who worked at least one day during the flu season.

d. GOAL #4: Greater than 90% of Tri City Medical Center inpatient **Acute** Rehab unit **and Behavioral Health Services** staff (per NHSN definition) will receive influenza vaccine.

12. Home Care, collects and reports the following:
    a. GOAL #1: CAUTI and CLABSI rates will be monitored and reported to the Infection Control Committee quarterly.
    b. GOAL #2: There will be less than two CAUTI infections in the calendar year.
        i. # Cases UTIs with foley catheter/Total # device days.
    c. GOAL #3: There will be no infections related to central lines in the calendar year.).
        i. # Cases BSI with Central Line/Total # device days.

~~I.~~J. REFERENCES:

1. County of San Diego Public Health & Human Services Agency, (June 2015) Public Health Services. Retrieved from http://www.sandiegocounty.gov/hhsa/programs/phs/
2. Centers for Disease Control and Preventions, National Healthcare Safety Network (NHSN) Tracking Infection in Acute Care Hospitals/Facilities. **(2016)**~~(2013, February)~~ http://www.cdc.gov/nhsn/acute-care-hospital/index.html
3. County of San Diego Tuberculosis Control and Refugee Health Program. (Ju**ly**~~ne~~ 2015) TB Statistics. Retrieved from **http://www.sandiegocounty.gov/hhsa/programs/phs/tuberculosis_control_program/**
~~3. http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/ComparativeData2013_final3-13-14Rev1031914.pdf~~
4. Friedman, C. (2014). Infection Prevention and Control Programs in P. Grota (Ed.), APIC Text of Infection Control and Epidemiology (4th ed). Washington DC; 2014
5. The City of San Diego (2015), Economic development: Populatio**nn**~~n. Retrieved on June 4, 2015: http://www.sandiego.gov/economic-development/sandiego/population.shtml~~ **https://www.sandiego.gov/economic-development/sandiego/**

~~J.~~K. RELATED DOCUMENTS:

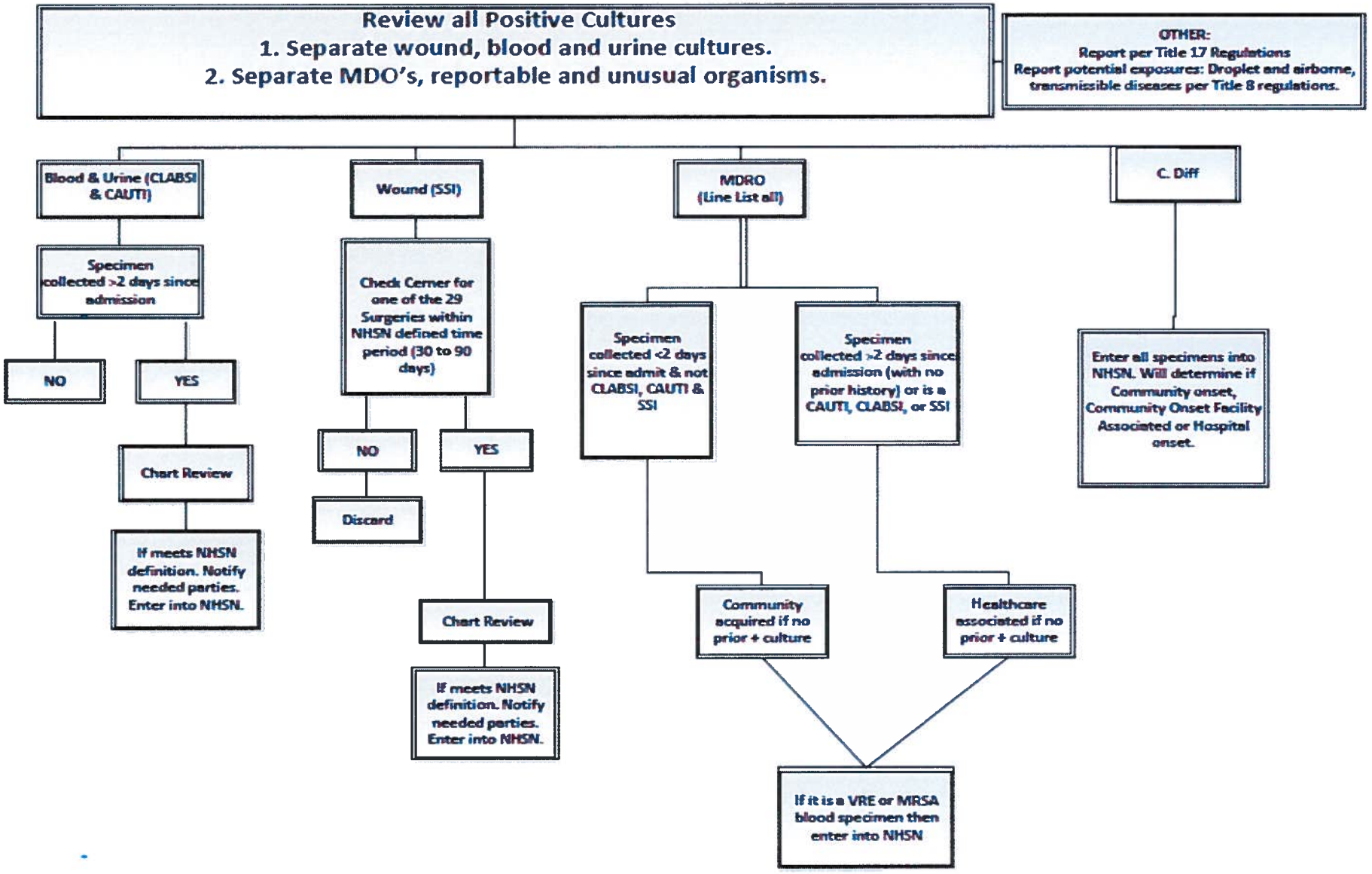
1. Infection Control Policy Manual, Philosophy
2. Infection Control Policy Manual, Epidemiologic Investigation of a Suspected Outbreak
3. ~~Infection Control Policy Manual, Facility Acquired Infections, Defined~~

INFECTION CONTROL PROGRAM TIMELINE FY 2015

Infection Control Committee	Meet			Meet			Meet			Meet		
Targeted Surveillance	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
SSI	*			*			*			*		
Multi-antibiotic Resistant Organisms • VRE • MRSA • ESBL • CRE	*			*			*			*		
CLABSI	*			*			*			*		
CAUTI	*			*			*			*		
VAE in ICU	*			*			*			*		
Home Health report of CAUTI and CLABSI rates	*			*			*			*		
Outbreak Investigation and Disease Reporting	*	*	*	*	*	*	*	*	*	*	*	*
OSHA Compliance												
• Tuberculosis Exposure Control Plan Review				*						*		
• Bloodborne Pathogen Exposure Control Plan Review	*											
Employee Health												
• TB Screening (PPD or questions)	*											
• N95 Fit-testing	*											
• Sharps & BBP Exposures	*			*			*			*		
• Infectious Diseases Exposures	*			*			*			*		
• Influenza Campaign				Begin			*			*		
Environment of Care												
• Infection control staff review of current construction projects	*	*	*	*	*	*	*	*	*	*	*	*
• Sterile Processing Department Report	*			*			*			*		
• Pharmacy Report on Biologicals and findings	*						*					
• Environment of Care Officer, Patient Safety Officer and/or Engineering report	*			*			*			*		
Surveillance Plan												
• Managers or Directors Meetings (Education & Planning)	*	*	*	*	*	*	*	*	*	*	*	
• Input (Education & Planning)												

• Present Risk Assessment and Surveillance Plan to ICC	*									*		
• ICC Approval of Plan	*									*		
•												
Performance Improvement Projects												
• Reducing Surgical Site Infections										*		
• Hand Hygiene Compliance	*	*	*	*	*	*	*	*	*	*	*	*
• Reducing CLABSIs												
Education												
• New Employees	*	*	*	*	*	*	*	*	*	*	*	*
• Unit Based or Topic Specific (As requested)- Performed through Quest, during rounds, presentations, power minute.	*		Net Learning	*	*	*	*	*	*		*	*

*Presented to IC


Review all Positive Cultures
1. Separate wound, blood and urine cultures.
2. Separate MDO's, reportable and unusual organisms.
OTHER:
Report per Title 17 Regulations
Report potential exposures: Droplet and airborne, transmissible diseases per Title 8 regulations.
Blood & Urine (CLABSI & CAUTI)
Specimen collected >2 days since admission
NO
YES
Chart Review
If meets NHSN definition. Notify needed parties. Enter into NHSN.
Wound (SSI)
Check Cerner for one of the 29 Surgeries within NHSN defined time period (30 to 90 days)
NO
Discard
YES
Chart Review
If meets NHSN definition. Notify needed parties. Enter into NHSN.
MDRO (Line List all)
Specimen collected <2 days since admit & not CLABSI, CAUTI & SSI
Specimen collected >2 days since admission (with no prior history) or is a CAUTI, CLABSI, or SSI
Community acquired if no prior + culture
Healthcare associated if no prior + culture
If it is a VRE or MRSA blood specimen then enter into NHSN
C. Diff
Enter all specimens into NHSN. Will determine if Community onset, Community Onset Facility Associated or Hospital onset.

Tri-City Health Care District
Oceanside, California

Infection Control Manual

ISSUE DATE: 7/2008 **SUBJEC: Toy Cleaning**

REVISION DATE: 7/2014 **STANDARD NUMBER: IC. 9.1**

Infection Control Department Approval:	**~~07/14~~01/17**
Infection Control Committee Approval	**~~07/14~~01/17**
Medical Executive Committee Approval:	**~~07/14~~02/17**
Professional Affairs Committee Approval:	**08/14**
Board of Directors Approval:	**08/14**

A. **BACKGROUND:~~PROCEDURE:~~**

1. Children can be in close proximity to one another and spend time in common areas, such as playrooms, where sharing of contaminated toys, equipment, and secretions can occur. Toys may be colonized with infectious pathogens.
2. An outbreak of multiresistant P. aeruginosa on an oncology ward related to bath toys has been described, as has a rotavirus outbreak in a similar population. There are no published guidelines on toy cleaning in the hospital setting, but we extrapolate from experience with community and home care of children.
3. Avoid high-risk toys, such as water-retaining toys, soft/stuffed toys, and others that are difficult to clean and dry. Stuffed and cloth toys quickly become colonized when used by hospitalized patients and have the potential to serve as fomites for infection and are discouraged.

B. **PROCEDURE:**

~~4.~~**1. Toys will be cleaned and disinfected** ~~Appropriate toy cleaning involves scrubbing with soap and water to remove surface dirt, followed by disinfection~~ with **a low level, non toxic** ~~the~~ hospital approved disinfectant~~. Toys are then thoroughly rinsed~~ and air-dried completely between patients.

~~5.~~**2.** Toy cleaning is performed by the Rehab Aide. Therapists perform cleaning on an as needed basis during therapy sessions.

~~6.~~**3.** Phenolics are not used.

~~7. Toys that have become contaminated (such as dropped on the floor or soiled with secretions) during use are segregated and immediately washed with detergent followed by disinfection with a low level, non toxic hospital-approved disinfectant. Toys should be air-dried completely.~~

~~8. Solid plastic toys can be washed in a dishwasher or on a hot cycle in a washing machine, but this method cannot be used for hollow toys that might fill with water—an outbreak of resistant Pseudomonas aeruginosa infection related to retained water in bath toys has been documented.~~

~~9. Toys and playroom surfaces are cleaned and disinfected daily by Environmental Services Department~~

~~10.~~**4.** Clean toys are clearly separated from dirty ones.

~~11.~~**5.** Sharing of toys between children is avoided to prevent cross-transmission.

~~B.~~**C. REFERENCES:**

1. West, K. L., Nyquist, A., Bair, T., Berg, W. & Spencer, S. (2014). Pediatrics. In P. Grota (Ed.), APIC Text of Infection Control and Epidemiology (4th ed. Vol. 2, 42- to 42-19) Washington, DC: APIC.

Tri-City Medical Center	Women and Newborn Services Neonatal Intensive Care Unit (NICU)
PROCEDURE:	**BLOOD PRODUCT ALIQUOT SYRINGES, EMERGENT PREPARATION OF**
Purpose:	To facilitate rapid preparation of blood aliquots for emergent use at the bedside.
Supportive Data:	Bedside preparation more rapid than procedure required in lab.
Equipment:	1. Neonatal/pediatric syringe set (150u filter and 60cc syringe) 2. Alaris smart site 3. Alaris male/female Luer lock caps ~~3.~~**4. Blood warmer**

A. **PROCEDURE:**

~~1. The charter medical neonatal syringe set with 150-micron filter is designed to prepare syringe aliquots of whole blood, red blood cells, platelets and fresh frozen plasma.~~

~~2.~~**1.** Per physician/**Allied Health Professional (AHP)** order, notify lab of emergent need for "O Negative Uncrossed –Matched Blood."

~~3.~~**2. Gather equipment.** ~~Obtain neonatal/pediatric syringe preparation bag~~

~~4.~~**3.** Confirm patient identity using two-identifier system **per hospital policy**. ~~Refer to Patient Care Services "Identification, Patient" (IV.A) policy.~~

4. Perform hand hygiene and don non-sterile gloves.

5. **If emergent blood requires warming, utilize the "Blood Administration Set-Neonatal" with 150 micron filter and spinlock, spike the blood bag, and follow the manufacturer's guidelines for warming.**

~~6. Attach the syringe set to the O negative Aliquot bag.~~

~~7.~~**6.** Slowly withdraw **warmed** blood from unit into ~~attached~~ 60 ml syringe. ~~Holding bag and syringe upright to displace residual air from syringe and gently push it back through filter and tubing~~.

~~8.~~**7.** Multiple syringes may be drawn from the same **unit**~~bag~~.

~~9.~~**8.** Label each syringe with patient label; include on label the blood type, unit number, date and time.

~~10. Utilize from syringe bag, Alaris male/female Luer lock caps for syringes and Alaris smart site on end of filter tubing as needed.~~

~~11.~~**9.** Refer to Patient Care Services **Procedure**: Blood Products Administration for administration procedure.

~~12.~~**10.** Once the unit is empty or blood administration completed, discard all components in biohazardous waste. Do not return blood unit to laboratory.

~~13.~~**11.** Document procedure in patient's medical record.

~~B. EXTERNAL LINKS:~~

B. RELATED DOCUMENTS:

1. Patient Care Services Procedure: Blood Products Administration

C. **REFERENCES:**

1. Charter Medical Ltd. product information: Neonatal/Pediatric Syringe Sets.

~~1.~~**2. MacDonald, M. G. & Ramasethu, J. (Eds.). (2013).** ***Atlas of procedures in Neonatology, 5th ed.*** **Lippincott Williams & Wilkins.**

~~D. APPROVAL PROCESS~~

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

NICU Department Review	Perinatal Collaborative Practice	Division of Neonatology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
09/07, 6/11, 8/12, 12/16	01/17	01/17	n/a	02/17		

Tri-City Medical Center	Women and Newborn Services Neonatal Intensive Care Unit (NICU)
PROCEDURE:	**CARDIO-RESPIRATORY MONITORING IN THE NICU**
Purpose:	~~To display heart and breathing rates and patterns and to identify events that are dangerous to the patient's health, i.e., apnea, abnormal heart rates~~ **To provide reliable and accurate monitoring of neonatal cardiac and respiratory activity.**
Supportive Data:	Cardio-respiratory monitoring should be used in any patient who requires intensive or intermediate care and in any patient at risk for apnea or rhythm disturbances.
Equipment:	1. Cardio-respiratory monitor 2. Neonatal monitoring electrodes
Issue Date: 9/07	

A. **POLICY:**

1. All patients admitted to the NICU will be placed on a cardio-respiratory monitor and continuously monitored until discharged from the NICU.
2. ~~The RN is responsible for monitoring the functioning of equipment.~~
   a. ~~Assure that heart rate and respiratory rate obtained by the monitor are consistent with rates obtained by auscultation.~~
3. ~~In the event of monitor malfunction:~~
   a. ~~Assess patient and provide support as necessary.~~
   b. ~~Check the monitor and electrodes for appropriate placement and settings.~~
   c. ~~If still malfunctioning, obtain a new monitor and notify Bio-Med of equipment failure. The patient will not be left unaccompanied until the monitor is replaced and found to be functioning appropriately.~~
4. ~~Alarms must be on at all times with appropriate limits set.~~
   a. ~~Limits are determined by the age and condition of the child or by a physician's order.~~
   b. ~~When alarms are silenced, they must be reactivated before leaving the patient's bedside.~~
   c. ~~Ensure that alarms and alarm limits are set and checked at the beginning of every shift.~~
5. ~~Check electrode placement and skin contact every shift. Place new electrodes on admission and whenever necessary.~~
6. ~~RN or RCP will respond to all alarms, assess the patient and intervene as necessary.~~

~~B. REPORTABLE CONDITIONS:~~

~~Notify the physician for:~~

1. ~~Parameters outside of pre-determined limits.~~
2. ~~Any significant changes in vital signs.~~
3. ~~An abnormal rhythm or heart rate.~~

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

1. **Skin should be clean and dry prior to placement of electrodes.**
2. **Do not place electrodes to broken or bruised skin.**
3. **Avoid placed electrodes directly on the nipples.**
1. ~~Place neonatal electrodes, RA and LA on either side of the anterior chest wall, avoiding the nipple area. Place one (1) electrode on the left upper quadrant of patient's abdomen.~~
4. **Basic three-lead configuration for electrode placement:**
   a. **White: Right lateral chest at level of the nipple line.**
   b. **Black: Left lateral chest at level of the nipple line.**
   c. **Red or green: Left lower rib cage.**
2. ~~Pulse oximetry will be monitored continuously unless discontinued with a physician's order. Refer to NICU "Pulse Oximetry, NICU" procedure.~~

Department Review	Perinatal Collaborative Practice	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/09, 6/11, 8/12, 12/16	01/17	01/17	n/a	02/17		

~~3.~~**5.** Connect electrodes, matching color/corresponding electrode placement, to the ECG cable attached to the monitor.

~~4.~~**6.** Ensure that the monitor is turned on and in neo mode. **Select the lead that provides the best signal and QRS size.**

7. Alarm parameters will be **audible and** ~~determined by the RN in collaboration with the physician based upon patient condition, day of life and gestational age.~~**set per NICU Standards of Care or physician/allied health professional (AHP)'s order.**

- **a. When alarms are silenced, they must be reactivated before leaving the patient's bedside.**
- **b. Ensure that alarms and alarm limits are set and checked at the beginning of every shift.**
- **c. Alarms should prompt immediate patient assessment.**
  - **i. Note alarm indication (i.e. tachycardia, apnea)**
  - **ii. Treat patient condition as necessary or correct the source of any false alarm.**
  - **~~i.~~iii. Notify physician/allied health professional if indicated.**

~~5.~~**8.** Electrodes will be changed as needed to provide an artifact free monitor tracing.

~~6. Audible alarms will be set at all times.~~

~~7. Patient may be monitored using trend mode at the discretion of the RN.~~

~~8. Place monitor in Lead II when running a strip.~~

~~D.~~C. DOCUMENTATION:

The following is to be documented in the patient's medical record:

1. Vital signs **per NICU Standards of Care**.
2. **Episodes requiring intervention.**
3. ~~Treatments~~ **Intervention performed** and **patient's** responses to intervention.~~s.~~
4. Alarm limits every shift.
5. **Physician/AHP notification ad hoc form as necessary.**

~~E. EXTERNAL LINKS:~~

~~F.~~D. REFERENCES:

1. Aehlert, B. (2009). ECGs Made Easy Pocket Reference, 4th Ed. Mosby: Elsevier.
2. Jacobson, C. (2003). Bedside cardiac monitoring. *Critical Care Nurse*, 21(6); 71-73.
3. Lippincott Manual of Nursing Procedures, 9th Ed. (2009). Lippincott, Williams & Wilkins.
4. **MacDonald, M. G. & Ramasethu, J. (Eds.). (2013). *Atlas of procedures in Neonatology, 5th ed.* Lippincott Williams & Wilkins.**
5. ~~4.~~ Smith-Temple, J. (2009). *Nurses Guide to Clinical Procedures*, 6th Ed. Lippincott, Williams & Wilkins.

~~G. APPROVAL PROCESS~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Medical Executive Committee~~
~~4. Professional Affairs Committee~~
~~5. Board of Directors~~

Tri-City Medical Center
Oceanside, California

WOMEN'S AND CHILDREN'S SERVICES MANUAL ~~— NICU~~

SUBJECT: NEONATAL ABSTINENCE SYNDROME, MANAGEMENT OF~~CORING~~

ISSUE DATE: 12/08
REVISION DATE: 4/09, 6/11, 8/12

Department Approval Date(s):	**11/16**
Perinatal Collaborative Practice Approval Date(s):	**11/16**
Division of Neonatology Approval Date(s):	**11/16**
Department of Pediatrics Approval Date(s):	**02/17**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**02/17**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

A. **DEFINITIONS:**

1. Neonatal Abstinence Syndrome (NAS):
- **a. A condition characterized by a constellation of drug withdrawal symptoms in the neonate, following intrauterine exposure to drugs of abuse.**

~~1.~~**2.** Drugs frequently associated with neonatal withdrawal include the following:
- a. High risk drug**s:**~~s include~~ **long-acting** opi**oids**~~ates~~ and narcotics: codeine, fentanyl, heroin and methadone, meperidine, morphine.
- **b.** Low risk/other drugs: **short-acting opioids,** barbiturates, caffeine, cocaine, diazepam and lorazepam, ethanol, marijuana, nicotine **and selective serotonin reuptake inhibitors (SSRI).**
  - **i. Withdrawal from these substances typically requires non-pharmacologic treatment only.**

3. Long-acting opioids:
- **a. Fentanyl transdermal patch**
- **b. Methadone**
- **c. Buprenorphine**
- **d. Oxymorphone hydrochloride extended-release (Opana)**
- **e. Oxycodone hydrochloride controlled-release (Oxycontin)**
- **f. Morphine sulfate extended release**

4. Short-acting opioids:
- **a. Hydrocodone**
- **b. Hydrocodone + APAP (Vicodin, Norco)**
- **c. Oxycodone + APAP (Percocet or oxycodone IR)**
- **d. Tramadol**
- **e. Fentanyl (IV)**
- **f. Morphine (IV or immediate release)**
- **g. Codeine**
- ~~b.~~**h. Hydromorphone (Dilaudid)**

~~2.~~**5.** General signs of drug exposure in the infant include:
- a. Central nervous system dysfunction, such as high-pitched cry, hyperactive reflexes, irritability, and disturbed sleep patterns.
- b. Metabolic, vasomotor and respiratory disturbances, such as sweating, mottling, fever, tachypnea, and sneezing.
- c. Gastrointestinal disturbances such as vomiting, loose stools, and poor feeding.

~~3.~~**6.** Goals of Neonatal Abstinence Syndrome (NAS) evaluation and management.
- a. **Proper feeding and growth.**~~Minimal GI symptomatology~~

b. **Facilitate appropriate development.t**~~Minimally disturbed sleep-wake cycles~~
c. **Foster the maternal-infant bond.**~~Socially interactive with caretaker(s)~~
~~c.~~**d. Prevent neurological sequelae.**

B. **POLICY:**

1. **Maternal use of narcotics or other illicit substances during pregnancy can result in the birth of infants with drug dependency with the potential for subsequent complications. The proper identification and care of these infants and their families is essential in minimizing medical complications and improving infant and family outcomes. A team approach involving Obstetrics, Neonatology, Newborn Service, Nursing, Social Work and Occupational therapy will optimize patient outcomes.**
2. **Infants at low risk for NAS from maternal non-narcotic or narcotic short acting prescription medication can generally remain in couplet care for a period of observation.**
3. **Infants at risk for NAS due to maternal use of methadone, heroin, buprenorphine or high dose prescription narcotic exposure should be admitted to the NICU. Infants exposed to multiple psychotropic medication exposure may also need to be considered for NICU admission.**
4. **Proper non-pharmacologic measures may be used to minimize the need for medical treatment and decrease the length of therapy.**
5. **Proper use of NAS scoring will help in consistency of treatment and weaning of medication used to treat NAS.**
6. **Adherence to NAS medication initiation and weaning protocols may assist in shortening the length of NAS therapy.**
7. **Encouraging families to visit daily and care for child may improve infant-parent attachment.**

~~1.~~**8. Discharge planning, including Social Services, should be started as soon as an exposed infant is identified. Detailed planning for the discharge of these high-risk infants may minimize readmission or adverse outcomes after discharge.**

~~2.~~**9. Individuals, who appear under the influence of drugs including alcohol, cannot be allowed to handle the infant and in most instances, should be asked to leave the unit at the discretion of the nursing, medical and social work staff.** ~~1. Neonatal abstinence scoring~~ **should**~~may be conducted for:~~

~~1. Infants born to drug-dependent mothers or if mother admits recent drug usage (within one month of delivery).~~
~~2. **Infants whose mothers have tested positive on urine drug screen**Mothers of infants with a positive drug screen.~~
~~3. Infants **displaying symptoms of withdrawal**having withdrawal symptoms.~~
~~4. Infants being weaned from treatment with drugs that **can** use physiological dependence, such as fentanyl **and morphine**.~~

C. **PROCEDURE:**

1. **Infants will be identified as at risk for NAS by:**
   a. **Prenatal identification of mother on narcotic medication.**
   b. **Mother with positive toxicology screen at delivery not explained as an in-hospital administered medication.**
   c. **Mother who discloses prenatal narcotic use at delivery**
2. **A urine and meconium toxicology screen will be sent on all infants delivered to mothers with concern for illicit or known drug use:**
   a. **Urine Toxicology Screen:**
      i. **After delivery, the RN will place urine collection bag on infant or cotton balls in the diaper**
      ii. **Stool contamination does not preclude assessment**
      iii. **If positive screen, notify attending physician or allied health professional (AHP) and social worker.**
3. **Meconium Toxicology Screen:**

a. **Use a tongue depressor to scrape meconium into a sterile container**
b. **Continue collection until all meconium is passed (until transitional stool).**
~~a.~~**c. Provider to follow up on result (can take up to 1 week or longer to result)**

4. **Management of Infants on Mother Baby: Low Risk for NAS (non-narcotic medication, low-dose prescription opiate with a short half-life, THC, methamphetamines):**
   a. **If an infant develops significant symptoms of withdrawal, the RN will notify the infant's provider for evaluation of the symptoms which may require transferring the infant to the NICU.**
   b. **Infants exposed to** marijuana **or methamphetamines do not need extended observation.**
   c. **Infants exposed to multiple medications (such as narcotics and benzodiazepines, or narcotics and multiple psychotropic medications) may not show signs of withdrawal until later; consider longer observation in the hospital and close, frequent follow up in the days after discharge.**
   d. **Consideration of medications, dose, exposure, half-life and complicating factors should be weighed when deciding length of hospital observation.**
5. **Mother Baby Couplet Care**
   a. **Mother and infant will remain together in couplet care for observation until the mother is discharged.**
   b. **Infant will not be on a cardio-respiratory monitor.**
   c. **Infant will be monitored for NAS using the Lipsitz scoring performed by RN every 6 hours and as needed if concern for escalating withdrawal symptoms. First assessment should be done around the time that the infant is transferred to mother baby.**
      i. **Scoring will occur at approximately 30-60 minutes after a feeding, at a time when an infant not at risk for NAS would normally be sedate.**
      ii. **Sleeping infants will not be disturbed and will receive a score of 0**
      iii. **Scoring for factors such as sneezing, yawning and emesis will be taken into consideration the entire period of evaluation since the last scoring.**
      iv. **Parents can be included when gathering information for the score.**
      v. **Infant with Lipsitz score greater than 8 will be transferred and admitted to NICU with orders from Provider.**
6. **Management of Infant at High Risk for NAS:**
   a. **Infant at high risk for NAS** ~~**whose**~~ **or infant in couplet care/newborn nursery with Lipsitz score greater than 8 or significant withdrawal symptoms should be admitted to NICU** for pharmacologic treatment, **per physician/AHP's orders.**
   b. **Finnegan Neonatal Abstinence Sscore** ~~**sheet**~~~~Using the Neonatal Drug Abstinence Sheet (*see attachment*)~~ in patient's electronic medical record.
      i. **The first score should be recorded two hours after birth or admission to Mother Baby/NBN/NICU. -This score reflects all behavior up to this first score.**
      ii. **Scoring is dynamic, all signs and symptoms observed during the scoring interval are included in the point total for that time period.**
      ~~i.~~**iii. Crying infants should be soothed prior to assessing of muscle tone, Moro reflex, and respiratory rate.**
      iv. **Infants will not be woken in order to obtain a Finnegan Score.**
7. **Breastfeeding/Breastmilk: the following mothers will be encouraged to breastfeed:**
   a. **Women engaged in substance abuse treatment program.**
   b. **Women who plan to continue in their substance abuse treatment program in the postpartum period.**
   c. **Women who have been abstinent from illicit drug use or licit drug abuse for 90 days prior to delivery and have demonstrated the ability to maintain sobriety in an outpatient setting.**
   d. **Women who have a negative maternal toxicology testing at delivery except for prescribed medications.**

e. **Women who received consistent prenatal care.**
f. **Women who do not have HIV or other contraindications to breastfeeding.**
g. **Women who are not taking a psychiatric medication that is contraindicated in lactation.**
h. **Women on a stable methadone maintenance regimen wishing to breastfeed, regardless of their methadone dose.**
i. **Women and their partners should be fully informed about the risk of rapid weaning from breastmilk or exposure to street drugs during lactation.**

8. **Non-Pharmacologic Treatment of Neonatal Abstinence:**
   a. **Use of non-pharmacological interventions should be initiated** immediately after birth and **prior to use of pharmacological interventions and include but are not limited to the following:**~~.~~
      i. **Skin to skin contact**
      ii. **Swaddling**
      iii. **Rocking**
      iv. **Massage**
      v. **Decreased sensory/environmental stimulation**
      vi. **Maintaining temperature stability**
      vii. **Protected sleep**
      viii. **Avoiding unnecessary handling and abrupt changes in the infant's environment**
      ix. **Avoiding overstimulation; do one procedure at a time, use partial swaddling with assessment and procedures**
      x. **When feeding, consider alternating use of pacifier and bottle to help compensate for excessive sucking and to assist with decreasing emesis.**
      ~~ii.~~**xi. Use of breastmilk (when appropriate) can help to decrease overall NAS symptoms.**

~~2.~~**9.** Pharmacological interventions:
   a. Begin pharmacological interventions when **Finnegan** scores **are greater than or equal to 8 x 2, the average of any three consecutive scores is 8 or greater (i.e 9, 7, 8), or greater than or equal to 12 x1.**
   b. **Refer to Neonatal Narcotic Withdrawal Syndrome, Pharmacological Treatment of (policy #8710-559) for medication interventions.**

10. **Discharge Planning for infants with diagnosed NAS:**
   a. **Discharge criteria:**
      i. **Infants who are exposed to methadone or buprenorphine but do not show signs of withdrawal severe enough to require narcotic medication should be watched in the hospital for a minimum of 5-7 days.**
      ii. **Infants who have been treated in the NICU for NAS with narcotics should be monitored closely for a minimum of 48 hours off medication before discharge.**
      iii. **Term NAS babies do not need a car seat challenge.**
      iv. **NAS infants are at an increased risk for SIDS and parents or guardians should know the importance of the safe sleep and anti-SIDS measures.**
   b. **Educate parents regarding the challenges associated with taking on the care of a NAS infant, with weeks of fussiness/ crying/ residual NAS symptoms being commonplace in the weeks following discharge.**
   c. **Follow-up developmental screening via High risk Infant Follow Up program may be indicated and depends on the infant's risk profile.**
   d. **If the mother is breastfeeding at discharge inform and provide a copy of the NICU discharge summary to parents for the mother's methadone clinic physician so as to minimize the risk of communication gap regarding breastmilk nutrition or rapid weaning**

e. Provide clear information in the discharge summary for the infant's pediatrician regarding ongoing concerns, residual NAS symptoms, medications to be weaned, breastmilk provision, and high risk social situations.

f. Home health referrals for nursing, social work, and therapy (if needed).

~~5. Scoring during and after drug treatment for withdrawal symptoms.~~

~~a. Consider drug treatment for withdrawal symptoms if:~~

~~b. The infant's score is at or greater than 12 or greater than 8 for three consecutive periods, and non-pharmacological interventions have not been effective.~~

~~c. The infant may be weaned from drug treatment 72 hours after treatment is initiated if scores continue to be less than 8, per physician's order. Scoring should be continued for a minimum of three days after therapy is discontinued to ensure that symptoms have not redeveloped.~~

~~d. Therapy may have to be restarted if the infant has a score greater than 8. Once therapy is discontinued and there are no scores greater than 8 for a total of three days, the scoring can be discontinued.~~

D. **REFERENCES:**

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4. Gardner, S. et al. (2016). Merenstein & Gardner's Handbook of Neonatal Intensive Care, 8th Edition. St. Louis, MO:Elsevier Inc.

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7. Prenatal Substance Exposure: Management of Neonates Inclusive of Neonatal Abstinence Syndrome (2016). UC San Diego Health System Women and Infant Services Policy and Procedure Manuel.

~~1.~~**8.** Verklan, T. & Walden, M. (2010). *Core curriculum for neonatal intensive care nursing,* 4th Ed. Philadelphia: Elsevier.

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Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES (WNS)

SUBJECT: INFANT SAFETY AND SECURITY

ISSUE DATE: 9/91
REVISION DATE(S): 10/91, 8/94, 9/00, 6/03, 8/09, 06/13

Department Approval Date(s):	**01/175**
Department of OB/GYN Approval Date(s):	**n/a**
Department of Pediatrics Approval Date(s):	**n/a**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**04/15**
Board of Directors Approval Date(s):	**04/15**

A. **POLICY:**

1. To protect infants from removal by unauthorized persons.
2. Refer to Patient Care Services procedure: "Infant Identification. Follow the procedure regarding banding of infants and mothers.
3. Procedures which address the safety and security of infants will be followed by all staff working at Tri-City Medical Center (TCMC).
4. To ensure that when the infant is removed from nursery and then released to:
   a. Banded birth mother or birth father/significant other or the intended legal parent(s)
   b. Identification band numbers must be presented to nursery staff
   c. The number given must match the number on the infant's identification band before the infant is released.
   d. If there is any question about the number given, hospital staff shall accompany baby to the mother's room and confirm identification band numbers at that time.
5. To ensure newborn infant is only removed from mother's care (hospital room) by authorized Women and Newborn Services' (WNS) staff, WNS staff will wear TCMC photo identification badges with distinctive TCMC Women and Newborn Services' logo.
   a. Mothers will be instructed upon admission regarding the method of identifying WNS photo ID badges.
   b. Staff without ~~w~~**W**omen's and ~~children's~~ **Newborn's** photo ID badges, (i.e., floats, students, outside registry) will wear temporary name tags that shall be distributed by the employee health staff and/or shift supervisor/designee
      i. Temporary name badge shall include staff name, shift, date and the distinctive WNS logo.
      ii. These name tags will be collected by the shift supervisor/designee at the end of the shift and destroyed.
6. Mothers will be instructed to release their infant only to WNS staff wearing this identification. This instruction will be discussed initially in OB education classes, and then reviewed and reinforced upon admission to the WNS unit through direct instruction and information sheets.
7. Newborn infants will be transferred outside the department through halls only in bassinets, attended by ~~two~~ WNS staff members.
   a. Anyone carrying an infant in arms in **WNS** hallways will be questioned.
   b. This information shall be explained by the registered nurse verbally and on preprinted information sheets upon admission to Labor and Delivery and again when transferred to the Mother-Baby unit after delivery.
8. To insure the safety of the mother-baby couplet, all visitors shall be closely monitored by the WNS staff and volunteers.

a. An occupied stroller is allowed on Women and Newborn Services, but not in the NICU area.
b. Car seats and are not permitted in the following areas unless bringing a car seat in for a car seat challenge:
   i. Labor and delivery
   ~~ii. Newborn nursery~~
      ~~1) Receiving nursery~~
   ~~iii. Postpartum~~
   ii. Mother Baby
   iii. NICU
c. Car seats may be allowed at the time and date of discharge or in the specified areas for pre-scheduled car seat challenge tests, newborn hearing screening or lactation consultation appointments.

9. WNS staff education will include the following:
   a. Upon hire and updated yearly, staff shall be instructed in the above policy.
   b. Staff shall be monitored for compliance by the shift Assistant Nurse Manager/or designee on each shift.
   c. Instructions shall include creating an awareness of the risk of infant abduction and what to look for when observing activity on the unit, i.e., individuals loitering, persons in uniform without appropriate identification badges.
   d. Instruction shall include appropriate action(s) to take when discrepancies in practice or questionable individuals are observed on the unit.
   e. A risk assessment shall be conducted annually by the environment of care officer and submitted to ~~EOC~~ **Environmental Health and Safety** ~~c~~**C**ommittee **(EHSC)**. ~~Individual staff members will be counseled for noncompliance during assessment periods.~~
10. Infant abduction:
   a. In the event of a suspected infant abduction, the attending staff nurse will immediately:
      i. Call "Code Adam" by dialing 66 (see Patient Care Services Code Adam Policy).

B. **RELATED DOCUMENTS:**
1. Patient Care Services Code Adam Policy