TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE PROFESSIONAL AFFAIRS COMMITTEE
OF THE BOARD OF DIRECTORS
September 14, 2017, Thursday
12:00 Noon– 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 August 2017 Meeting	3-15	2 min.	Committee
5.	New Business			
a.	Consideration and Possible Approval of Policies and Procedures	16-17		All
	Patient Care Policies and Procedures			
	1. Bed Utilization, Demand Greater than Capacity Policy-Tracked Changes	18-21		
	Bed Utilization, Demand Greater than Capacity Policy- Clean Copy	22-25		
	2. Blood Products Administration Procedure- Tracked Changes	26-30		
	Blood Products Administration Procedure- Clean Copy	31-34		
	3. Chain of Command Policy	35-37		
	4. Hand Off Communication Policy- Tracked Changes	38-42		
	Hand Off Communication- Clean Copy	43-45		
	5. Nursing Chain of Command Policy	46		
	6. Plan for Nursing Care- Tracked Changes	47-62		
	Plan for Nursing Care- Clean Copy	63-72		
	7. Rigid Laryngscope Reprocessing Procedure	73-74		
	8. Skin Preparation, Surgical Procedural Policy	75-76		
	9. Universal Protocol Procedure	77-82		
	Administrative Policies and Procedures			
	1. Decision Making for Unrepresented Patients	83-86		
	2. Mandatory Reporting Requirements- Tracked Changes	87-100		
	Mandatory Reporting Requirements- Clean Copy	101-102		
	3. Policy Approval- Administrative	103-106		
	Unit Specific **Behavioral Health Services**			
	1. Abuse Reporting Forms	107		
	Education			
	1. AHA: Non-TCHD Class Participants	108-110		
	2. Description of professional Education department	111		
	3. Inservice Education Policy	112		
	4. Mission and Vision of the Education Department Policy	113		
	Medical Staff			
	1. Election Process of Member (s)at Large for MEC	114		

	Outpatient Behavioral Health 1. Admission to Inpatient Behavioral Health Unit 2. Age Appropriate Care 3. Communications 4. Solicitation of Patients / Referral to Self 5. Substance Abuse 6. Suicide Assessment **Outpatient Infusion Center** 1. Adverse Reaction- Medication Event 2. Central Venous Access Devices, Adult 3. Hospital Admission from the Center 4. Outpatient Summary List Procedure 5. Patient Discharge 6. Physician Orders/ Request for Services **Pharmacy** 1. Transdermal Fentanyl Patch Prescribing and Use **Pulmonary** 1. Pulmonary Scope of Services 2. Respiratory Medication Administration **Rehabilitation** 1. Emergency Care Outpatient Services 2. Movies, Videos **Pre-Printed Orders** 1. Cardiac Cath Lab Medication Orders 2. Cardiac Rehabilitation Physician Referral orders 3. OB Scheduled C-Section Orders	115 116 117 118 119-120 121-122 123 124-134 135-136 137 138 139 140-142 143-145 146-147 148 149-150 151 152 153-154		
6.	Review and Discussion of CLINICAL Contracts- 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 October 12, 2017.		1 min	Chair
12.	Adjournment		1 min	Chair

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
August 10, 2017

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

Non-Voting Members Present: Steve Dietlin, CEO, Kapua Conley, COO/ Exe. VP , Sharon Schultz, CNE/ Sr. VP, Rick Barton, General Counsel, Marcia Cavanaugh, Sr. Director for Risk Management, Jami Piearson, Director Quality and Regulatory.

Others Present: Lisa Mattia, Tori Hong, Kathy Topp, Diane Sikora, Sharon Davies, Nancy Myers, Amy Hardt, Eva England, Mary Diamond, Kelli Kelli Larose, Robert Flores, Kevin McQueen, Sherry Miller, Steve Young, Jeremy Raimo, Patricia Guerra and Karren Hertz.

Members Absent: Scott Livingstone, Interim Chief Compliance Officer

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell called the meeting to order at 12:08 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 July 2017.	Director Mitchell called for a motion to approve the minutes from July 13, 2017 meeting. There were a number of corrections made by some members of the Committee.	The minutes were ratified and were approved by the group with the recommended amendments. Director Dagostino moved and Director Grass seconded the motion to approve the modified minutes from July 2017.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Administrative Policies and Procedures:** 1. Cellular Phones & Other Wireless Electronic Digital Devices Usage Policy	There was a recommendation to put smartphones in replacement of the brand names IPad and IPod. PDAs were deleted too from the list of electronics mentioned in this policy.	**ACTION:** The Administrative policies and procedures except for the Policy Approval were approved. Director Dagostino moved and Director Grass seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. E-Mail Access	A designated font is used for hospital email as it is a regulatory (CMS) requirement as per Jami Piearson.		
3. Policy & Procedure Approval- Administrative Process	Director Dagostino inquired about the Department Manual Coordinating Committee composed of Patricia and Natalie; they are the ones who oversee the compilation and modification of policies and	**ACTION:** This policy is being pulled out as verbiage regarding the review timeline of policies needs to be further reviewed.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	procedures in the hospital.		
Unit Specific **Behavioral Health Services** 1. 14 Day Certification Review Hearings	It was recommended to put CA Institutional Code as a reference for this policy because that is where the definition of 5150 is fully explained.	**ACTION:** The committee agreed to pull out all the BHU policies for further review. These policies need to have the same information as what is stated in the California Institutional Code.	Joy Melhado/ Patricia Guerra
2. 14 Day Involuntary Holds 5250	The CA Institutional Code should also be referenced in this policy for exact definition of statutory requirements. The committee agreed that this policy should be referred to Legal Department before coming back to this committee.		
3. 5270 - 30 days of Additional Intensive Treatment	The CA Institutional Code should be referenced in this policy for exact definition of statutory requirements.		
4. Advisement of Legal Status 72 Hour Hold	The CA Institutional Code should be referenced in this policy for exact definition of statutory requirements.		
Infection Control 1. Blood borne Pathogen Exposure Control Plan	This policy is being pulled out for re-evaluation. It was noted that the regular trash bag and the hazardous waste red bag should be defined clearly as some type of wastes need to be re-classified for potentially infectious effects.	**ACTION:** The Infection Control policies were approved with the exception of the Blood borne Pathogen Exposure Control plan policy. Dr. Contardo moved and Director Dagostino seconded the motion to approve the policies	Lisa Mattia/ Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
2. Department Specific Wound Care Center	This policy is a deletion.	moving forward for Board approval.	
3. Ebola Plan Policy	There is a specific protocol that the hospital use when dealing with patients of suspected Ebola. It was also mentioned that there is a room in ED (C-26) with negative pressure and a door to the outside that Suspected Ebola patients would come through.		
4. Mold Abatement	Director Mitchell made a minor correction on the section that says do not mix out bleach with solutions containing ammonia.	**ACTION:** Policy verbiage correction.	Patricia Guerra
5. Prion Diseases: Transmissible Spongiform Encephalopathies	This policy is currently being worked on; the term embalming was taken out on this policy as this process is not done at the hospital.		
6. Standard and Transmission-Based Precautions	There is no discussion on this policy.		
7. Disease Index: Type and Duration of Precautions for Selected Infections and Conditions	There is no discussion on this policy.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Medical Staff 1. Nurse Practitioner (NP)-Cardiology Standardized Procedures	There was a recommendation to add "Medical Staff" in the cover page of each policy that addresses NP. Sherry Miller added that the Medical Staff Dept. still has NPs undergo the same credentialing process as physicians. The peer review process for NPs includes a review of competencies, scope of practice and privileges, and audits and observations by their supervising physician.	**ACTION:** The Medical Staff policies and procedures were approved except for Physician Formats and Prevention of Fire in Head and Neck Surgery. Director Dagostino moved and Dr. Souza seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Credentialing Standards for Vertebral Augmentation	There is no discussion on this policy.	**ACTION:** Change statement on the last page to "supervising signature" and not "sponsoring signature".	Patricia Guerra
3. Focused Professional Practice Evaluation-Proctoring	Minimal discussion to clarify.	**ACTION:** The details on this policy are being revised as well the dates and references are being updated.	Sherry Miller
4. NP- Hospitalist Standardized Procedures	The qualification of CNOR for NPs shall be taken out in this policy.	**ACTION:** Add NRP certification.	Patricia Guerra
5. NP-Neonatal Standardized Procedures	The qualification for ACLS and CNOR for NPs should be deleted.	**ACTION:** Add NRP certification.	Patricia Guerra
6. NP- OB/ GYN Standardized Procedures	The NP functions as First Assist on surgery cases relating to OB-GYN surgeries.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
7. NP- Oncology Standardized Procedures	NPs do not need to be certified to order chemotherapy. The RNs are chemo-certified to do chemotherapy.		
8. NP- Orthopedic and Spine Institute Standardized Procedures	There no discussion on this policy.		
9. NP- Pediatrics Standardized Procedures	The CNOR and PALS qualifications for NP should be taken out. It was stated that pediatrics NPs go to rounds on normal newborns.	**ACTION**: Remove ACLS.	Patricia Guerra
10. Physician Formats Approval Process	This policy is being pulled out for further review. The Medical Records Department may have a department policy on dictation that this policy can be consolidated there.		
11. Prevention of Fire in Head and Neck Surgery	The information contained in this policy need be compared with the OR policy.	**ACTION:** Compare to current OR Policy.	Patricia Guerra
12. Psychiatry Division Standardized Procedures	It was clarified that NPs can admit inpatients to CSU only.		
NICU			
1. Developmental Supportive Care in the NICU	There was no discussion on this policy.	**ACTION:** The NICU procedure was approved. Director Dagostino moved and Director Grass seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Outpatient Behavioral Health 1. Abbreviations	These abbreviations are specific to BHU Department. The policy on Use of Hospital Abbreviations was added as a related document.	**ACTION:** The policies and procedures for Outpatient Behavioral Health except for Denied Payment and Substance Abuse were approved. Director Dagostino moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Admission and Eligibility Criteria	The CMS Local Coverage Determination was added to this policy as a reference.		
3. Admission Assessment	Sarah clarified to the group that this policy reflects the current CMS standards. Director Dagostino brought up the issue of insurance coverage determination which is partly covered under this policy. Sarah mentioned that the Outpatient Behavioral Health has their own billing system and denied payments rarely happen. Patients are always provided the treatment and intervention required regardless of insurance denial.		
4. Attendance & Leaving Early Without Notifying Staff	This is a policy deletion.		
5. Clinical Assessment	The CMS Local Coverage Determination was added to this policy as a reference.		
6. Community Meetings	This policy serves as a guideline that the department adheres to when it comes to		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	community meetings.		
7. Community Outings	There is no discussion on this policy.		
8. Contraband	There is no discussion on this policy.		
9. Daily Progress Notes	This policy was updated and the CMS Local Coverage Determination was added as a reference to this policy.		
10. Denied Payment	This policy is pulled; a further explanation is needed on how the department handles their denied payments in conjunction with hospital policy.	**ACTION:** This policy will be brought back to this committee.	Sarah Jayyousi
11. Destructive or Potentially Violent Behavior	All the staff in Behavioral Health undergoes CPI trainings which are mostly de-escalation techniques. This training is provided by the hospital so they can address harmful behaviors on the unit.		
12. Disaster Plan	The policy on Hospital Disaster was added as a related document for this policy.		
13. Discharge Planning and Discharge	The CMS Local Coverage Determination was added to this policy as a reference. There was a correction on the completed discharge summary; it should have said AHP instead of MD.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
14. Disclosure of Information Over the Telephone	This is a policy deletion.		
15. Dress Code for Patients	This policy serves as a guideline to define the dress code for patients attending the Outpatient Behavioral health services.		
16. Family Involvement	There is no discussion on this policy.		
17. Involuntary Patient Detention	The definition of 5150 according to the California Institutional Code should be referenced into this policy.		
18. Laboratory Services	The Outpatient Behavioral Health Department uses the hospital phlebotomist for patients needing lab services.		
19. Medical Emergencies	This policy outlines the Code Blue procedures on offsite locations.		
20. Medically Excused Absences	There is no discussion on this policy.		
21. Medicare Additional Document Request	There is no discussion on this policy.		
22. Non-Compliance with Program Rules	There is no discussion on this policy.		
23. Organizational Structure	There is no discussion on this policy.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
24. Patient Complaints	The hospital policy addressing patient complaints will be added as a related document for this policy.		
25. Physician Admission Order	The CMS Local Coverage Determination was added to this policy as a reference.		
26. Physician and Nurse Practitioner Orders	This policy will be consolidated into the hospital policy addressing physician and NP orders.		
27. Plan for Professional Services and Staff Composition	Policy name changed to "Scope of Services". Patients in Outpatient Behavioral Health usually receive no more than twelve (not eleven) units of service per week.		
28. Positive Reinforcement Techniques	This policy serves as a guideline to provide parameters for use of positive reinforcement techniques in behavioral health patients.		
29. Psychiatric Emergencies	This policy needs a reference.	**ACTION:** Add a reference.	Sarah Jayyousi
30. Referral and Admission Screening	There is no discussion on this policy.		
31. Release of Information	This is a policy deletion.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
32. Role of Therapist	It was identified that the therapists in Outpatient Behavioral Health act as licensed professional clinicians for each patient being seen in the department. The responsibilities of a therapist are outlined and mostly cater to the population that the Program serves. Medical Directors are in attendance daily.		
33. Smoke Free Environment	The smoke-free policy of the hospital will be added as a related document to this policy.		
34. Standards for Clinical and Professional Practice	There is no discussion to this policy.		
35. Substance Abuse	This policy is being pulled as the group agreed there needs to be a solid definition of substance abuse as it pertains and relates to the Behavioral Health patients.	**ACTION:** Define substance abuse.	Sarah Jayyousi
36. Summary of Care List	This policy is more of a transfer document; the summary of care list of each patient is included in the patient's medical record.		
37. Telephone Use by Patients	This is a policy deletion.		
38. Treatment Planning	There is no discussion on this policy.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Outpatient Infusion Center			
1. Medical Emergencies	There is no discussion on this policy	**ACTION:** The procedure for Outpatient Infusion Center was approved. Director Dagostino moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Rehabilitation			
1. Community Out-reach Groups	There was a minor correction on the purpose of the Parkinson's group; the purpose is to help maintain, not restore maximum function of the patient.	**ACTION:** The procedure for Rehabilitation was approved. Director Dagostino moved and Dr. Souza seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Telemetry			
1. Monitoring Telemetry Patients Using the DASH 3000	Dr. Johnson asked for clarification on monitoring of invasive lines. He was unaware we had this capability because PACU RNs informed him that the Telemetry staff cannot "have" these patients and therefore he writes orders for the A-line to be removed when he would rather leave it in overnight or sends them to ICU when they do not need to be in the ICU. Dr. Souza also stated he was not aware Tele has the capability to monitor invasive lines and that the educator need to get the word out to the physicians. Priscilla responded that the volume of these patients is low and some staff may have refused to accept the	**ACTION:** Remedial education to be provided to Tele RNs regarding invasive lines so that their comfort in providing care for these patients will be realized in their acceptance from PACU. **ACTION:** The Telemetry policies and procedures were approved. Director Dagostino moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board	Priscilla Reynolds Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	patients from PACU because of their comfort level. She and the Tele management team are not aware of the staff refusing to accept these patients.	approval.	
2. Skin and Wound Team Rounds	This policy needs more references.	**ACTION:** Add appropriate references.	Patricia Guerra
6. Clinical Contracts	It was reported there are no clinical contracts for review this month.	**ACTION:** None.	Director Mitchell
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Director Dagostino moved, Dr. Johnson seconded and it was unanimously approved to go into closed session at 1:15 PM.	Director Mitchell
8. Return to Open Session	The Committee return to Open Session at 2:20PM.		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 2:22 PM.		Director Mitchell

PROFESSIONAL AFFAIRS COMMITTEE
September 14, 2017

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services		
1. Bed Utilization, Demand Greater than Capacity Policy – **Tracked Changes** Bed Utilization, Demand Greater than Capacity Policy – **Clean Copy**	3 Year Review, Practice Change	
2. Blood Products Administration Procedure – **Tracked Changes** Blood Products Administration Procedure – **Clean Copy**	3 Year Review, Practice Change	
3. Chain of Command Policy	Practice Change	
4. Hand Off Communication Policy – **Tracked Changes** Hand Off Communication Policy – **Clean Copy**	3 Year Review, Practice Change	
5. Nursing Chain of Command Policy	DELETE	
6. Plan for Nursing Care – **Tracked Changes** Plan for Nursing Care – **Clean Copy**	Practice Change	
7. Rigid Laryngoscope Reprocessing Procedure	3 Year Review, Practice Change	
8. Skin Preparation, Surgical Procedural Policy	3 Year Review, Practice Change	
9. Universal Protocol Procedure	Practice Change	
Administrative Policies & Procedures		
1. Decision Making for Unrepresented Patients 397	NEW	
2. Mandatory Reporting Requirements 236 – **Tracked Changes** Mandatory Reporting Requirements 236 – **Clean Copy**	Practice Change	
3. Policy Approval-Administrative 240	Practice Change	
Unit Specific		
Behavioral Health Services		
1. Abuse Reporting Forms	3 Year Review, Practice Change	
Education		
1. AHA Non-TCMC Course Participants Policy	3 Year Review, Practice Change	
2. Description of Professional Education Department	3 Year Review, Practice Change	
3. Inservice Education Policy	3 Year Review	
4. Mission and Vision of the Education Department Policy	3 Year Review	

PROFESSIONAL AFFAIRS COMMITTEE
September 14, 2017

CONTACT: Sharon Schultz, CNE

	Policies and Procedures	Reason	Recommendations
	Medical Staff		
1.	Election Process Members at Large MEC 8710-531	Practice Change	
	Outpatient Behavioral Health		
1.	Admission to Inpatient Behavioral health Unit	3 Year Review, Practice Change	
2.	Age Appropriate Care	3 Year Review, Practice Change	
3.	Communications	DELETE	
4.	Solicitation of Patients & Referral to Self	DELETE	
5.	Substance Abuse	3 Year Review, Practice Change	
6.	Suicide Assessment	3 Year Review, Practice Change	
	Outpatient Infusion Center		
1.	Adverse Reaction - Medication Event	3 Year Review, Practice Change	
2.	Central Venous Access Devices	DELETE	
3.	Hospital Admission from the Center	3 Year Review	
4.	Outpatient Summary List Procedure	DELETE	
5.	Patient Discharge	3 Year Review	
6.	Physician Orders Request for Services	3 Year Review	
	Pharmacy		
1.	Transdermal Fentanyl Patch Prescribing and Use	Practice Change	
	Pulmonary		
1.	Pulmonary Scope of Services	3 Year Review, Practice Change	
2.	Respiratory Medication Administration	Practice Change	
	Rehabilitation		
1.	Emergency Care Outpatient 1504	Practice Change	
2.	Movies, Videos TR 902	DELETE	
	Pre-Printed Orders		
1.	Cardiac Cath Lab Medication Orders 8711-4536	3 Year Review, Practice Change	
2.	Cardiac Rehabilitation Physician Referral Orders	NEW	
3.	OB Scheduled C-Section Orders 8711-1118	3 Year Review, Practice Change	

Tri-City Medical Center
Oceanside, California

TRACKED CHANGES

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 01/02

SUBJECT: Bed Utilization, Temporary Opening and Closing of Inpatient Beds/Units~~Demand Greater than Capacity~~

REVISION DATE: 03/02, 06/03, 01/04, 06/05, 03/10 08/10, 12/13

POLICY NUMBER: III.G

Department Approval:	05/17
Clinical Policies &and Procedures Committee Approval:	~~09/13~~02/~~16~~06/17
Nursing Executive Committee Approval:	~~09/13~~07/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	08/17
Professional Affairs Committee Approval:	11/13
Board of Directors Approval:	12/13

A. **TEMPORARY OPENING OF BEDS/UNITS ~~DEMAND GREATER THAN CAPACITY~~:**

1. Admissions to the **inpatient** nursing units shall not be denied without express consent from the Director, Administrative Supervisor, Manager, or Chief Nurse Executive or designee.

2. Acute Care Services (ACS):

~~2.~~**a.** ~~Overflow of~~ **ACS** ~~acute care~~ patients **may be placed** outside of the designated nursing units ~~may occur when bed demand is greater than capacity~~ **to maximize resources**.

~~3.~~**b.** **ACS** ~~cute care a~~areas shall be staffed and equipped accordingly.

~~4.~~**3. Telemetry:**

a. During increased Telemetry census, Telemetry patients **may**~~can~~ be placed on 4 Pavilion **(4P)** and staffed with Telemetry **Registered Nurses (RN)** ~~nurses~~ at **a ratio of one RN to 4 patients (1:4).** ~~the Telemetry Staffing ratio of 1:4.~~

~~5.~~**i. All patients will be assigned a room on Telemetry by a Telemetry Assistant Nurse Manager (ANM) or Relief Charge Registered Nurse (RN)**

~~a. Monitor Tech and Secretary independent of Monitor Tech duties.~~

ii. Patients with admission or transfer orders not written by a cardiologist or cardiovascular surgeon may be assigned a room on 4P

iii. Patients with admission or transfer orders written by a cardiologist or cardiovascular surgeon will be assigned a room on 2E, 2W, 4E or 4W

~~b. Only Telemetry patients transferred from Telemetry unit can be sent to 4P. Telemetry level of care patients can't be directly admitted to 4P.~~

~~i. Admission criteria must be followed for acceptable patients (i.e. No chest pain on 4P).~~

4. Intensive Care Unit (ICU):

~~6.~~**a.** During increased Telemetry census for admissions only, limited program flexibility shall be initiated. Four Intensive Care Unit (ICU) beds will be designated as Telemetry admits beds for a period not to exceed 72 hours. These beds shall be staffed using licensed nurse-to-patient ratios representative of the ICU staffing ratio 1:2.

~~a.~~**i.** Nurse Managers/ANMs shall notify Regulatory Services as soon as possible, by phone or by email for submission of "temporary permission for increased patient accommodations request review and approval sheet."

5. Women and Newborn Services (WNS):

a. Overflow of Mother/Baby outside of the designated nursing units may occur when bed demand is greater than capacity. Mother/Baby shall be staffed and equipped accordingly.

6. Neonatal Intensive Care (NICU):

~~b.~~a. Per NICU Policy: NICU Placement: Overflow to Alternate Location (Temporary Overflow).

B. **TEMPORARY CLOSING OF BEDS/UNITS:**

1. **Inpatient ~~B~~b**eds may be closed as a result of census, staffing, infection control, emergency, or maintenance problems.
   a. Beds shall not be closed without express consent of the Unit Director or Manager or Administrative Supervisor (nights only).
   b. Prior to closure of a unit, the ~~Assistant Nurse Manager~~ ANM or designee is responsible for communication with the Administrative Supervisor to evaluate the potential need for beds by other departments.
2. **Patient acuity and safety will be taken into consideration when deciding to close a unit.**
3. **The ~~Assistant Nurse Manager~~ ANM or designee must complete the Closure of Nursing Unit Checklist before the unit/beds can be considered closed and submitted to the Regulatory Compliance Department.**
4. **Intensive Care Unit:**
   a. Two code blue nurses are assigned from the unit that remains open.
   b. The crash cart and defibrillator on the closed unit must still be checked every shift.
   c. The code blue response defibrillator will remain on 1East and code blue drugs will remain in the refrigerator on 1West. It is the responsibility of the code blue RN to check the crash cart and defibrillator on the closed unit.
   ~~1.~~d. The charge nurse or designee must check the emergency procedure trays on 1 East and 1 West

C. **ADMITTED PATIENTS WAITING FOR BEDS:**

1. Registration staff shall notify the Administrative Supervisor, ANM or Manager when a patient is to be admitted and a bed is not available.
2. The Administrative Supervisor, ANM or Manager shall assign the appropriate area for direct admits based on patient assessment, physician orders, and availability.

D. FORM(S):

1. Closure of NICU Overflow Area-Checklist
2. Closure of Nursing Unit Checklist - Sample
~~D.~~3. Opening of Nursing Unit Checklist - Sample

E. **RELATED DOCUMENT(S):**

~~1. Intensive Care Unit Policy: Closure of Beds~~
~~2. Telemetry Policy: Opening/Closure of Telemetry Beds/Units~~
1. ~~Women's and Children's Services Manual NICU – NICU Placement: Overflow to Alternative Location (Temporary Overflow) Procedure~~NICU Policy: NICU Placement: Overflow to Alternate Location (Temporary Overflow) Procedure

Closure of Nursing Unit Checklist

Location:_____Date:_____ Person(s) Completing:_____

- ☐ Confirm the appropriate beds are available after all transfers and /or discharges are complete
- ☐ Complete Narcotic check on medication Pyxis (inventory)

Notify the Following: (These task may be delegated to an Unit Secretary)

- ☐ Administrative Supervisor (AS)
- ☐ Staffing Office
- ☐ Pharmacy (to turn off Pyxis access)
- ☐ Information Technology (IT) /AS (nights/weekends) (Notify to "shut down" printers)
- ☐ Facilities Management
- ☐ Security
- ☐ Private Branch Exchange (PBX)
- ☐ Notify the Monitor Technician (MT)
- ☐ Environmental Services
- ☐ Food & Nutrition
- ☐ Security
- ☐ Medical Records

Equipment Checks & Storage as follows (or per Unit guidelines):

- ☐ Crash Cart - Document on Crash Cart Checklist "Unit Closed" in the appropriate date field
- ☐ Plug in infusion pumps - store in a patient room
- ☐ Plug in Work Station on Wheels/WOWs and store in a locked room
- ☐ Place clean bedside commodes - in a patient room ~~and visitor's chairs in patient's room~~
- ☐ **Place visitor's chairs in patient's room**
- ☐ Store glucometer, doppler, pulse oximeter and other unit specific equipment in Medication Room
- ☐ Store Crash Cart and Defibrillator in Medication Room
- ☐ Nurse Locators - Place in the supply room located near the nurse's station
- ☐ Patient Charts – Store empty charts in designated area
- ☐ Patient Medications - transfer with patient or return medications to Pharmacy

Verify Patient PHI information is secured - if PHI is found, discard in Shred Bin. Check the unit for the following:

- ☐ Check all drawers and cabinets to ensure there is no unsecured PHI or logs with patient information
- ☐ Patient census
- ☐ SBAR and hand-off forms with patient information
- ☐ TASK list
- ☐ Check Physician's dictation room (including copier) for any PHI
- ☐ Check all printers for PHI
- ☐ Check all patient rooms for PHI
- ☐ Check all supply rooms for PHI

Telemetry boxes and lead wires:

- ☐ Count Telemetry Transmitters (boxes) and lead wires. # of Telemetry boxes = _____ # of Lead wires = _____
- ☐ Open battery latch to prevent battery contact with latch or remove batteries
- ☐ Store clean Telemetry boxes and lead wires in wire baskets above the sink near nurses' station

Cleaning Requirements:

- ☐ Notify Environmental services to clean unit
- ☐ Verify each patient room is clean
- ☐ Turn off the lights and close doors of each patient room
- ☐ Turn off the lights in Physician Dictation Room, Supply Rooms, etc

Turn off power on the following:

- ☐ Computer monitors
- ☐ Pharmacy fax machine
- ☐ Telemetry monitoring screens
- ☐ Copier and printer **to be turned off after 2 hours and final sweep for PHI (shared copier may be left on.**
- ☐ Forward phones to designated unit if applicable
- ☐ Close fire doors to unit and ensure they are locked
- ☐ Turn off the lights on the unit.
- ☐ Place unit keys in the ANM Office

***Fax completed form to ~~Laura Gipson,~~the Regulatory Compliance Specialist at 760-806-4645**

Opening of Nursing Unit Checklist

Location:_____Date:_____ Person(s) Completing:_____

- ☐ Confirm the need to open beds are available after all transfers and /or discharges are complete
- ☐ Complete Narcotic check on medication Pyxis (inventory)

Notify the Following: (These task may be delegated to an Unit Secretary)

- ☐ Administrative Supervisor (AS)
- ☐ Staffing Office
- ☐ Pharmacy (to turn on Pyxis access)
- ☐ Information Technology (IT) /AS (nights/weekends) (Notify to turn on printers)
- ☐ Facilities Management
- ☐ Security
- ☐ Private Branch Exchange (PBX)
- ☐ Notify the Monitor Technician (MT)
- ☐ Environmental Services
- ☐ Food & Nutrition
- ☐ Medical Records

Equipment Checks - Return equipment to operating locations and plug them into a power source:

- ☐ Crash Cart – Mark off the days the unit was closed on Crash Cart ~~Checklist as~~**Checklist as** "Unit Closed"
- ☐ Unlock supplies and equipment.
- ☐ Nurse Locators ~~- Place in the supply room located near the nurse's station~~
- ☐ Patient Charts ~~- Store in designated area~~
- ☐ ~~Patient Medications - transfer with patient or return medications to Pharmacy~~
- ☐ Check the expiration date on food left in the refrigerator as applicable

Verify Patient PHI information is secured - Check the unit for the following:

- ☐ Check all drawers and cabinets to ensure there is no unsecured PHI or logs with patient information
- ☐ Patient census - discard in the Shred Bin
- ☐ SBAR and hand-off forms with patient information - discard in the Shred Bin
- ☐ TASK list - discard in the Shred Bin
- ☐ Check Physician's dictation room (including copier) for any PHI
- ☐ Check all printers for PHI
- ☐ Check all patient rooms for PHI
- ☐ Check all supply rooms for PHI

Telemetry boxes and lead wires:

- ☐ Count Telemetry Transmitters (boxes) and lead wires. # of Telemetry boxes = _____ # of Lead wires = _____
- ☐ Place new batteries in Telemetry boxes for assigned beds
- ☐ Store clean Telemetry boxes and lead wires in wire baskets above the sink near nurses' station

Cleaning Requirements:

- ☐ Notify Environmental services to clean unit **as needed**
- ☐ Verify each patient room is clean
- ☐ Turn ~~off~~ **on** the lights and ~~close~~ **open** doors of each patient room
- ☐ Turn ~~off~~ **on** the lights in Physician Dictation Room

Turn on power on the following:

- ☐ Computer monitors
- ☐ Pharmacy fax machine
- ☐ Telemetry monitoring screens
- ☐ ~~Leave c~~**C**opier and printer ~~power "ON"~~**wait sufficient time for cued jobs to print and secure PHI**
- ☐ Cancel forward on phones as if applicable, confirm telephones are working
- ☐ Open fire doors to unit
- ☐ Turn on the lights on the unit.

***Fax completed form to ~~Laura Gipson,~~ the Regulatory Compliance Specialist at 760-806-4645**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

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ISSUE DATE: 01/02

SUBJECT: Bed Utilization, Temporary Opening and Closing of Inpatient Beds/Units

REVISION DATE: 03/02, 06/03, 01/04, 06/05, 03/10 08/10, 12/13

POLICY NUMBER: III.G

Department Approval:	05/17
Clinical Policies and Procedures Committee Approval:	06/17
Nursing Executive Committee Approval:	07/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	08/17
Professional Affairs Committee Approval:	11/13
Board of Directors Approval:	12/13

A. **TEMPORARY OPENING OF BEDS/UNITS:**

1. Admissions to the inpatient nursing units shall not be denied without express consent from the Director, Administrative Supervisor, Manager, or Chief Nurse Executive or designee.
2. Acute Care Services (ACS):
   a. ACS patients may be placed outside of the designated nursing units to maximize resources.
   b. ACS areas shall be staffed and equipped accordingly.
3. Telemetry:
   a. During increased Telemetry census, Telemetry patients may be placed on 4 Pavilion (4P) and staffed with Telemetry Registered Nurses (RN) at a ratio of one RN to 4 patients (1:4).
      i. All patients will be assigned a room on Telemetry by a Telemetry Assistant Nurse Manager (ANM) or Relief Charge Registered Nurse (RN)
      ii. Patients with admission or transfer orders not written by a cardiologist or cardiovascular surgeon may be assigned a room on 4P
      iii. Patients with admission or transfer orders written by a cardiologist or cardiovascular surgeon will be assigned a room on 2E, 2W, 4E or 4W
4. Intensive Care Unit (ICU):
   a. During increased Telemetry census for admissions only, limited program flexibility shall be initiated. Four Intensive Care Unit (ICU) beds will be designated as Telemetry admits beds for a period not to exceed 72 hours. These beds shall be staffed using licensed nurse-to-patient ratios representative of the ICU staffing ratio 1:2.
      i. Nurse Managers/ANMs shall notify Regulatory Services as soon as possible, by phone or by email for submission of "temporary permission for increased patient accommodations request review and approval sheet."
5. Women and Newborn Services (WNS):
   a. Overflow of Mother/Baby outside of the designated nursing units may occur when bed demand is greater than capacity. Mother/Baby shall be staffed and equipped accordingly.
6. Neonatal Intensive Care (NICU):
   a. Per NICU Policy: NICU Placement: Overflow to Alternate Location (Temporary Overflow).

B. **TEMPORARY CLOSING OF BEDS/UNITS:**

1. Inpatient beds may be closed as a result of census, staffing, infection control, emergency, or maintenance problems.
   a. Beds shall not be closed without express consent of the Unit Director or Manager or Administrative Supervisor (nights only).
   b. Prior to closure of a unit, the ANM or designee is responsible for communication with the Administrative Supervisor to evaluate the potential need for beds by other departments.
2. Patient acuity and safety will be taken into consideration when deciding to close a unit.
3. The ANM or designee must complete the Closure of Nursing Unit Checklist before the unit/beds can be considered closed and submitted to the Regulatory Compliance Department.
4. Intensive Care Unit:
   a. Two code blue nurses are assigned from the unit that remains open.
   b. The crash cart and defibrillator on the closed unit must still be checked every shift.
   c. The code blue response defibrillator will remain on 1East and code blue drugs will remain in the refrigerator on 1West. It is the responsibility of the code blue RN to check the crash cart and defibrillator on the closed unit.
   d. The charge nurse or designee must check the emergency procedure trays on 1 East and 1 West

C. **ADMITTED PATIENTS WAITING FOR BEDS:**

1. Registration staff shall notify the Administrative Supervisor, ANM or Manager when a patient is to be admitted and a bed is not available.
2. The Administrative Supervisor, ANM or Manager shall assign the appropriate area for direct admits based on patient assessment, physician orders, and availability.

D. **FORM(S):**

1. Closure of NICU Overflow Area-Checklist
2. Closure of Nursing Unit Checklist - Sample
3. Opening of Nursing Unit Checklist - Sample

E. **RELATED DOCUMENT(S):**

1. NICU Policy: NICU Placement: Overflow to Alternate Location (Temporary Overflow) Procedure

Closure of Nursing Unit Checklist

Location:_____Date:_____ Person(s) Completing:_____

- ☐ Confirm the appropriate beds are available after all transfers and /or discharges are complete
- ☐ Complete Narcotic check on medication Pyxis (inventory)

Notify the Following: (These task may be delegated to an Unit Secretary)

- ☐ Administrative Supervisor (AS)
- ☐ Staffing Office
- ☐ Pharmacy (to turn off Pyxis access)
- ☐ Information Technology (IT) /AS (nights/weekends) (Notify to "shut down" printers)
- ☐ Facilities Management
- ☐ Security
- ☐ Private Branch Exchange (PBX)
- ☐ Notify the Monitor Technician (MT)
- ☐ Environmental Services
- ☐ Food & Nutrition
- ☐ Security
- ☐ Medical Records

Equipment Checks & Storage as follows (or per Unit guidelines):

- ☐ Crash Cart - Document on Crash Cart Checklist "Unit Closed" in the appropriate date field
- ☐ Plug in infusion pumps - store in a patient room
- ☐ Plug in Work Station on Wheels/WOWs and store in a locked room
- ☐ Place clean bedside commodes - in a patient room
- ☐ Place visitor's chairs in patient's room
- ☐ Store glucometer, doppler, pulse oximeter and other unit specific equipment in Medication Room
- ☐ Store Crash Cart and Defibrillator in Medication Room
- ☐ Nurse Locators - Place in the supply room located near the nurse's station
- ☐ Patient Charts – Store empty charts in designated area
- ☐ Patient Medications - transfer with patient or return medications to Pharmacy

Verify Patient PHI information is secured - if PHI is found, discard in Shred Bin. Check the unit for the following:

- ☐ Check all drawers and cabinets to ensure there is no unsecured PHI or logs with patient information
- ☐ Patient census
- ☐ SBAR and hand-off forms with patient information
- ☐ TASK list
- ☐ Check Physician's dictation room (including copier) for any PHI
- ☐ Check all printers for PHI
- ☐ Check all patient rooms for PHI
- ☐ Check all supply rooms for PHI

Telemetry boxes and lead wires:

- ☐ Count Telemetry Transmitters (boxes) and lead wires. # of Telemetry boxes = _____ # of Lead wires = _____
- ☐ Open battery latch to prevent battery contact with latch or remove batteries
- ☐ Store clean Telemetry boxes and lead wires in wire baskets above the sink near nurses' station

Cleaning Requirements:

- ☐ Notify Environmental services to clean unit
- ☐ Verify each patient room is clean
- ☐ Turn off the lights and close doors of each patient room
- ☐ Turn off the lights in Physician Dictation Room, Supply Rooms, etc

Turn off power on the following:

- ☐ Computer monitors
- ☐ Pharmacy fax machine
- ☐ Telemetry monitoring screens
- ☐ Copier and printer to be turned off after 2 hours and final sweep for PHI (shared copier may be left on.
- ☐ Forward phones to designated unit if applicable
- ☐ Close fire doors to unit and ensure they are locked
- ☐ Turn off the lights on the unit.
- ☐ Place unit keys in the ANM Office

***Fax completed form to the Regulatory Compliance Specialist at 760-806-4645**

Opening of Nursing Unit Checklist

Location:_____Date:_____ Person(s) Completing:_____

- ☐ Confirm the need to open beds are available after all transfers and /or discharges are complete
- ☐ Complete Narcotic check on medication Pyxis (inventory)

Notify the Following: (These task may be delegated to an Unit Secretary)

- ☐ Administrative Supervisor (AS)
- ☐ Staffing Office
- ☐ Pharmacy (to turn on Pyxis access)
- ☐ Information Technology (IT) /AS (nights/weekends) (Notify to turn on printers)
- ☐ Facilities Management
- ☐ Security
- ☐ Private Branch Exchange (PBX)
- ☐ Notify the Monitor Technician (MT)
- ☐ Environmental Services
- ☐ Food & Nutrition
- ☐ Medical Records

Equipment Checks - Return equipment to operating locations and plug them into a power source:

- ☐ Crash Cart – Mark off the days the unit was closed on Crash Cart Checklist as "Unit Closed"
- ☐ Unlock supplies and equipment.
- ☐ Nurse Locators
- ☐ Patient Charts
- ☐ Check the expiration date on food left in the refrigerator as applicable

Verify Patient PHI information is secured - Check the unit for the following:

- ☐ Check all drawers and cabinets to ensure there is no unsecured PHI or logs with patient information
- ☐ Patient census - discard in the Shred Bin
- ☐ SBAR and hand-off forms with patient information - discard in the Shred Bin
- ☐ TASK list - discard in the Shred Bin
- ☐ Check Physician's dictation room (including copier) for any PHI
- ☐ Check all printers for PHI
- ☐ Check all patient rooms for PHI
- ☐ Check all supply rooms for PHI

Telemetry boxes and lead wires:

- ☐ Count Telemetry Transmitters (boxes) and lead wires. # of Telemetry boxes = _____ # of Lead wires = _____
- ☐ Place new batteries in Telemetry boxes for assigned beds
- ☐ Store clean Telemetry boxes and lead wires in wire baskets above the sink near nurses' station

Cleaning Requirements:

- ☐ Notify Environmental services to clean unit as needed
- ☐ Verify each patient room is clean
- ☐ Turn on the lights and open doors of each patient room
- ☐ Turn on the lights in Physician Dictation Room

Turn on power on the following:

- ☐ Computer monitors
- ☐ Pharmacy fax machine
- ☐ Telemetry monitoring screens
- ☐ Copier and printer wait sufficient time for cued jobs to print and secure PHI
- ☐ Cancel forward on phones as if applicable, confirm telephones are working
- ☐ Open fire doors to unit
- ☐ Turn on the lights on the unit.

***Fax completed form to the Regulatory Compliance Specialist at 760-806-4645**

Tri-City Medical Center	Distribution: Patient Care S	TRACKED CHANGES

PROCEDURE:	BLOOD PRODUCTS ADMINISTRATION
Purpose:	To outline the nursing care and management of adult/adolescent/pediatric/newborn patients receiving blood or blood products. This includes packed red blood cells (PRCs), irradiated blood products, platelet concentrates, and fresh frozen plasma.
Supportive Data:	Blood and blood products are unlike other intravenous medications administered due to the human/organic nature of the substance. Special precautions and timeliness are required for proper management of the patient receiving a transfusion. A patient receiving blood must be accompanied by a nurse when leaving the nursing floor. ~~Refer to "Special Considerations" sections for specific information related to each blood product listed above and for procedures for all transfusions.~~ All non-autologous PRCs and all platelet pheresis products used at this hospital are leuko-reduced.
Equipment:	Blood Product 1. Blood Administration Set with a 170 micron filter 2. Normal Saline 3. IV Electronic Infusion Pump 4. Automatic BP machine 5. Pressure pump bag (if indicated)

A. **DEFINITIONS**

1. Qualified transfusionists are:

a. Registered Nurses (RN) who have completed annual/ongoing competency in blood/blood product administration~~,~~

b. **A**~~a~~nesthesiologists

~~1.~~**c.** ~~and in surgery, p~~**P**erfusionists **in surgery**.

B. **PROCEDURE**

1. Refer to Mosby's Nursing Skills procedure: Blood Products: Administering for complete information.
2. Confirm patient identity using two-identifier system. Refer to Patient Care Services **Policy** ~~"~~Identification, Patient~~"~~ ~~(IV.A) policy~~.
3. Verify order and complete a Transfusion Request Form
   a. A nurse will verify that patient has received, read and understands, "A Patient's Guide to Blood Transfusions". The nurse will also verify that the patient has had opportunity to discuss this process with their physician.
      i. After reviewing the copy of "A Patient's Guide to Blood Transfusions" if the patient, parent, conservator or guardian refuses to permit the use of blood or blood derivatives in their care or the care of the patient, the patient will date, time and sign the refusal section of the consent.
      ii. When a patient is a minor or physically or mentally incapable of understanding and signing the consent, a parent, conservator or guardian may sign. **Check**~~An "X" is placed in~~ the box~~,~~ which indicates the relationship of the signature for consent.
   b. Obtain patient's signature on consent form, if not previously signed, for all blood products from Transfusion Service.
      i. Notify physician-ordering blood if patient has not received informed consent regarding blood administration.
   c. Record ID number from the Transfusion Service identification band on Transfusion Request Form.
4. Obtain blood products from the Transfusion Service:

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Blood Utilization Review Committee	~~Pharmacy & Therapeutics Committee~~	Medical Executive Committee	Professional Affairs Committee	Board of Directors
5/94, 7/09; 10/10;5/12	05/12;03/13; **01/15**	05/12;3/13; **2/15**	**04/17**	~~07/17~~	06/12;6/13, **08/17**	07/12;7/13	07/12;7/13

a. Only Tri-City Medical Center employees may pick up blood products from the lab.

b. **Transfusion Services will use a dual bag system to protect patients' privacy and contain possible spillage of blood products not transported in a cooler. Single and double units will be placed in a reclosable clear plastic bag. This clear plastic bag will be placed in a white bag labeled "Handle with Care: Human Blood.** ~~To contain possible spillage of blood products not transported in a cooler and protect patients' privacy, Transfusion Services will use a dual bag system and place single and double units in a reclosable clear plastic bag which will be placed in a white bag labeled "Handle with Care Human Blood". The Transfusion Request form will be secured to the outside of the white bag for transport.~~

5. Initiate the transfusion within 30 minutes of obtaining it from the Transfusion Service

a. It is permissible to start the transfusion even if it is delayed more than 30 minutes from issue as long as the entire unit can be infused within 4 hours of issue. After 4 hours the remainder of the unit must be discarded.

i. Blood and blood products that are not going to be transfused should be returned to the Transfusion Service immediately, as they are temperature sensitive.

ii. Any unused blood or blood product unit, if not transfused should be returned to the Transfusion Service.

~~a.~~**iii. Do not store blood products in any refrigerator outside of the Transfusion Service.**

~~a.~~**b.** EXCEPTION: ~~Surgery~~ **Areas designated by the laboratory** may be issued ice chests to store blood while waiting to be transfused ~~intra-operatively~~. Ice blocks are good for 6 hours, after which they must be switched for fresh ice blocks. The blood bank monitors the time limit of the ice blocks. Any remaining units of blood in the ice chest at the conclusion of the procedure must be returned to blood bank.

~~i. Blood and blood products that are not going to be transfused should be returned to the Transfusion Service immediately, as they are temperature sensitive.~~

~~ii. Any unused blood or blood product unit, if not transfused should be returned to the Transfusion Service.~~

~~b. Do not store blood products in any refrigerator outside of the Transfusion Service.~~

6. Verify the following information from blood products, unit tag, patient chart, and patient information from attached armbands with another RN (in Operating Room may verify information with a Perfusionist/Anesthesiologist. The RN /perfusionist/anesthesiologist administering the blood products must participate in the verification process.

a. Unit tag, armband number highlighted on forms must match the number on the Transfusion Service identification band attached to the patient.

i. Return blood product to Transfusion Services if number does not match.

b. Patient's name and medical record number on hospital armband with unit tag and Transfusion Record form.

c. Type of blood product issued matches blood product ordered by Physician.

d. Blood group and Rh type on blood product label matches blood group and Rh type on unit tags and for red cell products is compatible with patient's blood group and Rh type on the unit tags.

~~b.~~**i.** Platelet and cryoprecipitate ABO/Rh types may not **match**~~be compatible~~ **the patient's blood ABO/Rh but are compatible to be transfused**. Call the Transfusion Service with questions concerning ABO/Rh compatibility.

~~d.~~**e.** Donor unit number on blood product label matches donor unit number on unit tag and Transfusion Record form.

~~e.~~**f.** Expiration date/time on blood product label has not elapsed.

i. If the expiration date is the current calendar day, the blood products must be infused by midnight or the remainder discarded at midnight.

~~f.~~**g.** Compatibility status if blood product is red blood cell unit.

~~g.~~**h.** Document verification on Transfusion Record form and Blood Administration Powerform.

7. Pressure Pump/Bag may be used if blood needs to be infused at a rapid rate.

a. Use only external pressure devices equipped with a pressure gauge, and that exert uniform pressure against all parts of the blood container.
b. Maintain 300 mmHg or less when pressure transfusing blood components as higher pressures may cause bag rupture or hemolysis through small-gauge lines.

8. Blood may be infused using an electronic infusion device.
9. Blood warmer may be used. Use only equipment specifically designed to warm blood product and maintain blood warmer temperature at specified temperature for equipment used throughout transfusion.
10. Document temperature of blood warmer on Transfusion Record form.
11. **Intravenous (**IV) push medication may only be given via the lowest injection port while the normal saline is infusing immediately before or after transfusing the blood product.
12. Change the blood administration set after 4 hours. Up to 2 units may be given with each set if the total infusion time is less than or equal to 4 hours.
13. Assess and document vital signs **(including blood pressure, heart rate, respiratory rate, and temperature)** on Blood Administration Powerform:
    a. ~~p~~**P**re-transfusion
        i. It is recommended that vital signs be obtained immediately prior to initiating a transfusion not to exceed 1-2 hours prior to the transfusion initiation
    b. 15 minutes after blood product~~,~~
    c. 1 hour after blood product initiated
    d. ~~then e~~**E**very 1 hour until blood product infused ~~and~~
    ~~2.~~**e.** ~~i~~**I**mmediately post transfusion.
    ~~a. Vital signs include blood pressure, heart rate, respiratory rate, and temperature.~~
~~3.~~**14.** Complete Transfusion Record and Blood Administration Powerform including documentation of amount of blood product infused and any adverse reactions and place the chart copy of the Transfusion Record in the laboratory section of the patient's chart. Return the Blood Bank copy to the Lab.
    a. Document any adverse reactions on the Transfusion Reaction section of the Blood Administration Powerform.
    b. A form must be completed for each unit of blood product transfused.
~~13.~~**15.** Upon discharge of Outpatients, provide patient with an "Outpatient Post Transfusion Reaction" information sheet.
~~14.~~**16.** Initiate Blood Transfusion Reaction process for suspected transfusion reaction.
    a. Check unit and patient information to verify that the unit was started on the correct patient.
    b. See Mosby's Nursing Skills Transfusions: Reaction Management
    c. Complete Reaction section of the Blood Administration Powerform and the Transfusion Record form.
    d. Send blood product with attached blood administration set, the printed Blood Administration form, the Blood Bank Transfusion Record, record forms and first void urine specimen to Transfusion Service.
~~15.~~**17.** Dispose of blood product containers, and administration sets in red bags**, if no transfusion reaction**.

~~B. Special Considerations For: RH Immune Globulin~~
~~1. Ordered and obtained from the Laboratory~~
~~2. Administer Rhogam or MicRhoGAM within 72 hours of exposure to achieve optimal effect.~~
~~3. Prior to administration, verify order for fetal maternal hemorrhage screen (Kleihauer-Betke test), mother may need additional Rh Immune globulin (300 mcg standard dose)~~
~~a. Exposure to greater than 30 mL Rh-D-positive blood or 15 mL of fetal cells (i.e., abruptio placenta, placenta previa, intrauterine manipulation, and manual removal of placenta)~~
~~4. Verify the information from Rh Immune Globulin product label, unit tag, and patient information from attached armbands for the following:~~
~~a. Unit tag armband number highlighted on form must match the number on the~~

~~Transfusion Service identification band attached to the patient. If number does not match, return Rh Immune Globulin to laboratory.~~

~~b. Patient's name and medical record number on hospital armband with unit tag.~~

~~c. Rh Immune Globulin lot number on product matches lot number on unit tag.~~

~~d. Expiration date on Rh Immune Globulin.~~

~~5. Verify mother's blood type and Rh prior to administration.~~

~~6. Verify baby's blood type and Rh prior to administration.~~

~~7. Complete patient identification card and give to patient after to Rhogam administration.~~

C. **Special Considerations For: Pediatric/Neonatal**

1. A nurse will verify that patient/parent/legal guardian has received, read and understands a patient guide to blood transfusion. The nurse will also verify that the patient/parent/legal guardian has had opportunity to discuss this process with their physician. Obtain consent for blood and blood products administration from parents.
2. Verify Newborn Screening has been obtained prior to the first PRC transfusion providing Hct greater than 25 or as ordered by the physician.
3. Ensure that all blood products are CMV negative for newborns or per physician order.
4. Consult with physician regarding the use of irradiated blood and donor specific blood.
5. "Double check" all blood products prior to administration to ensure that the proper blood is administered to the infant in the neonatal intensive care (NICU).
6. Administer all blood products via **an** Alaris **pump** ~~syringe module~~ except with exchange transfusions.
7. Prime tubing with blood product and attach to T-connector or double or triple lumen connector tubing.
8. Administer blood products through largest bore catheter available (24 gauge minimum recommended).
9. Transfuse PRCs per physician order.
10. Allow blood products to warm to room temperature (approximately 20 minutes) prior to administration to reduce thermal stress.
11. Transfuse blood over time specified by physician order, but not more than 4 hours. If transfusion orders require infusion greater than 4 hours, request smaller aliquots from the Transfusion Service.
12. Use a controlled blood warmer when performing large volume transfusions (exchange transfusions).
13. Document, to the nearest tenth of an mL, the amount of blood product infused in the **electronic health**~~medical~~ record **(EHR)**.

D. **Special Considerations For: Intraoperative Reinfusion of Processed Blood**

1. Processed units will use a new **set**~~via flex bag~~ each time.
2. Label each unit with patient's full name, Medical Record Number, date, time of start of collection, time of expiration and for "Autologous Use Only", at time of collection.
3. Reinfusion of intra operatively processed blood must begin within 6 hours of end of collection.
4. Blood collected intra operatively is to be transfused to the donor only.
5. Contraindicated in cases of sepsis or malignancy.

E. **RELATED DOCUMENTS:**

~~8.~~**1. Patient Care Services Constavac, Reinfusion of Blood Procedure**

~~E.~~**F. REFERENCES:**

1. Transfusion Therapy Guidelines for Nurses, National Blood Resource Education Program, Public Health Service of National Institutes of Health, U.S. Department of Health/Human Services.
2. Stryker Constavac Blood Conversion (CBC) System Operating Instructions, 98. See TCMC Equipment Manual.
~~9. Fletcher M.A., MacDonald M.G. (Eds), Atlas of Procedures in Neonatology. J.B. Lippincott Co.,~~

~~1996, Transfusion of Blood & Blood Products.~~

~~10.~~3. Technical Manual, American Association of Blood Banks, 17th Edition, 2011.

~~3.~~4. Blood Utilization Review Committee. Chair, Gary Wilcox, M.D., 2000.

~~4.~~5. AWHONN Core Curriculum for Neonatal Intensive Care Nursing, Deacon, J, and O'Neil, P (Eds), ~~2nd~~ 5th Edition, W. B. Saunders, Philadelphia 1999.

~~11. C.A.T.S. Fresenius Manual: 2nd Edition, 1998~~

~~12. Cell Saver Manual.~~

~~13.~~6. American Blood Banks Association,Standards for Blood Banks and Transfusion Services, 27th Ediction: Bethe~~sd~~a, AABB, 2011

~~14. Besuner, P. (2007). Associtation of Women's Health, Obstetric and Neonatal Nurses (AWHONN) Templates for Protocols and Procedures for Maternity Services, 2nd Edition. Washington, DC.~~

~~15.~~7. Merenstein, G.B., Gardner, S.L. (**2011**~~2006~~). Handbook of Neonatal Intensive Care, ~~7~~6th Edition. Mosby-Elsevier: Philidelphia, PA.

Tri-City Medical Center	Distribution: Patient Care S	CLEAN COPY

PROCEDURE:	BLOOD PRODUCTS ADMINISTRATION
Purpose:	To outline the nursing care and management of adult/adolescent/pediatric/newborn patients receiving blood or blood products. This includes packed red blood cells (PRCs), irradiated blood products, platelet concentrates, and fresh frozen plasma.
Supportive Data:	Blood and blood products are unlike other intravenous medications administered due to the human/organic nature of the substance. Special precautions and timeliness are required for proper management of the patient receiving a transfusion. A patient receiving blood must be accompanied by a nurse when leaving the nursing floor. All non-autologous PRCs and all platelet pheresis products used at this hospital are leuko-reduced.
Equipment:	Blood Product 1. Blood Administration Set with a 170 micron filter 2. Normal Saline 3. IV Electronic Infusion Pump 4. Automatic BP machine 5. Pressure pump bag (if indicated)

A. **DEFINITIONS:**

1. Qualified transfusionists are:
   a. Registered Nurses (RN) who have completed annual/ongoing competency in blood/blood product administration
   b. Anesthesiologists
   c. Perfusionists in surgery.

B. **PROCEDURE:**

1. Refer to Mosby's Nursing Skills procedure: Blood Products: Administering for complete information.
2. Confirm patient identity using two-identifier system. Refer to Patient Care Services Policy Identification, Patient.
3. Verify order and complete a Transfusion Request Form
   a. A nurse will verify that patient has received, read and understands, "A Patient's Guide to Blood Transfusions". The nurse will also verify that the patient has had opportunity to discuss this process with their physician.
      i. After reviewing the copy of "A Patient's Guide to Blood Transfusions" if the patient, parent, conservator or guardian refuses to permit the use of blood or blood derivatives in their care or the care of the patient, the patient will date, time and sign the refusal section of the consent.
      ii. When a patient is a minor or physically or mentally incapable of understanding and signing the consent, a parent, conservator or guardian may sign. Check the box which indicates the relationship of the signature for consent.
   b. Obtain patient's signature on consent form, if not previously signed, for all blood products from Transfusion Service.
      i. Notify physician-ordering blood if patient has not received informed consent regarding blood administration.
   c. Record ID number from the Transfusion Service identification band on Transfusion Request Form.
4. Obtain blood products from the Transfusion Service:
   a. Only Tri-City Medical Center employees may pick up blood products from the lab.
   b. Transfusion Services will use a dual bag system to protect patients' privacy and contain

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Blood Utilization Review Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
5/94, 7/09; 10/10;5/12	05/12;03/13; 01/15	05/12;3/13; 2/15	04/17	06/12;6/13, 08/17	07/12;7/13	07/12;7/13

possible spillage of blood products not transported in a cooler. Single and double units will be placed in a reclosable clear plastic bag. This clear plastic bag will be placed in a white bag labeled "Handle with Care: Human Blood.

5. Initiate the transfusion within 30 minutes of obtaining it from the Transfusion Service
   a. It is permissible to start the transfusion even if it is delayed more than 30 minutes from issue as long as the entire unit can be infused within 4 hours of issue. After 4 hours the remainder of the unit must be discarded.
      i. Blood and blood products that are not going to be transfused should be returned to the Transfusion Service immediately, as they are temperature sensitive.
      ii. Any unused blood or blood product unit, if not transfused should be returned to the Transfusion Service.
      iii. Do not store blood products in any refrigerator outside of the Transfusion Service.
   b. Exception: Areas designated by the laboratory may be issued ice chests to store blood while waiting to be transfused. Ice blocks are good for 6 hours, after which they must be switched for fresh ice blocks. The blood bank monitors the time limit of the ice blocks. Any remaining units of blood in the ice chest at the conclusion of the procedure must be returned to blood bank.
6. Verify the following information from blood products, unit tag, patient chart, and patient information from attached armbands with another RN (in Operating Room may verify information with a Perfusionist/Anesthesiologist. The RN/perfusionist/anesthesiologist administering the blood products must participate in the verification process.
   a. Unit tag, armband number highlighted on forms must match the number on the Transfusion Service identification band attached to the patient.
      i. Return blood product to Transfusion Services if number does not match.
   b. Patient's name and medical record number on hospital armband with unit tag and Transfusion Record form.
   c. Type of blood product issued matches blood product ordered by Physician.
   d. Blood group and Rh type on blood product label matches blood group and Rh type on unit tags and for red cell products is compatible with patient's blood group and Rh type on the unit tags.
      i. Platelet and cryoprecipitate ABO/Rh types may not match the patient's blood ABO/Rh but are compatible to be transfused. Call the Transfusion Service with questions concerning ABO/Rh compatibility.
   e. Donor unit number on blood product label matches donor unit number on unit tag and Transfusion Record form.
   f. Expiration date/time on blood product label has not elapsed.
      i. If the expiration date is the current calendar day, the blood products must be infused by midnight or the remainder discarded at midnight.
   g. Compatibility status if blood product is red blood cell unit.
   h. Document verification on Transfusion Record form and Blood Administration Powerform.
7. Pressure Pump/Bag may be used if blood needs to be infused at a rapid rate.
   a. Use only external pressure devices equipped with a pressure gauge, and that exert uniform pressure against all parts of the blood container.
   b. Maintain 300 mmHg or less when pressure transfusing blood components as higher pressures may cause bag rupture or hemolysis through small-gauge lines.
8. Blood may be infused using an electronic infusion device.
9. Blood warmer may be used. Use only equipment specifically designed to warm blood product and maintain blood warmer temperature at specified temperature for equipment used throughout transfusion.
10. Document temperature of blood warmer on Transfusion Record form.
11. Intravenous (IV) push medication may only be given via the lowest injection port while the normal saline is infusing immediately before or after transfusing the blood product.
12. Change the blood administration set after 4 hours. Up to 2 units may be given with each set if

the total infusion time is less than or equal to 4 hours.

13. Assess and document vital signs (including blood pressure, heart rate, respiratory rate, and temperature) on Blood Administration Powerform:
    a. Pre-transfusion
        i. It is recommended that vital signs be obtained immediately prior to initiating a transfusion not to exceed 1-2 hours prior to the transfusion initiation
    b. 15 minutes after blood product
    c. 1 hour after blood product initiated
    d. Every 1 hour until blood product infused
    e. Immediately post transfusion.
14. Complete Transfusion Record and Blood Administration Powerform including documentation of amount of blood product infused and any adverse reactions and place the chart copy of the Transfusion Record in the laboratory section of the patient's chart. Return the Blood Bank copy to the Lab.
    a. Document any adverse reactions on the Transfusion Reaction section of the Blood Administration Powerform.
    b. A form must be completed for each unit of blood product transfused.
15. Upon discharge of Outpatients, provide patient with an "Outpatient Post Transfusion Reaction" information sheet.
16. Initiate Blood Transfusion Reaction process for suspected transfusion reaction.
    a. Check unit and patient information to verify that the unit was started on the correct patient.
    b. See Mosby's Nursing Skills Transfusions: Reaction Management
    c. Complete Reaction section of the Blood Administration Powerform and the Transfusion Record form.
    d. Send blood product with attached blood administration set, the printed Blood Administration form, the Blood Bank Transfusion Record, record forms and first void urine specimen to Transfusion Service.
17. Dispose of blood product containers, and administration sets in red bags, if no transfusion reaction.

C. **Special Considerations For: Pediatric/Neonatal**

1. A nurse will verify that patient/parent/legal guardian has received, read and understands a patient guide to blood transfusion. The nurse will also verify that the patient/parent/legal guardian has had opportunity to discuss this process with their physician. Obtain consent for blood and blood products administration from parents.
2. Verify Newborn Screening has been obtained prior to the first PRC transfusion providing Hct greater than 25 or as ordered by the physician.
3. Ensure that all blood products are CMV negative for newborns or per physician order.
4. Consult with physician regarding the use of irradiated blood and donor specific blood.
5. "Double check" all blood products prior to administration to ensure that the proper blood is administered to the infant in the neonatal intensive care (NICU).
6. Administer all blood products via an Alaris pump except with exchange transfusions.
7. Prime tubing with blood product and attach to T-connector or double or triple lumen connector tubing.
8. Administer blood products through largest bore catheter available (24 gauge minimum recommended).
9. Transfuse PRCs per physician order.
10. Allow blood products to warm to room temperature (approximately 20 minutes) prior to administration to reduce thermal stress.
11. Transfuse blood over time specified by physician order, but not more than 4 hours. If transfusion orders require infusion greater than 4 hours, request smaller aliquots from the Transfusion Service.
12. Use a controlled blood warmer when performing large volume transfusions (exchange

transfusions).

13. Document, to the nearest tenth of an mL, the amount of blood product infused in the electronic health record (EHR).

D. **Special Considerations For: Intraoperative Reinfusion of Processed Blood**

1. Processed units will use a new set each time.
2. Label each unit with patient's full name, Medical Record Number, date, time of start of collection, time of expiration and for "Autologous Use Only", at time of collection.
3. Reinfusion of intra operatively processed blood must begin within 6 hours of end of collection.
4. Blood collected intra operatively is to be transfused to the donor only.
5. Contraindicated in cases of sepsis or malignancy.

E. **RELATED DOCUMENTS:**

1. Patient Care Services Constavac, Reinfusion of Blood Procedure

F. **REFERENCES:**

1. Transfusion Therapy Guidelines for Nurses, National Blood Resource Education Program, Public Health Service of National Institutes of Health, U.S. Department of Health/Human Services.
2. Stryker Constavac Blood Conversion (CBC) System Operating Instructions, 98. See TCMC Equipment Manual.
3. Technical Manual, American Association of Blood Banks, 17th Edition, 2011.
4. Blood Utilization Review Committee. Chair, Gary Wilcox, M.D., 2000.
5. AWHONN Core Curriculum for Neonatal Intensive Care Nursing, Deacon, J, and O'Neil, P (Eds), 5th Edition, W. B. Saunders, Philadelphia 1999.
6. American Blood Banks Association,Standards for Blood Banks and Transfusion Services, 27th Ediction: Bethesda, AABB, 2011
7. Merenstein, G.B., Gardner, S.L. (2011). Handbook of Neonatal Intensive Care, 7th Edition. Mosby-Elsevier: Philidelphia, PA.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 12/01 **SUBJECT:** Chain of Command

REVISION DATE: 06/03, 12/04, 10/05, 03/10, 06/13 **POLICY NUMBER:** I.J

Department Approval ~~Date(s)~~:	~~04/16~~04/17
Clinical Policies and~~&~~ Procedures Committee Approval:	~~05/16~~06/17
Nurse Executive Council Approval:	~~05/16~~07/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~06/16~~08/17
Professional Affairs Committee Approval:	07/16
Board of Directors Approval:	07/16

A. **PURPOSE:**

1. Chain of Command provides employees an expeditious process to resolve administrative, clinical, or other patient safety or service issues in order to provide safe patient care. All employees are encouraged to use the chain of command to present an issue of concern and pass it up the lines of authority until a resolution is reached. In situations where the safety of the patient or of employees, visitors, and others does not allow time for use of the chain of command, employees shall take the concern to the highest level he/she deems necessary.

B. **POLICY:**

1. Tri-City Healthcare District **(TCHD)** will not tolerate any acts of reprisal against those who raise issues concerning quality patient care.
2. All **TCHD employees and** health care providers (HCP) are responsible for ensuring that patients receive quality care and should implement chain of command to obtain necessary patient care interventions when the quality of care or safety of a patient is in question.
3. Examples of when to implement the chain of command may, include but are not limited to the following:
   - **a. An unresolvable issue creating a patient care/safety concern.**
   - **b. A conflict delaying or preventing the provision of patient services.**
   - **c. A disruption in ~~a~~ services(s) that cannot be resolved in an appropriate timeframe.**
   - ~~a.~~**d.** A conflict exists concerning the plan of care/physician orders for the patient.
   - ~~b.~~**e.** The plan of care is unclear and caregiver is unable to get clarification from physician.
   - ~~c.~~**f.** Qualified care professional providers are unavailable: Registered Nurses (RNs), physicians, and other essential care providers.
   - ~~d.~~**g.** Unprofessional behavior by or impairment of the healthcare providers that jeopardize patient care.
   - ~~e.~~**h.** Instances where a physician has not responded in a timely manner to a deteriorating patient condition.
   - ~~f.~~**i.** The RNs assessment of the patient varies significantly from physician's assessment.
   - ~~g.~~**j.** In clinical situations where the RN believes the physician has not responded in a manner to fully address the issues raised, that may present an immediate risk to the patient.
4. **Occurrence of an event in an area that disrupts operations and affects the public or may warrant regulatory notification:**
   - **a. Contact immediately, Monday through Friday, Area Manager/Director who will call their Area Chief and Area Chief to notify Chief Executive Officer (CEO).**

b. Contact immediately nights, holidays, Saturday and/or Sunday, Administrative Supervisor (AS) who will call the Clinical Administrator on Call and Administrator on Call to notify the CEO.

~~4.~~**5.** The next level of authority shall be contacted if issues are not resolved in an appropriate time frame. Progression continues through the levels of authority until the issue is resolved.

a. In some instances, one or more levels may be passed over ~~due~~**up to the area Chief or CEO due** to extremely sensitive subjects or when the higher level of authority may be the individual involved.

~~5.~~**6.** For conflicts that cannot be resolved between employees related to patient care/safety issues, the order in which the lines of authority shall be contacted are as follows:

a. The employees shall attempt to address and resolve conflict outside of the patient care area.

b. If unresolved, then the **Supervisor on Duty/Department Supervisor** ~~Assistant Nurse Manager~~ is notified.

c. If unresolved, then the ~~Clinical~~ Manager and/or ~~Administrative Supervisor~~ **AS** is notified.

d. If unresolved, then the Director is notified.

e. If unresolved, then the Senior Director is notified.

f. If unresolved, then the ~~Chief Nurse Executive (CNE)~~**Area Chief** is notified.

~~6.~~**7.** For conflicts involving physicians/Allied Health Professionals **(AHP)**, the order in which the lines of authority shall be contacted upon initiation of chain of command is as follows:

a. The HCP shall contact the ~~Assistant Nurse Manager~~**Department Supervisor/Manager** in a confidential manner to express concerns.

b. If unresolved, the ~~Clinical~~ Manager and/or ~~Administrative Supervisor~~ **AS** is notified.

c. If unresolved, the Director is notified.

d. If unresolved, the Senior Director is notified.

e. If unresolved, the ~~Senior Executive~~**Clinical Administrator on Call and** ~~, or if unavailable the~~ Administrator on Call is notified.

f. If unresolved, the ~~Medical Director~~**Department/Division Chair** of the identified department/**division** is notified.

g. If unresolved, the Chief Of Medical Staff **and CEO** ~~is~~**are** notified

h. If unresolved, the President/Chief Executive Officer is notified.

8. The ~~Administrative Supervisor~~ **AS** is available as a resource when contacting all levels of authority.

C. PROCEDURE FOR CONTACTING PHYSICIANS:

1. For instances when a call is placed to a physician and the physician has not responded in a timely manner:

a. Urgent situations:

i. If the physician has not returned the call within five (5) minutes, the HCP will contact Private Branch Exchange (PBX) for assistance in contacting the physician.

ii. PBX will make several attempts to contact the physician. If the physician has still not responded within thirty (30) minutes, PBX will notify the AS of the lack of physician response. The AS will contact the HCP for additional information regarding the situation.

iii. The AS will contact the Chief of Service.

iv. The AS will contact the Clinical On-Call as needed.

b. Non-urgent situations:

i. If the physician has not returned the call within thirty (30) minutes, the HCP will contact PBX for assistance in contacting the physician.

ii. PBX will make several attempts to contact the physician. If the physician has still not responded within one (1) hour, PBX will notify the AS of the lack of physician response. The AS will contact the HCP for additional information regarding the situation.

~~i.~~iii. **The AS will contact the Chief of Service as needed.**

~~C.~~D. **DOCUMENTATION:**

1. The HCP shall document the following in the medical record under clinical notes without including personal opinions:
   a. Date, time, and name of person contacted
   b. Events and observations objectively as they occur
   c. Specific facts and accurate times
2. Quality review report (QRR) shall be completed and submitted to Risk Management.

~~D.~~E. **RELATED DOCUMENTS:**

1. Administrative Policy: Incident Report – Quality Review Report (QRR) RL Solutions 396

Tri-City Medical Center
Oceanside, California

TRACKED CHANGES

PATIENT CARE SERVICES

ISSUE DATE: 10/05	**SUBJECT:** Hand-Off, Communication
REVISION DATE: 02/06, 01/08, 07/08, 04/09, 08/12	**POLICY NUMBER:** IV.F

Department Approval:	**05/17**
Clinical Policies & Procedures Committee Approval:	**~~06/12~~07/17**
Nursing Executive Committee Approval:	**~~06/12~~07/17**
Medical Executive Committee Approval:	**~~07/12~~08/17**
Professional Affairs Committee Approval:	**08/12**
Board of Directors Approval:	**08/12**

A. **PURPOSE:**

1. **To improve the effectiveness or communication among caregivers.**
2. ~~1.~~ To provide a consistent, standardized, interactive approach to hand-off communications between patient caregivers ~~in accordance with 2012 National Patient Safety Goal 02.03.01~~.
3. ~~2.~~ To ensure healthcare providers communicate new, changes or updates in patient information throughout a shift **using a standardized communication process**.

B. **DEFINITION(S):**

1. **Health Care Team**: A Registered Nurse (RN), or Certified Nursing Assistant (CNA)/Advanced Care Technician (ACT) assigned to a nursing unit.
2. **Safety Hand-Off: Providing safety information including, but not limited to:**
   - a. **Patient name, diagnosis**
   - b. **Orientation (for example alert, confused, forgetful)**
   - c. **Code status, if applicable**
   - d. **Isolation status, if applicable**
   - e. **Communication barriers (hard of hearing, legally blind, non-English speaking), if applicable**
   - f. **Patient safety concerns, for example fall risk, conditions affecting ability to transfer safely**
3. **SBAR (Situation-Background-Assessment-Recommendation): a technique that provides a framework for communication between members of the health care team about a patient's condition.**
   - a. **Situation: concise statement(s) identifying the problem**
   - b. **Background: Pertinent and brief details (information) that relates to the situation**
   - c. **Assessment: your patient assessment findings, lab results, diagnostic results**
   - ~~a.~~d. **Recommendation: suggested treatments, medications, plan of care etc., that will decrease or resolve the situation**

~~2. **Shift-to-Shift Hand-Off Communication:** a process for communicating patient information between the on-coming and off-going nursing shifts as both nurses review and discuss pertinent patient information while observing the patient.~~

~~3. **Ticket to Ride:**~~

- ~~a. Form used as a method of hand-off communication during departmental transfers~~.

C. **POLICY:**

1. Healthcare providers shall use the ~~Situation, Background, Assessment, Recommendations (~~SBAR~~)~~ process when **providing** ~~conducting~~ hand-off communication.
2. Hand-off communication shall:

a. Be accurate, clear, complete, and include information about the patient's care, treatments and required services.
b. Include an opportunity for verbal communication and allow for face-to-face or telephone interaction, so questions **or concerns** about a patient's care can be **asked and** answered.
   i. Clarification and validation techniques shall be utilized to make sure there is a common understanding about expectations.
c. Include information about a patient's current condition and recent or anticipated changes.
d. Hand-Off Rounds: ~~a process by which patients are observed by the off-going and on-coming nurses at their bedside during~~ shift-to-shift hand-off communication will include rounding by the on-coming and off-going nurses.

3. A consistent method for patient hand-off communication shall be conducted throughout the organization during the following:
   a. Change of shift
   b. Break relief
   c. Prior to the transfer of care to another nursing unit
   ~~d. Respiratory Care Practitioner (RCP) to RCP~~
   ~~e.~~**d.** Prior to and after transfer of care to another department for a procedure/test, i.e. radiology, surgery, cardiac catherization, inpatient dialysis unit
   ~~f.~~**e.** Prior to transferring/**discharging** a patient to another facility
   ~~g. Prior to discharge to a skilled nursing facility~~
   ~~h. Any c~~**C**~~hange in level of care requirements~~ **~~identified by non-TCMC employees assisting with the safety of patients on the Progressive Care Unit~~** ~~communicated to California Department of Corrections and Rehabilitation (CDCR) authority for forensic patients~~
4. Shift Team Update: A brief verbal communication between licensed staff (RN) and ACTs to provide pertinent information regarding individual patient assignments.
   a. Shift team updates shall be initiated by the on-coming healthcare team after shift-to-shift hand-off communication.
   b. Shift Team Updates shall continue throughout the shift as needed, to improve communication between all members of the health care team.

~~b.~~**5. If patient is transported and unaccompanied by a licensed nurse, nurse shall provide a safety hand-off to the transporter.**

D. **HAND-OFF COMMUNICATION REFERENCES:**

1. The following references may be used **to provide**~~for~~ hand-off communications:
   a. History and Physical
   b. Electronic Health Record (EHR) patient care applications ~~Appropriate Cerner PowerChart Organizer tabs~~ i.e. ~~O~~**o**rders, ~~L~~**l**abs, ~~V~~**v**ital ~~S~~**s**igns
   ~~b.~~**c. Electronic kardex**
   ~~c.~~**d.** Electronic Medication Administration Record (eMAR)
   ~~d.~~**e.** Medication Administration Record (MAR) summary
   ~~e.~~**f.** Physician's Orders
   ~~f.~~**g.** Physician's Progress Notes
   ~~g.~~**h.** Chart Summary Screen
   ~~h.~~**i.** SBAR Shift-to Shift Hand-off Communication form

E. **NURSING SHIFT-TO-SHIFT HAND-OFF / TRANSFER OF CARE TO ANOTHER NURSI~~S~~NG UNIT:**

~~2.~~**1.** May include but is not limited to:
   a. Patient Information (name, age, physician, diagnosis)
   b. Code status
   c. Isolation status
   d. Allergies

e. Abnormal assessment findings **(labs, vital signs, physical assessment)**
f. Pertinent Physician Orders
g. Any patient safety concerns (i.e. falls, medications **that may contribute to falls, seizure precautions, and/or** equipment)
h. Case management/social service concerns related to the plan of care
i. Medications/key interventions requiring follow-up by ~~given by~~the receiving unit or oncoming shift
i. Pain level and time pain medication was last given, if applicable
~~**Recommendation to review computer**~~

~~3.~~**2.** Surgical Services hand-off shall include nursing shift-to-shift hand-off information as well as:
a. All pertinent **pre/**post-surgical/**procedural** information
b. Whereabouts of family and belongings

~~E.~~**F. BREAK RELIEF:**
1. **Patient information** (name, age, physician, diagnosis)
2. Current condition and status (level of consciousness, vital signs)
3. Code status
4. Isolation status
5. Patient safety
6. Medications or tasks due or in progress ~~i.e. blood transfusion~~
7. ~~Other specific concerns/information related to the break time i.e. c~~**C**alls placed to physicians

~~F. TRANSFER OF CARE TO ANOTHER NURSING UNIT~~
~~1. Transfer hand-off shall include but is not limited to nursing shift-to-shift hand-off information.~~
~~2. Documentation~~
~~a. Sending nurse shall document on Off Unit/Transfer Assessment Powerform and complete the Ticket to Ride~~
~~b. Receiving nurse shall document receipt of patient on the Off Unit/Transfer Assessment Powerform and on the Ticket to Ride.~~
~~3. If patient is transferred unaccompanied by a licensed nurse, nurse shall provide hand-off to the transporter.~~

~~G. TRANSFER OF CARE TO TRANSPORTERS:~~
~~1. If patient is transferred unaccompanied by a licensed nurse, nurse shall provide verbal hand-off to the transporter and review the Ticket to Ride.~~

~~H.~~**G. RESPIRATORY CARE PRACTITIONER (RCP) TO RCP:**
1. A verbal report, face-to-face, or telephone hand-off shall be conducted.
a. When verbal report, face-to-face, or telephone hand-off is not possible, a written report shall be completed by the off-going RCP.
i. The off-going RCP written report shall include the hand-off information listed below.
2. Hand-off ~~shall~~ **may** include**, but not limited to,** the following information:
a. Patient identifiers
b. Code status
c. Isolation status
d. Pulmonary Diagnoses
e. Time last treatment was conducted
f. Breath sounds
g. Vital signs including last pulse oximeter reading
h. Cough and/or sputum
i. Mental status including vision or hearing impairments
j. Abnormal or unusual respiratory conditions (i.e. hemoptysis)
k. Pertinent lab results

l. Ventilator settings as applicable
m. Patient safety concerns, for example fall risk and conditions affecting ability to transfer safely~~Fall risk~~
~~m.~~**n. Medications/key interventions requiring follow-up by given by the oncoming shift**

~~I. SURGICAL SERVICES PATIENT TRANSFERS:~~
~~1. Surgical Services hand-off shall include nursing shift-to-shift hand-off information as well as:~~
~~a. All pertinent post-surgical information~~
~~b. Whereabouts of family and belongings~~

~~J. FROM PATIENT CARE AREAS TO SURGERY:~~
~~1. The Pre-Operative or Post-Anesthesia Care Unit (PACU) RN shall call the floor/ED and hand-off from the primary care nurse or designee responsible for the patient or review the Pre-Operative Procedure Powerform on Cerner.~~
~~2. Hand-off communication shall include the following:~~
~~a. Pertinent shift-to-shift information~~
~~b. Verification of information on pre-op~~

~~K. PROCEDURE TRANSFERS:~~ **(see new procedure)**
~~1. Sending Department:~~
~~a. Healthcare provider to complete and update the Cerner Off Unit/Transfer Assessment Powerform and Ticket to Ride~~
~~b. Ensure patient's hardcopy chart accompanies patient.~~
~~c. If patient is transferred unaccompanied by a licensed nurse, nurse shall provide hand-off to the transporter.~~
~~d. Telemetry and Acute Care Services (ACS) Monitored units nursing staff shall notify the Monitor Tech per the Transporter Communication Procedure~~
~~2. Procedural/Diagnostic Department:~~
~~a. Shall receive a safety hand-off from the transporter.~~
~~b. Shall review the Off Unit/Transfer Assessment Powerform.~~
~~c. Contact the healthcare provider if there are any questions.~~
~~d. Prior to transferring the patient update Cerner Off Unit/Transfer Assessment Powerform.~~
~~e. If patient is transferred unaccompanied by a licensed nurse, nurse shall provide verbal hand-off to the transporter and review the Ticket to Ride.~~
~~3. Return to Sending Department (following procedure):~~
~~a. Shall receive a safety hand-off from the transporter~~
~~b. Healthcare provider shall review the Cerner Off Unit/Transfer Assessment Powerform: Procedure Area Report~~
~~c. Assess the patient~~
~~d. Document receipt of patient on the Off Unit/Transfer Assessment Powerform: Return/Received screen and complete Ticket to Ride~~
~~e. Document any changes in the patient's status in the medical record~~

H. RELATED DOCUMENT(S):

~~L.~~1. ~~TRANSFER TO ANOTHER FACILITY: See~~ **Patient Care Services Policy:** Transfer of Patients ~~Policy~~
~~M.~~2. ~~DISCHARGE: See~~**Patient Care Services Policy:** Discharge of Patients ~~Policy~~

~~N.~~I. REFERENCES:

1. Caruso, E. (2007~~, February~~). The evolution of nurse-to-nurse bedside report on a medical-surgical cardiology unit. *MEDSURG Nursing, 16*(1), 17-22.
2. Maxson, P. M., Derby, K. M., Wrobleski, D. M., & Foss, D. M. (2012). Bedside Nurse-to-NurseHandoff Promotes Patient Safety. *MEDSURG Nursing*, *21*(3), 140-145.

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4. Risenber, L. A., Leisch, J. & Cunningham, J. (2010~~, April~~). Nursing handoffs: A systematic review of the literature. *AJN, American Journal of Nursing*, 110(4), 24-34
5. Patient safety: "a ticket to ride" protects patients off the unit. *Nursing 2012, 39* (5), 57-58. Retrieved from http://www.nursingcenter.com/Inc?journal?Article_ID=858666
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Tri-City Medical Center
Oceanside, California

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PATIENT CARE SERVICES

ISSUE DATE: 10/05	**SUBJECT:** Hand-Off, Communication
REVISION DATE: 02/06, 01/08, 07/08, 04/09, 08/12	**POLICY NUMBER:** IV.F

Department Approval:	05/17
Clinical Policies & Procedures Committee Approval:	07/17
Nursing Executive Committee Approval:	07/17
Medical Executive Committee Approval:	08/17
Professional Affairs Committee Approval:	08/12
Board of Directors Approval:	08/12

A. **PURPOSE:**
1. To improve the effectiveness or communication among caregivers.
2. To provide a consistent, standardized, interactive approach to hand-off communications between patient caregivers.
3. To ensure healthcare providers communicate new, changes or updates in patient information throughout a shift using a standardized communication process.

B. **DEFINITION(S):**
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   a. Patient name, diagnosis
   b. Orientation (for example alert, confused, forgetful)
   c. Code status, if applicable
   d. Isolation status, if applicable
   e. Communication barriers (hard of hearing, legally blind, non-English speaking), if applicable
   f. Patient safety concerns, for example fall risk, conditions affecting ability to transfer safely
3. SBAR (Situation-Background-Assessment-Recommendation): a technique that provides a framework for communication between members of the health care team about a patient's condition.
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   b. Background: Pertinent and brief details (information) that relates to the situation
   c. Assessment: your patient assessment findings, lab results, diagnostic results
   d. Recommendation: suggested treatments, medications, plan of care etc., that will decrease or resolve the situation

C. **POLICY:**
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      i. Clarification and validation techniques shall be utilized to make sure there is a common understanding about expectations.

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   a. Change of shift
   b. Break relief
   c. Prior to the transfer of care to another nursing unit
   d. Prior to and after transfer of care to another department for a procedure/test, i.e. radiology, surgery, cardiac catherization, inpatient dialysis unit
   e. Prior to transferring/discharging a patient to another facility
4. Shift Team Update: A brief verbal communication between licensed staff (RN) and ACTs to provide pertinent information regarding individual patient assignments.
   a. Shift team updates shall be initiated by the on-coming healthcare team after shift-to-shift hand-off communication.
   b. Shift Team Updates shall continue throughout the shift as needed, to improve communication between all members of the health care team.
5. If patient is transported and unaccompanied by a licensed nurse, nurse shall provide a safety hand-off to the transporter.

D. **HAND-OFF COMMUNICATION REFERENCES:**

1. The following references may be used to provide hand-off communications:
   a. History and Physical
   b. Electronic Health Record (EHR) patient care applications i.e. orders, labs, vital signs
   c. Electronic kardex
   d. Electronic Medication Administration Record (eMAR)
   e. Medication Administration Record (MAR) summary
   f. Physician's Orders
   g. Physician's Progress Notes
   h. Chart Summary Screen
   i. SBAR Shift-to Shift Hand-off Communication form

E. **NURSING SHIFT-TO-SHIFT HAND-OFF / TRANSFER OF CARE TO ANOTHER NURSING UNIT:**

1. May include but is not limited to:
   a. Patient Information (name, age, physician, diagnosis)
   b. Code status
   c. Isolation status
   d. Allergies
   e. Abnormal assessment findings (labs, vital signs, physical assessment)
   f. Pertinent Physician Orders
   g. Any patient safety concerns (i.e. falls, medications that may contribute to falls, seizure precautions, and/or equipment)
   h. Case management/social service concerns related to the plan of care
   i. Medications/key interventions requiring follow-up by the receiving unit or oncoming shift
      i. Pain level and time pain medication was last given, if applicable
2. Surgical Services hand-off shall include nursing shift-to-shift hand-off information as well as:
   a. All pertinent pre/post-surgical/procedural information
   b. Whereabouts of family and belongings

F. **BREAK RELIEF:**

1. Patient information (name, age, physician, diagnosis)
2. Current condition and status (level of consciousness, vital signs)
3. Code status

4. Isolation status
5. Patient safety
6. Medications or tasks due or in progress
7. Calls placed to physicians

G. **RESPIRATORY CARE PRACTITIONER (RCP) TO RCP:**

1. A verbal report, face-to-face, or telephone hand-off shall be conducted.
   a. When verbal report, face-to-face, or telephone hand-off is not possible, a written report shall be completed by the off-going RCP.
      i. The off-going RCP written report shall include the hand-off information listed below.
2. Hand-off may include, but not limited to, the following information:
   a. Patient identifiers
   b. Code status
   c. Isolation status
   d. Pulmonary Diagnoses
   e. Time last treatment was conducted
   f. Breath sounds
   g. Vital signs including last pulse oximeter reading
   h. Cough and/or sputum
   i. Mental status including vision or hearing impairments
   j. Abnormal or unusual respiratory conditions (i.e. hemoptysis)
   k. Pertinent lab results
   l. Ventilator settings as applicable
   m. Patient safety concerns, for example fall risk and conditions affecting ability to transfer safely
   n. Medications/key interventions requiring follow-up by given by the oncoming shift

H. **RELATED DOCUMENT(S):**

1. Patient Care Services Policy: Transfer of Patients
2. Patient Care Services Policy: Discharge of Patients

I. **REFERENCES:**

1. Caruso, E. (2007). The evolution of nurse-to-nurse bedside report on a medical-surgical cardiology unit. *MEDSURG Nursing, 16*(1), 17-22.
2. Maxson, P. M., Derby, K. M., Wrobleski, D. M., & Foss, D. M. (2012). Bedside Nurse-to-NurseHandoff Promotes Patient Safety. *MEDSURG Nursing*, *21*(3), 140-145.
3. Hand-off communications. (2007). AORN Journal, 86S146-9:10.1016/J.Aorn.2007.11.012 CINAHL Plus
4. Risenber, L. A., Leisch, J. & Cunningham, J. (2010). Nursing handoffs: A systematic review of the literature. *AJN, American Journal of Nursing*, 110(4), 24-34
5. Patient safety: "a ticket to ride" protects patients off the unit. *Nursing 2012, 39* (5), 57-58. Retrieved from http://www.nursingcenter.com/Inc?journal?Article_ID=858666
7. Patients at this hospital have a "ticket to ride." Healthcare Benchmarks Qual Improv. 2006; 13(9): 102-104

Tri-City Medical Center
Oceanside, California

DELETE – Incorporated into Patient Care Services: Plan of Nursing Care

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 3/02

SUBJECT: Nursing Chain of Command

REVISION DATE: 6/03, 5/05, 4/09, 1/11

POLICY NUMBER: I.J

Department Approval:	~~12/16~~04/17
Clinical Policies & Procedures Committee Approval:	~~11/1102/17~~06/17
Nursing Executive Committee Approval:	~~11/1102/17~~07/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~01/1203/17~~08/17
Professional Affairs Committee Approval:	02/12
Board of Directors Approval:	02/12

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

~~1. The Chief Nurse Executive (CNE) is ultimately responsible for oversight of operations of all nursing units.~~

~~2. The Senior Director of Preoperative and Women's and Childrens' Services provides coverage of effectiveness of daily operations of all nursing units in the absence of the CNE~~

~~3. The Clinical Managers and Directors are responsible to the CNE s for the operation of assigned nursing units or services.~~

~~4. The Assistant Nurse Managers (ANM) is responsible to the Manager/Director, CNE and/or Administrative Supervisor on duty for managing staff and directing patient care on their assigned shift.~~

~~5. The Registered Nurse (RN) is responsible to the ANM/Relief Charge Nurse for providing total patient care utilizing the nursing process.~~

~~6. The designated RN acts as a "patient manager" to provide outcome oriented patient management within a fiscally responsible time frame. Support staff (i.e. Nursing Assistants, Unit Secretaries and Technicians) report to the RN.~~

~~7. The Administrative Supervisors on duty are responsible to the Clinical Managers/Director for the management of patient care activities and hospital operations on their assigned shift. They have authority to act in the absence of the CNE and Clinical Managers/Director. They report to the Director of Education, Clinical Informatics, and Staffing.~~

~~8. The Director of Education, Clinical Informatics, and Staffing is responsible for maintaining oversight of the Staffing Office, Resource Network, and Administrative Supervisors.~~

~~9. Clinical Educators are responsible to Directors and the Director of Education, Clinical Informatics, and Staffing for staff education in assigned areas of responsibilities.~~

Tri-City Medical Center
Oceanside, California

TRACKED CHANGES

Plan for Nursing Care

I. **PURPOSE**

A. The hospital-wide plan for the provision of services is designed to assure:
   1. Patient Care Services **(PCS)** are appropriately integrated throughout the organization;
   2. Adequate resources are available to assess, plan, deliver, manage, and evaluate patient care;
   3. The design of patient care services provided throughout the organization is appropriate to the scope and level of care required by the patients served;
   4. Uniform performance of patient care is provided throughout the organization.

B. The hospital-wide plan for the provision of services is reviewed at least annually or as deemed necessary due to changing patient populations or other internal or external factors such as:
   1. Patient care requirements;
   2. The Hospital's recruitment, retention, and staff development capabilities;
   3. Information from performance improvement, risk management, utilization management, safety reviews and other evaluation activities;
   4. Evaluation of innovations and improvements in patient care;
   5. Affiliations, managed care contracts and reimbursement changes;
   6. Feedback from patients, families, hospital staff, and physicians regarding patient care concerns or issues;
   7. The Hospital's Strategic and Facilities Plan and annual budget;~~.~~
   8. Regulatory or accreditation changes;
   ~~8.~~9. Collective Bargaining Agreement (CBA) revisions.

C. This review is to be performed by the Executive Team, the Medical Executive Committee, and the Board of Directors.

II. **DEFINITION OF NURSING**

~~1. The practice of the profession of nursing is defined as diagnosing and treating human response to actual or potential health problems within the following domains:~~
~~a. Protection,~~
~~b. Promotion and optimization of health and abilities,~~
~~c. Prevention of illness and injury,~~
~~d. Alleviation of suffering through the diagnosis and treatment of human response~~
~~e. Advocacy in the care of individuals,families, communities, and populations.~~

A. Nursing is the protection, promotion and optimization of health and abilities, prevention of illness and ~~and~~ injury, alleviation of suffering through the diagnosis and treatment of human response and advocacy in the care of individuals, families, communities and populations. American Nurses Association, Scope of Practice, 2015 3rd Ed.

III. **NURSING VISION AND DISTRICT VALUES**

A. To become known for nursing care that is the magnetic force which attracts the community to Tri-City **Healthcare District (TCHD)**~~Medical Center~~.

~~A.~~B. The needs of our patients come first.

~~a. We are Tri-City Nursing, Patients are our # 1 Priority~~
~~b. We are dedicated to providing Quality patient care and service for our patients~~

Department Review	Clinical Policies and Procedures	Nurse Executive Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
07/16, 06/17	09/16, 07/17	09/16, 07/17	n/a	10/16, 08/17		

~~c. We are Caring and demonstrate this to patients, physicians and each other with concern dignity, kindness and respect.~~
~~d. We strive for the Safety and well being of our patients and each other.~~
~~e. We have a strong sense of Integrity, being ethical and transparent in all we do.~~
~~f. We promote Innovation in Nursing Practice, believing that evidence and research influence outcomes.~~
~~g. We commit to community Stewardship to achieve community health and wellness~~

IV. GUIDING PRINCIPLES

A. We never lose sight of our patients' and families' needs and expectations.
B. We strive to make the most efficient use of our resources.
C. We are alert for opportunities to improve.
D. We encourage patients and families to participate in their care and decisions affecting their care.
E. We focus on team relationships and healthy interpersonal skills.
F. We enter into partnerships with patients, families, and other health care professionals eagerly.
G. We base our decisions for care on the nursing practice act, nursing standards and nursing evidence-based research.
H. We acknowledge that maintaining the highest standards of patient care is a never-ending process which involves the patient, family, all health care providers, and the community at large.
I. We view learning as a lifelong process which is essential to our development.
J. We embrace change to promote and advance the delivery of care to our patients.
K. We utilize informatic solutions and technology to support all areas of nursing, including but not limited to, the direct provision of care, establishing effective administrative systems, managing and delivering educational experiences, enhancing lifelong learning and supporting nursing research.

V. PHILOSOPHY OF NURSING/CORE BELIEFS

A. Nurses at ~~Tri-City Medical Center~~**TCHD** believe that Professional Nursing is both an art and a science; a dynamic practice based upon the nursing process and a combination of knowledge, skills and the provision of care that incorporates professional values, compassion, and commitment to excellence. We believe:
   1. Caring - is the essence of nursing. A caring approach includes: knowledge, adaptable approaches based on the care-recipient's unique needs, patience, honesty, trust, humility, hope and courage.
   2. Diversity - is a core element for caring and leadership. It requires that the individual affirm his or her own unique self while learning to respect and address the needs of others who may have different values.
   3. Accountability - is the hallmark of professional practice. It requires responsibility to set personal standards for accomplishing expected goals, objectives and outcomes; for relationships and working together (collegiality); for supporting colleagues/peers; and for adherence to organizational policy and procedure.
   4. Integrity - is the foundation for clinical practice, leadership, and learning. It encompasses a commitment to people (staff, colleagues, families, community, and adherence to the professional nursing code of ethics and professional nursing standards of practice.
   5. Advocacy - is an inherent element of nursing ethics and nursing practice. As an advocate, the nurse is responsible for safeguarding, promoting, and supporting the patient's values and decisions.
   6. Scholarship – is a life-long practice where the nurse acquires ongoing knowledge for expert practice in professional nursing, transcultural nursing care and leadership. Experienced nurses serve as mentors to others in assisting them to achieve a higher level of evidence-based practice.

VI. SCOPE OF PATIENT CARE

A. Patient care at ~~Tri-City Medical Center~~**TCHD** encompasses health promotion, disease prevention and treatment activities in the community, home, acute care, inpatient and outpatient arena. This care is provided collaboratively by health care providers with specialized knowledge, judgment and skill. Patient care is planned, coordinated, provided, delegated and supervised by professional health care providers who recognize physical, psychological, and spiritual needs of patients.

1. **All PCS departments have a plan that describes their scope of service.**

VII. PRACTICE STANDARDS

A. American Nurses Association Code of Ethics for Nurses **2015 2nd Ed.**– Ethics is an integral part of the foundation of nursing practice. The Code of Ethics for Nurses provides a framework for nurses at ~~Tri-City Medical Center~~**TCHD** to use in ethical analysis and decision-making. The nine provisions of the Code of Ethics describe the most fundamental values and commitments of the nurse, boundaries of duty and loyalty and duties beyond individual patient encounters. **These interpretive statements are** ~~It is~~ not negotiable in any setting~~.~~**:**

1. **Respect for Others**
2. **Commitment to the Patient**
3. **Advocacy for the Patient**
4. **Accountability and Responsibility for Practice**
5. **Duty to Self and Duty to Others**
6. **Contribution to Healthcare Environments**
7. **Advancement of the Nursing profession**
8. **Promotion of Community and World Health**
9. **Promotion of the Nursing Profession**

B. American Nurses Association Scope & Standards for Nursing Practice – This scope statement and standards of nursing practice guide, define and direct professional nursing practice in all settings and outlines the expectations of the professional role within which all registered nurses must practice.

~~A.~~**C.** California Nurse Practice Act – The Nurse Practice Act outlines the laws and regulations that define the scope of nursing practice in the state of California. ~~Tri-City~~**TCHD** nurses are responsible to be informed of these laws.

~~A. American Association of Critical-Care Nurses Healthy Work Environment- Healthy work environments foster excellence in patient care. Tri-City Medical Center Nurses are committed to establishing and sustaining work and care environments that are healthy, healing, humane and respectful of the rights, responsibilities, needs and contributions of all people – including patients, their families and nurses.~~

VIII. PATIENT CARE MODEL: SYNERGY (uses trademark)

A. ~~Tri-City Medical Center~~**TCHD** Nurses use the Synergy Model for patient care to match the needs of our patients to the competencies of the nurse to ensure optimal outcomes.

B. The Synergy model delineates three levels of outcomes: those derived from the patient, those derived from the nurse, and those derived from the healthcare system.

C. Nurse Competencies:

1. Clinical judgment, including decision making, critical thinking and basic nursing skills.
2. Caring practices, responding to the unique needs of patients and families.
3. Advocacy to help identify and resolve concerns as they arise.
4. Collaboration with the entire team of caregivers.
5. Sensitivity and response to diversity to incorporate differences into patient care.
6. Facilitation of learning to ensure patients and families know how to continue care.
7. Clinical inquiry, including questioning and evaluation of practices to provide the best possible care.
8. Systems thinking to take a holistic approach to every care giving situation.

D. Patient Characteristics:

1. Participation in decision making about treatment options.

2. Involvement in care.
3. Level of stability (critical, fair, and stable).
4. Complexity of the illness or injury.
5. Resiliency of the patient.
6. Vulnerability or susceptibility to stressors of all types.
7. Availability of resources, including support systems upon discharge.
8. Predictability of the illness or injury.

IX. PROFESSIONAL STAFF NURSE CORE PERFORMANCE EXPECTATIONS

A. Assessment:
   1. The Registered Nurse (RN) collects comprehensive data pertinent to the patient's health or the situation.

B. Diagnosis:
   1. The RN analyzes the assessment data to determine the diagnosis of issues.

C. Outcome Identification:
   1. The RN identifies expected outcomes for a plan individualized to the patient or the situation.

D. Planning:
   1. The RN develops a plan that prescribes strategies and alternatives to attain expected outcomes.

E. Implementation:
   1. The RN implements the plan
   2. Coordination of Care:
      a. The RN coordinates care
   3. Health Teaching& Health Promotion:
      a. The RN employs strategies to promote health and a safe environment
   4. Consultation:
      a. The advanced practice registered nurse and the nursing role specialist provide consultation to influence the identified plan, enhance the abilities of others, and effect change.

F. Evaluation:
   1. The RN determines the patient's progress toward the attainment of expected outcomes and the effectiveness of nursing care.

X. PROFESSIONAL RESPONSIBILITIES OF THE REGISTERED NURSE

A. Takes initiative for own learning gaps, seeks experiences and formal and independent learning activities to maintain and develop clinical and professional skills and knowledge.

B. Is aware of own positive and negative biases and limitations.

~~C. Submits scheduling requests for Paid Time Off (PTO), per unit guidelines~~

~~A. Call-in for unscheduled absences per policy/procedure.~~

~~D.~~**C.** Has self confidence in own expertise.
~~Resource for new staff.~~

~~E.~~**D.** Involves patient/family in the plan of care; informs team members of patient needs, goals, preferences and expected outcomes.

~~F.~~**E.** Actively participates in report, rounds, staffing, shared decision-making activities develops plan of care; discusses it with patient, family and care team and revises it as necessary.

~~G.~~**F.** Accesses current nursing journals on research, best practices, technology and innovations.

~~H.~~**G.** Actively participates in unit retention strategies.

~~I.~~**H.** Embraces opportunities to preceptor,~~ and~~ mentor colleagues, **and students,** sharing learning **to further the practice of nursing.**~~ and is open to new processes and practices~~

~~J.~~**I.** Embraces change as a mechanism to promote patient care and the nursing profession.

XI. STAFFING PLANS

A. Staffing plans and scheduling for patient care service departments are developed based on the mandated RN to patient ratio and intensity of care that needs to be provided, the frequency of the care to be provided, and a determination of the level of staff that can most appropriately (competently and confidently) provide the type of care needed.

B. Each department has a formalized staffing grid which is reviewed at ~~bi~~annually based on the following: Hours Per Patient Day/Hours Unit Of Service, utilization review, employee turnover, performance assessment and improvement activities, changes in customer needs/expectations, "Best Practice" information from other sources, new services planned, patient volume and population changes, and risk management. Staffing grids are decentralized in the Staffing Office and are kept in unit/departmental documents.

C. The Hospital and CNA bargaining unit will meet annually to validate the acuity assignment process.

XII. **DELIVERY OF NURSING CARE**

~~D.~~**A.** ~~There~~ Areas ~~seventeen (17) areas~~ where nursing care is delivered **under the Division of Nursing (including but not limited to)**:

~~i. Medical & SurgicalRehabilitation~~
~~b. Oncology~~
~~i. Medical Monitoring~~
~~ii. Behavioral Health Services~~
~~iii. Cardiology Services~~
~~iv. Emergency Services~~
~~v. Home Health~~
~~vi. Infusion Centers~~
~~vii. Intensive Care Unit~~
~~viii. Neonatal Intensive Care Unit~~
~~ix. Forensic Unit~~
~~x. Radiology Services~~
~~xi. Surgical Services~~
~~xii. Telemetry~~
~~xiii. Women's and Children's Services~~
~~xiv. Wound Care~~

1. Acute Care Services (1 North, ~~/~~**Inpatient** Acute Rehabilitation **(ARU)**, 2 Pavilion, ~~3 Pavilion, 4~~ Pavilion~~, 3NS~~**):**

   a. Acute Care Services develop, implement, and evaluate a plan of nursing care for adult (14 years and older) acute care patients who are acutely ill or injured and are in varying stages of recuperation from diagnostic, therapeutic, or surgical intervention.

      i. 1 North: Orthopedic diagnoses are emphasized~~. as outlined in~~

      ~~i.~~**ii.** Inpatient Acute Rehabilitation (ARU): The ARU provides restorative and maintenance programs for the adult patient (ages 14 years and older) suffering from cerebral vascular disease and other diseases or conditions requiring neurological or functional rehabilitation services. This plan incorporates mutual interdisciplinary interactions while maintaining patient advocacy. This plan of care includes the patient, family/significant others, the nurse, social worker, admissions liaison and utilization review coordinator, physical therapist, occupational therapist, speech therapist, therapeutic recreational specialist, discharge coordinator and the Medical Director of the Acute Rehabilitation Unit.

      ~~ii.~~**iii.** 2 Pavilion: Oncological diagnoses are emphasized; along with general medical surgical diagnosis.

      ~~1) 3 Pavilion: Closed~~

~~iii.~~**iv.** 4 Pavilion: Medical monitoring unit available for rate monitoring only. Neurology patients, specifically with stroke and seizure diagnosis; dialysis.

2. Behavioral Health Services/**Crisis Stabilization Unit**:
   a. The Behavioral Health Unit/**Crisis Stabilization Unit** develops, implements, and evaluates a plan of psychiatric nursing care to adults 18 years and older who are significantly impaired as a result of psychiatric disorders. This plan incorporates active interdisciplinary treatment teams consisting of psychiatric nurses and physicians, social services personnel, psychologists, mental health workers, and recreational therapists. The plan of care utilizes a variety of pharmacologic, behavioral, and psychotherapeutic interventions (groups and individual therapy) to restore optimal patient
3. Emergency Services:
   a. The Emergency Department provides comprehensive services and develops, implements, and evaluates a nursing plan of care for all patients presenting to the department, and provides medical direction to paramedics via the Base Station radio. The plan of care incorporates mutual interdisciplinary interactions while maintaining patient's advocacy and includes the patient, family, significant others and the nurse in response to the psychological and physical needs.
4. Home Health:
   a. The Home Health Department develops, implements, evaluates and executes a comprehensive care plan for patients 18 years and older who meet the criteria. Home Health provides services for Medicare, Medi-Cal and contracted insurance companies. Home Health is Medicare certified and follows the guidelines of homebound status for Medicare. The plan of care is multidisciplinary which includes RN, **Licensed Vocational Nurse** (LVN), **Certified Home Health Aid** (CHHA), **Registered Diatition** (RD), Physical and Occupational Therapy, Social Services, patient, family and caregivers as an integral part of achieving restorative status. The Home Health team promotes patient advocacy interacting with physicians and community resources for positive physical, emotional and spiritual outcomes.
5. Infusion Center- Outpatient Hospital:
   a. The purpose of this area is to meet the needs of patients who require blood transfusions, antibiotic therapy, arthritic infusions, **and** IV infusions for dehydration. Offsite Outpatient infusion is for Chemotherapy.
6. Intensive Care Unit:
   a. The Intensive Care Unit develops, implements, and evaluates a plan of nursing care for patients 14 years of age and older or weighing at least 35 kilograms with actual or potential life threatening medical or surgical conditions.
7. Neonatal Intensive Care Unit (NICU):
   a. The purpose of this unit is to develop, implement, and evaluate a plan of care for ~~newborn~~ infants **born prematurely and/or infants** who are critically ill~~ and need assistance and intervention to achieve an optimal transition to extrauterine life~~. **Patient needs are met through individualized and specialized care coordinated through the interdisciplinary team approach.** This plan **emphasizes supportive, developmental and therapeutic care unique to the needs of each infant** ~~incorporates mutual interdisciplinary interactions while maintaining patient advocacy~~ and includes the ~~patient,~~ family~~,~~ **and/or designated family/infant support members**~~ and the nurse in response to psychological and physical needs~~.
8. **Progressive Care** ~~Forensic~~ Unit/**Specialty Clinic**:
   a. This is a 41 bed secured unit that provides various services to patients age 18 and above demonstrating aberrant behavior requiring 24 hour supervision concurrently with their medical condition. Justice involved

individuals may be placed on this unit. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available bed.

- **i. Continuous Cardiac Monitoring (See Telemetry ~~Policy~~: Admission and Discharge Criteria Policy)**
- **ii. Chemotherapy Administration (See Patient Care Services: Chemotherapy Administration Procedure)**
- **iii. Acute rehabilitation**
- **iv. Ante-partum care**
- **v. Post-partum care**
- ~~xv.~~**vi. Medical-Surgical**

~~xvi. This is a 44 bed Locked unit that is under the division of nursing as well as the California Department of Corrections and rehabilitation. The Unit has 16 monitored bed capability for telemetry, a rehabilitation room for acute rehab and medical surgical beds for general acute care.~~

9. **Perioperative/Perianesthesia** ~~Surgical~~ Services:
   a. Post-Anesthesia Care Unit (PACU):
      i. Provides nursing care to patients in the post-operative/post anesthetic phase of the Perioperative period. Nursing care plans are developed, implemented and evaluated on individual patient needs. Nursing care is provided to deliver a safe, effective and appropriate level of **care to patients 14 years of age and older.** ~~patient care. All ages of patients are cared for in the PACU from pediatric patients through geriatric patients.~~
   b. Pre-Operative Hold:
      i. The purpose of this unit is to assess, implement and evaluate a plan of pre-admission education to pre-operative patients **14 years of age and older,** and significant others~~, from pediatric patients through geriatric adult patients~~. Each patient's needs are met through individualized and specialized nursing care coordinated through the interdisciplinary team approach for care. The plan emphasizes supportive, therapeutic, and preventive care inclusive of the unique physical and emotional needs of the patient.
   c. Surgery:
      i. The purpose of Surgery/Operating Room is to provide surgical care to patients **fourteen (14) years of age and older** throughout the intraoperative phase of patient care. The endoscopy suite is also included within the surgery department. Nursing care plans are developed, implemented, and evaluated for each individual patient who enters the operating room. **Most**~~All~~ surgical specialties are provided, including cardiac. There are no trauma or transplant services provided. ~~All ages of patients are treated in the operating room, from pediatric through geriatric adults.~~
   d. ~~Special Procedure Recovery Area (SPRA)~~**Outpatient Post-Anesthesia Care Unit**:
      i. The purpose of this area is to provide nursing care to patients ~~receiving outpatient infusions and/or~~ requiring recovery from outpatient interventional procedure**s or stage two recovery (when needed)**~~s~~. Nursing care is provided to deliver a safe, effective and appropriate level of patient care.
   e. Preoperative Education (Outpatient Service Center):
      i. **The purpose of this area is to provide preoperative education to and assessment of patients prior to the day of the surgical procedure.**

Patients may either have face to face visits, or a telephone call for assessment and education.

10. Telemetry **(2 East, 2 West, 4 East, 4 West and 3 Pavilion)**:
    a. The purpose of Telemetry is to develop, implement, and evaluate the Plan of Nursing Care for all clients. Telemetry accepts patients 14 years of age and older who require cardiac monitoring, arterial line monitoring, chronic mechanical ventilation, mechanical ventilator weaning, or patients requiring intensity of service which cannot be provided in the acute care setting.
11. Women~~'s~~ and **Newborn**~~Infant~~ Services:
    a. The Women~~'s~~ and **Newborn**~~Children's~~ Services department develops, implements, and evaluates a plan of care for the mother and family experiencing the birth of a child or pregnant women experiencing medical/surgical/obstetrical complications. This plan incorporates mutual interdisciplinary interactions while maintaining patient advocacy. This plan of care includes the patient, family, significant others and the nurse in response to psychological and physical needs.
12. **Wound Care (Inpatient and Outpatient):**
    a. **The Wound Care Team provides advanced therapy and treatment for patients with non-healing wounds or who are at risk for limb loss. A plan is developed after thorough assessment of factors that may impede healing including vascular insufficiency, infection, biomechanical forces, and physical and psychological needs. Interventions such as prevention/protection, debridement, grafts, or hyperbaric oxygen are implemented and reassessment/updating of the plan occurs at least weekly and as needed. Wound volume is tracked to assure ~~that~~ anticipated healing trajectories are met. The patient, family and significant others, as well as a multidisciplinary Wound Team, are involved in the plan of care.**

~~E.~~**B.** Areas where Nursing Care is delivered, not under the Division of Nursing:

1. Nursing care departments not specifically reporting to the chief nurse executive are overseen by the chief nurse executive via a dotted line relationship, ongoing meetings, regular communication opportunities, review and oversight of nursing practice issues, and approval of policies and procedures.
2. Cardiac Catheterization Lab:
    a. The purpose of the Cardiac Catheterization Laboratory is to diagnose the exact nature, extent and severity of a patient's heart disease to determine the correct therapeutic approach. Patient's needs are met through individualized and specialized nursing care coordinated through the interdisciplinary team approach for care.
3. Cardiac Rehabilitation:
    ~~c.~~**a. The purpose of the Cardiac Rehabilitation department is to evaluate, monitor, and educate patients on the importance of risk factor modification and lifestyle changes necessary to improve quality of life and overall cardiovascular health and to avoid any further complications or events pertaining to heart health. Patient treatment plans are developed by a multidisciplinary staff based on individual patient needs, medical history, and goals. The main foci are the ECG monitored exercise training session, medication understanding and compliance, diabetes management, and weight management.**
4. Cardio~~ac~~vascular **Health** Institute:
    a. The Cardiovascular Health Institute focus is disease prevention, education, and treatment through a multidisciplinary approach of Cardiology, Interventional Radiology, Cardiac and Vascular Surgery and through cardiovascular screenings. Patient's needs are met through a Nursing Clinical Care Coordinator who coordinates and manages patient-focused

care, communicates openly with the patient's physicians, and simplifies and streamlines the experience.

5. Neurovascular Institute:

a. The Neuroscience Institute is a co-management collaborative between Tri-City Healthcare District and physicians who practice within all domains of neurological and neurosurgical health. The objective is to provide high quality, seamless care for all patients who receive care from the most basic screening to most complex neurosurgical procedures. The multi-disciplinary approach is aimed at achieving the highest quality patient outcome of care that is delivered in the most efficient manner.

6. Orthopaedic Institute:

~~d.~~**a. The Orthopaedic and Spine Institute is a co-management collaborative between Tri-City Healthcare District and physicians who practice within all domains of orthopedic and spine services. The objective is to provide high quality, seamless care for all patients who receive care from the most basic musculoskeletal screening to most complex joint and spinal procedures. The multi-disciplinary approach is aimed at achieving the highest quality patient outcome of care that is delivered in the most efficient manner.**

~~3.~~**7.** Interventional Radiology:

a. Interventional Radiology is a sub-specialty of Diagnostic Radiology that has evolved over the past 25 years to become an integral part of comprehensive nursing care, providing alternatives to surgery for a broad range of health problems. Patient's needs are met through individualized and specialized nursing care coordinated through the interdisciplinary team approach for care.

~~XII.~~XIII. INTEGRATION OF PATIENT CARE AND SUPPORT SERVICES

A. A collaborative multidisciplinary team approach, which takes into account the unique knowledge, judgment and skills of a variety of disciplines in achieving desired patient outcomes, serves as a foundation for integration. Open lines of communication exist between departments providing patient care, patient services and support services within the hospital, and as appropriate with community agencies to ensure efficient, effective and continuous patient care.

B. To facilitate effective interdepartmental relationships, problem-solving and shared decision making is encouraged at the point of service within the organization. Staff is encouraged to address one another's issues and concerns and seek mutually acceptable solutions. Supervisors and managers have the authority to solve problems and seek solutions within their span of control. Positive interdepartmental communications are strongly expected as part of our service standards.

C. When problems/issues identified involve two or more areas providing patient care, patient services or support services, supervisors or managers may elect to establish an interdepartmental work group of the personnel from the areas involved for the purpose of identifying mutually acceptable solutions. Other options would include nursing professional practice or operations. Leaders have several options for solutions to interdepartmental issues. Some of these options include: establishing interdepartmental work groups/committees (ad hoc or permanent); referring to the Performance Improvement Committee for consideration in forming a Rapid Improvement Event; and addressing issues in staff meetings.

~~XIII.~~XIV. REPORTING RELATIONSHIPS

A. The clinical practice departments are organized and grouped according to services offered and are under the management of a Director/Manager. Each Director/Manager is accountable to the Chief Nurse Executive (CNE) for patient care and services provided in their areas.

1. Staff meetings shall be conducted by the Director/Clinical Manager or designee with a mechanism established for all staff members' participation.

2. The Manager/ANM shall meet with their assigned Director/CNE at least monthly.

~~1.~~3. **Directors/Managers shall ensure staff communication meetings are held at least monthly.**

4. **Directors/ /Managers may attend the Medical Staff Division Meetings when appropriate.**

B. The Chief Nurse Executive (CNE):

1. **Assures that the clinical departments are organized consistently with the variety and complexity of patient care service and the scope of clinical activities.**
2. **Is responsible and accountable for the daily operations of the PCS units and is a member of the Senior Leadership Team and participates in Board meetings as a C-Suite member.~~Executive Council~~.**
3. Reports the status of the plan for Nursing Services to the **Clinical ~~Patient Care~~** Quality Committee, and to Board of Directors.
4. Attends **Medical Executive as the representative for the Department of Nursing.**

C. **Patient Care Services Councils communicate with medical staff committees in the following way:**

1. **Quality reports to the Medical Quality/Peer Review Committee and QAPI.~~Medical Executive Committee (MEC)~~**
2. **CNE sits on the ~~reports to~~ Medical Executive Committee (MEC) as a non -voting member.**
3. **Medical Executive Committee reports to the Board of Directors (BOD)**

~~XIV.~~XV. QUALITY

A. Each Nursing area has developed a plan for patient care with metrics for quality and performance improvement. These are measured at least monthly and reported to the through QAPI and the Board annually. Areas of monitoring include but are not limited to:

1. **Comprehensive unit-based safety program** (CUSP) Projects
2. **Catheter-associated urinary tract infection (CAUTI)**
3. **Central line-associated bloodstream infection (CLABSI)**
~~2.~~4. Falls
~~3.~~5. Hand washing
~~4.~~6. **Hospital acquired condition** (HAC)
~~5.~~7. Medication Administration
8. Skin Care

B. **Task forces, teams, committees and councils with staff participation as appropriate, shall be utilized to address issues identified through the Performance Improvement process.**

~~XV.~~XVI. BUDGET

A. The plan for the provision of patient services includes the hospital's budget process and considers the following:

1. Patient requirements and their implications for staffing;
2. The hospital's ability to attract and develop staff;
3. Relevant information from performance improvement, risk management, utilization review, and other evaluation activities pertaining to unit, area, or departmental staffing;
4. Feedback and specific concerns raised by patients, staff, and physicians.

B. In preparation for each fiscal year, the Department Director and/or Manager develop an operating and capital budget for each respective cost center and it is then submitted to the executive team and Board of Directors for final approval. Actual performance compared to the budget is reviewed regularly during the course of the fiscal year and is distributed to the department Director and/or Manager. A formal annual review of the effectiveness of the budgetary plan is made following the close of each fiscal year. Requests for capital equipment expenditures are initiated within each department/unit and are forwarded to the vice presidents, Chief Executive Officer, Chief Operating Office, Chief Nurse Executive, **Chief Financial Officer,** Chief Human Resources Officer, Chief Compliance Officer; for certain capital items, referral to the Board of Directors for final approval is required.

~~XVI.~~XVII. NURSING LEADERSHIP

A. To maintain a working environment that encourages professional growth through practice, education and research, peer review, resulting in quality nursing care and satisfaction.

B. The Role of Nursing Leadership ~~i~~In Facilitating Excellent Nursing Care

1. We recognize the excellence delivered by our staff. As nurse leaders, we believe our critical role is making this excellence possible.
2. We believe nurses who provide direct patient care provide invaluable direction, information and insight into the delivery of patient care and nursing practice, therefore; every attempt to ensure their attendance at Shared Decision-Making Council meetings is made.
3. Nursing is a profound partnership between nurses and patients. Nurses help patients to achieve their potential for health and to cope with their illness/injury. The professional nurse combines superb technical skill with an expert knowledge base. The professional nurse then needs an outstanding knack for communication-ease to achieve the best patient outcomes.

~~XVII.~~XVIII. NURSING SHARED-DECISION MAKING STRUCTURE

A. The Shared-Decision Making (SDM) structure shall be clearly defined through which the nursing staff will coordinate and integrate the delivery of nursing care. The SDM structure will recognize participation from all nursing staff members and will give evidence of shared decision making within the formal structure of the nursing staff.

B. The Purpose of ~~Shared Decision (~~SDM~~)~~:

1. To provide a structure that supports the point of care and sustains ownership and accountability at the point of service. This structure builds a culture for people to be together, to tell the story. It creates: shared meaning and purpose in work, healthy relationships and meaningful conversations. All staff is encouraged to begin to participate at the level that they are most comfortable with, and then to "spread their wings" as they become more familiar with the concept of SDM, feeling empowered to contribute to decisions and trust that the community of nursing embraces their contributions, it will flourish. Decisions are made through consensus. Proposed decisions are brought to the various nursing committees for discussion, revisions, approval or disapproval. Final decisions are based on research, evidence, regulations and/or best practices.

XIX. SHARED DECISION MAKING COMMITTEES

~~1.~~A. Patient Care Services (PCS) is managed through application of Interdisciplinary Shared Leadership.

~~2.~~1. The councils of the PCS areas operate under Shared Leadership.

a. A staff and management representative of the unit-based committees may participate in the councils

b. Staff members/Assistant Nurse Managers (ANM) shall participate in committees/councils as assigned and shall be provided time for attendance when on duty. (See Professional Nursing Governance Bylaws for detail).

~~a. There are ten (10) committees that will assume responsibility for the management, operation, and integration of the community of nursing.~~

~~**B. Nursing Executive Committee (NEC)**~~

~~**1. Accountability**~~

~~a. To transform the culture of nursing at TCMC. Provides the foundation (anchor) to link the communities of nursing into a group think process.~~

~~b. NEC will provide leadership to all other councils and serve as a clearinghouse for projects (Magnet) and issues, disseminating them to the appropriate Committees. Nursing Leaders will begin the dialogue process and provide communication role modeling throughout the organization.~~

2. Membership
   a. Membership includes Registered Nurse Directors from the Division of Nursing.
3. Responsibilities
   a. Oversee our Professional Practice Model and ensure effectiveness.
   b. Ensure integration of our Synergy, our care delivery model.
   c. Oversee nursing clinical quality outcome performance and ensure improvements in nursing sensitive outcomes.

C. Professional Practice
1. Accountability
   a. To assure the accountability of nursing practice for all issues, materials, activities and behaviors related to clinical practice. In addition, as a clearinghouse for interdisciplinary practices and processes, the committee will evaluate the appropriateness and effectiveness of patient care delivery across the continuum and make recommendations to the appropriate leaders.
2. Membership
   a. Membership includes: staff from each unit/department and an Advanced Practice Nurse representative, Director of Professional Practice, guests from multiple disciplines as requested.
3. Responsibilities
   a. To ensure adherence to the scope of practice of the professional nurse at TCMC
   b. To validate the role and responsibilities of patient care support staff at TCMC
   c. To provide input into job descriptions for clinical staff
   d. To review and recommend generic and unit specific competencies
   e. To review, approve and revise clinical standards of care, through consensus, where nursing care is delivered
   f. To establish an evaluating and peer review format for all nursing staff
   g. To incorporate nursing evidence and research findings into clinical practice
   h. To support and hold peers accountable to the patient care delivery model (SYNERGY) and system
   i. To collaborate with other healthcare disciplines on the development of processes across the continuum of care
   j. To participate in making recommendations for the nursing documentation system
   k. To participate in the implementation process of the career advancement model

D. Quality
1. Accountabilities
   a. To identify solutions to problems, improve practice and increase understanding of professional issues brought forth from staff, physicians, other disciplines or regulatory agencies. To establish a mechanism for non-punitive reporting.
2. Membership
   a. Members include selected staff and leaders from nursing.
3. Responsibilities
   a. To develop, revise and approve the nursing quality improvement plan
   b. To integrate nursing quality improvement with learning
   c. To endorse and monitor unit-based quality improvement plans
   d. To assure that appropriate quality health care is delivered to each person in a unique way.
   e. To allow staff an avenue to seek clarification on standards of performance and practice.
   f. To promote professionalism.
   g. To challenge professional practice standards that is not upheld throughout the Organization.
   h. To ensure that unexpected outcomes for care are evaluated, investigated and appropriate actions taken in accordance with the Code of Ethics.
   i. To evaluate outcomes of work redesign initiative

E. Patient Education Committee
1. Accountability
a. To identify opportunities for improvement in patient education materials (taking into account health literacy,) introduce new methodologies for teaching and learning, and comply with regulations.
2. Membership
a. Staff, educators and operational leaders.
3. Responsibilities
a. To ensure optimal patient education materials
b. To provide the opportunity for patient journaling
c. To assess literacy and educate to the patients level of understanding
d. To create and maintain an environment consistent with nursing management philosophy and our conceptual framework.
e. To collaborate with other departments, especially case management/discharge planning and disciplines to optimize patient and family compliance.

F. Clinical Policies & Procedures Committee
1. Accountability
a. The CPP Committee is charged with providing guidelines for the development, review, revision, and archiving of all policies and procedures, which are, applicable to patient care. All policies and procedures are to be reviewed every 3 years and revised as necessary. Standardized procedures are to be reviewed every 2 years and revised as necessary. Standards of care and professional practice, research, regulations, certifying bodies and best practices will all guide and impact our policy development. When there is disagreement on a policy and we have options to choose, we will do so by consensus. Specific committees and individuals will be consulted as appropriate.
2. Membership
a. Lead by an Advanced Practice Nurse and selected educators, leaders and staff from the Nursing Division, Laboratory and Pharmacy.
3. Responsibilities of Council
a. To monitor and ensure compliance with established standards of care
b. To collaborate with other disciplines to monitor and evaluate compliance with standards of care and make recommendations for continuous quality improvement
c. To monitor and ensure compliance with regulatory standards
d. To learn of compliance or deviance with standards at staff and interdisciplinary meetings
e. To give input, make recommendations, share evidence on work redesign initiatives

G. Wound Care
1. Accountability
a. To provide ongoing education, practice improvement and staff involvement in the identification, staging, care and proper documentation of wounds in the inpatient setting. Also provides a venue to review new products for wound and skin care and is the body that manages the prevalence studies.
2. Membership
a. Wound, Ostomy, Continence nurse (WOCN), Enterostomal Therapist (ET), managers, nurses, techs, Performance Improvement (PI) and educators from the entire patient care areas.
3. Responsibilities
a. Provide educational opportunities for the bedside nurse
b. Discuss practice issues and develop improvements
c. Review new products
d. Provide a support network for the bedside nurse

e. Review and develop policies and procedures
f. Organize and implement the prevalence studies on a quarterly basis
g. Increase awareness

H. Falls
1. Accountability
a. To identify problems, develop solutions, improve practice, and increase awareness in regard to patient falls in the inpatient areas.
2. Membership
a. Members include nursing administration and management, risk management, education, PI and facilities as well as staff nurses
3. Responsibilities
a. Increase awareness
b. Educate staff on an ongoing basis
c. Develop policies and procedures
d. Develop and implement preventative strategies
e. Analyze and monitor data and benchmarking
f. Review new fall prevention products
g. Support staff in fall prevention activities
h. Provide data to other committees
i. Review documentation for completeness and accuracy

I. Code Blue/Emergency Response
1. Accountability
a. 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.
b. 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.
c. 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.
d. The role of the Rapid Response Team is to:
e. Assess
f. Stabilize
g. Assist with communication
h. Educate and support
i. Assist with transfer to a higher level of care if necessary
2. Membership
a. Designated ICU RNs
b. Respiratory Care Practitioners
c. Pharmacy

3. Responsibilities
a. The goal of the team is to provide early and rapid intervention in order to promote better outcomes such as:
b. Reduce cardiac and/or respiratory arrests in the hospital
c. Reduce or more timely transfer to the Intensive Care Unit (ICU) or a higher level of care
d. Reduce patient intubations
e. Reduce number of hospital deaths
f. The ICU 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.

g. The Primary Nurse is a critical member of the team who shall provide report, remain in room to collaborate with the ICU Nurse, and assist in the care of the patient.

h. 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.

J. Research and Evidence-Based Practice (EBP)

1. Accountability

a. To define, implement and maintain educational standards that promote professional growth and ongoing clinical competency. To seek to define nursing care through the participation in clinical research and evidence-based data. The Research and EBP Committee is the oversight body for nursing research.

2. Membership

a. Director of Education, Education Specialists, Clinical Educators, Director of Professional Practice, Clinical Nurse Specialist, Staff Nurse Preceptors.

3. Responsibilities

a. To validate nursing knowledge

b. To generate new knowledge and make recommendations for change

c. To encourage and promote investigative practice

d. To promote nurses' individual accountability for mandatory education and facilitate credentialing/recertification

e. To foster an environment that allows for partnering with nursing support staff

f. To define, implement and maintain educational standards that promote professional growth and ongoing clinical competency. To seek to define nursing care through the participation in clinical research and evidence-based data. The Research and EBP Committee is the oversight body for nursing research.

K. Nursing Informatics Council (NIC)

1. Accountability

a. The Nursing Informatics Council is charged with providing guidelines and oversight for the development of any new nursing informatic solutions that are implemented at TCMC. Changes and/or revisions to current applications as well as the development of new applications are presented and approved by this committee.

2. Membership

a. Director of Education and Clinical Informatics, Clinical Nurse Analysts, IT Analysts, IT Application Manager, Nursing Department End-users, and Pharmacy Analyst.

3. Responsibilities

a. To assess and implement effective informatic solutions at TCMC.

b. To establish an evaluation and approval council for any nursing changes to clinical documentation.

c. To provide a mechanism for nursing end-user system requests to be evaluated and implemented.

d. To gain insight and feedback from nursing stakeholders regarding clinical documentation changes.

e. To provide an avenue to communicate and educate departmental stakeholders on nursing informatics changes.

f. To provide structure to review application implementation progress and quality data in order to revise or improve processes if necessary.

XX. RELATED DOCUMENT(S):

A. Patient Care Services: Chemotherapy Administration Procedure

B. Telemetry: Admission and Discharge Criteria Policy

~~XVIII.~~**XXI.** **REFERENCES:**

~~a. AACN Healthy Work Environment Standards~~

~~b. Hardin S. R. & Kaplow~~

~~A. Nursing Informatics: Scope and Standards of Practice, 2008~~

~~B.~~**A.** **American Nurses Association. (2015)** *Code of Ethics for Nurses* ***with Interpretive Statements*****. Washington, D.C.: American Nurses Publishing.** ~~2015~~0

~~C.~~**B.** **American Nurses Association. (2015)** *Nursing: Scope and Standards of Practice.*~~, 2015~~0

~~D.~~**C.** California Nurse Practice Act (2016)4

~~E.~~**D.** ~~Tim Porter~~ O'Grady, **T. P. (1999)** *Leading the Revolution in Health Care.*~~, 1999 pg~~ 164.

Tri-City Medical Center
Oceanside, California

CLEAN COPY

Plan for Nursing Care

I. **PURPOSE**

A. The hospital-wide plan for the provision of services is designed to assure:
   1. Patient Care Services (PCS) are appropriately integrated throughout the organization;
   2. Adequate resources are available to assess, plan, deliver, manage, and evaluate patient care;
   3. The design of patient care services provided throughout the organization is appropriate to the scope and level of care required by the patients served;
   4. Uniform performance of patient care is provided throughout the organization.

B. The hospital-wide plan for the provision of services is reviewed at least annually or as deemed necessary due to changing patient populations or other internal or external factors such as:
   1. Patient care requirements;
   2. The Hospital's recruitment, retention, and staff development capabilities;
   3. Information from performance improvement, risk management, utilization management, safety reviews and other evaluation activities;
   4. Evaluation of innovations and improvements in patient care;
   5. Affiliations, managed care contracts and reimbursement changes;
   6. Feedback from patients, families, hospital staff, and physicians regarding patient care concerns or issues;
   7. The Hospital's Strategic and Facilities Plan and annual budget;
   8. Regulatory or accreditation changes;
   9. Collective Bargaining Agreement (CBA) revisions.

C. This review is to be performed by the Executive Team, the Medical Executive Committee, and the Board of Directors.

II. **DEFINITION OF NURSING**

A. Nursing is the protection, promotion and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response and advocacy in the care of individuals, families, communities and populations. American Nurses Association, Scope of Practice, 2015 3rd Ed.

III. **NURSING VISION AND DISTRICT VALUES**

A. To become known for nursing care that is the magnetic force which attracts the community to Tri-City Healthcare District (TCHD).

B. The needs of our patients come first.

IV. **GUIDING PRINCIPLES**

A. We never lose sight of our patients' and families' needs and expectations.

B. We strive to make the most efficient use of our resources.

C. We are alert for opportunities to improve.

D. We encourage patients and families to participate in their care and decisions affecting their care.

E. We focus on team relationships and healthy interpersonal skills.

F. We enter into partnerships with patients, families, and other health care professionals eagerly.

Department Review	Clinical Policies and Procedures	Nurse Executive Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
07/16, 06/17	09/16, 07/17	09/16, 07/17	n/a	10/16, 08/17		

G. We base our decisions for care on the nursing practice act, nursing standards and nursing evidence-based research.
H. We acknowledge that maintaining the highest standards of patient care is a never-ending process which involves the patient, family, all health care providers, and the community at large.
I. We view learning as a lifelong process which is essential to our development.
J. We embrace change to promote and advance the delivery of care to our patients.
K. We utilize informatic solutions and technology to support all areas of nursing, including but not limited to, the direct provision of care, establishing effective administrative systems, managing and delivering educational experiences, enhancing lifelong learning and supporting nursing research.

V. PHILOSOPHY OF NURSING/CORE BELIEFS

A. Nurses at TCHD believe that Professional Nursing is both an art and a science; a dynamic practice based upon the nursing process and a combination of knowledge, skills and the provision of care that incorporates professional values, compassion, and commitment to excellence. We believe:
   1. Caring - is the essence of nursing. A caring approach includes: knowledge, adaptable approaches based on the care-recipient's unique needs, patience, honesty, trust, humility, hope and courage.
   2. Diversity - is a core element for caring and leadership. It requires that the individual affirm his or her own unique self while learning to respect and address the needs of others who may have different values.
   3. Accountability - is the hallmark of professional practice. It requires responsibility to set personal standards for accomplishing expected goals, objectives and outcomes; for relationships and working together (collegiality); for supporting colleagues/peers; and for adherence to organizational policy and procedure.
   4. Integrity - is the foundation for clinical practice, leadership, and learning. It encompasses a commitment to people (staff, colleagues, families, community, and adherence to the professional nursing code of ethics and professional nursing standards of practice.
   5. Advocacy - is an inherent element of nursing ethics and nursing practice. As an advocate, the nurse is responsible for safeguarding, promoting, and supporting the patient's values and decisions.
   6. Scholarship – is a life-long practice where the nurse acquires ongoing knowledge for expert practice in professional nursing, transcultural nursing care and leadership. Experienced nurses serve as mentors to others in assisting them to achieve a higher level of evidence-based practice.

VI. SCOPE OF PATIENT CARE

A. Patient care at TCHD encompasses health promotion, disease prevention and treatment activities in the community, home, acute care, inpatient and outpatient arena. This care is provided collaboratively by health care providers with specialized knowledge, judgment and skill. Patient care is planned, coordinated, provided, delegated and supervised by professional health care providers who recognize physical, psychological, and spiritual needs of patients.
   1. All PCS departments have a plan that describes their scope of service.

VII. PRACTICE STANDARDS

A. American Nurses Association Code of Ethics for Nurses 2015 2nd Ed.– Ethics is an integral part of the foundation of nursing practice. The Code of Ethics for Nurses provides a framework for nurses at TCHD to use in ethical analysis and decision-making. The nine provisions of the Code of Ethics describe the most fundamental values and commitments of the nurse, boundaries of duty and loyalty and duties beyond individual patient encounters. These interpretive statements are not negotiable in any setting:
   1. Respect for Others
   2. Commitment to the Patient

3. Advocacy for the Patient
4. Accountability and Responsibility for Practice
5. Duty to Self and Duty to Others
6. Contribution to Healthcare Environments
7. Advancement of the Nursing profession
8. Promotion of Community and World Health
9. Promotion of the Nursing Profession

B. American Nurses Association Scope & Standards for Nursing Practice – This scope statement and standards of nursing practice guide, define and direct professional nursing practice in all settings and outlines the expectations of the professional role within which all registered nurses must practice.

C. California Nurse Practice Act – The Nurse Practice Act outlines the laws and regulations that define the scope of nursing practice in the state of California. TCHD nurses are responsible to be informed of these laws.

VIII. PATIENT CARE MODEL: SYNERGY (uses trademark)

A. TCHD Nurses use the Synergy Model for patient care to match the needs of our patients to the competencies of the nurse to ensure optimal outcomes.

B. The Synergy model delineates three levels of outcomes: those derived from the patient, those derived from the nurse, and those derived from the healthcare system.

C. Nurse Competencies:
1. Clinical judgment, including decision making, critical thinking and basic nursing skills.
2. Caring practices, responding to the unique needs of patients and families.
3. Advocacy to help identify and resolve concerns as they arise.
4. Collaboration with the entire team of caregivers.
5. Sensitivity and response to diversity to incorporate differences into patient care.
6. Facilitation of learning to ensure patients and families know how to continue care.
7. Clinical inquiry, including questioning and evaluation of practices to provide the best possible care.
8. Systems thinking to take a holistic approach to every care giving situation.

D. Patient Characteristics:
1. Participation in decision making about treatment options.
2. Involvement in care.
3. Level of stability (critical, fair, and stable).
4. Complexity of the illness or injury.
5. Resiliency of the patient.
6. Vulnerability or susceptibility to stressors of all types.
7. Availability of resources, including support systems upon discharge.
8. Predictability of the illness or injury.

IX. PROFESSIONAL STAFF NURSE CORE PERFORMANCE EXPECTATIONS

A. Assessment:
1. The Registered Nurse (RN) collects comprehensive data pertinent to the patient's health or the situation.

B. Diagnosis:
1. The RN analyzes the assessment data to determine the diagnosis of issues.

C. Outcome Identification:
1. The RN identifies expected outcomes for a plan individualized to the patient or the situation.

D. Planning:
1. The RN develops a plan that prescribes strategies and alternatives to attain expected outcomes.

E. Implementation:
1. The RN implements the plan

2. Coordination of Care:
   a. The RN coordinates care
3. Health Teaching& Health Promotion:
   a. The RN employs strategies to promote health and a safe environment
4. Consultation:
   a. The advanced practice registered nurse and the nursing role specialist provide consultation to influence the identified plan, enhance the abilities of others, and effect change.

F. Evaluation:
   1. The RN determines the patient's progress toward the attainment of expected outcomes and the effectiveness of nursing care.

X. PROFESSIONAL RESPONSIBILITIES OF THE REGISTERED NURSE

A. Takes initiative for own learning gaps, seeks experiences and formal and independent learning activities to maintain and develop clinical and professional skills and knowledge.
B. Is aware of own positive and negative biases and limitations.
C. Has self confidence in own expertise.
D. Involves patient/family in the plan of care; informs team members of patient needs, goals, preferences and expected outcomes.
E. Actively participates in report, rounds, staffing, shared decision-making activities develops plan of care; discusses it with patient, family and care team and revises it as necessary.
F. Accesses current nursing journals on research, best practices, technology and innovations.
G. Actively participates in unit retention strategies.
H. Embraces opportunities to preceptor, mentor colleagues, and students, sharing learning to further the practice of nursing.
I. Embraces change as a mechanism to promote patient care and the nursing profession.

XI. STAFFING PLANS

A. Staffing plans and scheduling for patient care service departments are developed based on the mandated RN to patient ratio and intensity of care that needs to be provided, the frequency of the care to be provided, and a determination of the level of staff that can most appropriately (competently and confidently) provide the type of care needed.
B. Each department has a formalized staffing grid which is reviewed at annually based on the following: Hours Per Patient Day/Hours Unit Of Service, utilization review, employee turnover, performance assessment and improvement activities, changes in customer needs/expectations, "Best Practice" information from other sources, new services planned, patient volume and population changes, and risk management. Staffing grids are decentralized in the Staffing Office and are kept in unit/departmental documents.
C. The Hospital and CNA bargaining unit will meet annually to validate the acuity assignment process.

XII. DELIVERY OF NURSING CARE

A. Areas where nursing care is delivered under the Division of Nursing (including but not limited to):
   1. Acute Care Services (1 North, Inpatient Acute Rehabilitation (ARU), 2 Pavilion, 4 Pavilion):
      a. Acute Care Services develop, implement, and evaluate a plan of nursing care for adult (14 years and older) acute care patients who are acutely ill or injured and are in varying stages of recuperation from diagnostic, therapeutic, or surgical intervention.
         i. 1 North: Orthopedic diagnoses are emphasized.
         ii. Inpatient Acute Rehabilitation (ARU): The ARU provides restorative and maintenance programs for the adult patient (ages 14 years and older) suffering from cerebral vascular disease and other diseases or conditions

requiring neurological or functional rehabilitation services. This plan incorporates mutual interdisciplinary interactions while maintaining patient advocacy. This plan of care includes the patient, family/significant others, the nurse, social worker, admissions liaison and utilization review coordinator, physical therapist, occupational therapist, speech therapist, therapeutic recreational specialist, discharge coordinator and the Medical Director of the Acute Rehabilitation Unit.

iii. 2 Pavilion: Oncological diagnoses are emphasized; along with general medical surgical diagnosis.

iv. 4 Pavilion: Medical monitoring unit available for rate monitoring only. Neurology patients, specifically with stroke and seizure diagnosis; dialysis.

2. Behavioral Health Services/Crisis Stabilization Unit:
   a. The Behavioral Health Unit/Crisis Stabilization Unit develops, implements, and evaluates a plan of psychiatric nursing care to adults 18 years and older who are significantly impaired as a result of psychiatric disorders. This plan incorporates active interdisciplinary treatment teams consisting of psychiatric nurses and physicians, social services personnel, psychologists, mental health workers, and recreational therapists. The plan of care utilizes a variety of pharmacologic, behavioral, and psychotherapeutic interventions (groups and individual therapy) to restore optimal patient
3. Emergency Services:
   a. The Emergency Department provides comprehensive services and develops, implements, and evaluates a nursing plan of care for all patients presenting to the department, and provides medical direction to paramedics via the Base Station radio. The plan of care incorporates mutual interdisciplinary interactions while maintaining patient's advocacy and includes the patient, family, significant others and the nurse in response to the psychological and physical needs.
4. Home Health:
   a. The Home Health Department develops, implements, evaluates and executes a comprehensive care plan for patients 18 years and older who meet the criteria. Home Health provides services for Medicare, Medi-Cal and contracted insurance companies. Home Health is Medicare certified and follows the guidelines of homebound status for Medicare. The plan of care is multidisciplinary which includes RN, Licensed Vocational Nurse (LVN), Certified Home Health Aid (CHHA), Registered Diatition (RD), Physical and Occupational Therapy, Social Services, patient, family and caregivers as an integral part of achieving restorative status. The Home Health team promotes patient advocacy interacting with physicians and community resources for positive physical, emotional and spiritual outcomes.
5. Infusion Center- Outpatient Hospital:
   a. The purpose of this area is to meet the needs of patients who require blood transfusions, antibiotic therapy, arthritic infusions, and IV infusions for dehydration. Offsite Outpatient infusion is for Chemotherapy.
6. Intensive Care Unit:
   a. The Intensive Care Unit develops, implements, and evaluates a plan of nursing care for patients 14 years of age and older or weighing at least 35 kilograms with actual or potential life threatening medical or surgical conditions.
7. Neonatal Intensive Care Unit (NICU):
   a. The purpose of this unit is to develop, implement, and evaluate a plan of care for infants born prematurely and/or infants who are critically ill. Patient needs are met through individualized and specialized care coordinated through the interdisciplinary team approach. This plan emphasizes supportive,

developmental and therapeutic care unique to the needs of each infant and includes the family and/or designated family/infant support members.

8. Progressive Care Unit/Specialty Clinic:
   a. This is a 41 bed secured unit that provides various services to patients age 18 and above demonstrating aberrant behavior requiring 24 hour supervision concurrently with their medical condition. Justice involved individuals may be placed on this unit. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available bed.
      i. Continuous Cardiac Monitoring (See Telemetry: Admission and Discharge Criteria Policy)
      ii. Chemotherapy Administration (See Patient Care Services: Chemotherapy Administration Procedure)
      iii. Acute rehabilitation
      iv. Ante-partum care
      v. Post-partum care
      vi. Medical-Surgical
9. Perioperative/Perianesthesia Services:
   a. Post-Anesthesia Care Unit (PACU):
      i. Provides nursing care to patients in the post-operative/post anesthetic phase of the Perioperative period. Nursing care plans are developed, implemented and evaluated on individual patient needs. Nursing care is provided to deliver a safe, effective and appropriate level of care to patients 14 years of age and older.
   b. Pre-Operative Hold:
      i. The purpose of this unit is to assess, implement and evaluate a plan of pre-admission education to pre-operative patients 14 years of age and older, and significant others. Each patient's needs are met through individualized and specialized nursing care coordinated through the interdisciplinary team approach for care. The plan emphasizes supportive, therapeutic, and preventive care inclusive of the unique physical and emotional needs of the patient.
   c. Surgery:
      i. The purpose of Surgery/Operating Room is to provide surgical care to patients fourteen (14) years of age and older throughout the intraoperative phase of patient care. The endoscopy suite is also included within the surgery department. Nursing care plans are developed, implemented, and evaluated for each individual patient who enters the operating room. Most surgical specialties are provided, including cardiac. There are no trauma or transplant services provided.
   d. Outpatient Post-Anesthesia Care Unit:
      i. The purpose of this area is to provide nursing care to patients requiring recovery from outpatient interventional procedures or stage two recovery (when needed). Nursing care is provided to deliver a safe, effective and appropriate level of patient care.
   e. Preoperative Education (Outpatient Service Center):
      i. The purpose of this area is to provide preoperative education to and assessment of patients prior to the day of the surgical procedure. Patients may either have face to face visits, or a telephone call for assessment and education.
10. Telemetry (2 East, 2 West, 4 East, 4 West and 3 Pavilion):
   a. The purpose of Telemetry is to develop, implement, and evaluate the Plan of Nursing Care for all clients. Telemetry accepts patients 14 years of age and older who require cardiac monitoring, arterial line monitoring, chronic mechanical

ventilation, mechanical ventilator weaning, or patients requiring intensity of service which cannot be provided in the acute care setting.

11. Women and Newborn Services:
    a. The Women and Newborn Services department develops, implements, and evaluates a plan of care for the mother and family experiencing the birth of a child or pregnant women experiencing medical/surgical/obstetrical complications. This plan incorporates mutual interdisciplinary interactions while maintaining patient advocacy. This plan of care includes the patient, family, significant others and the nurse in response to psychological and physical needs.
12. Wound Care (Inpatient and Outpatient):
    a. The Wound Care Team provides advanced therapy and treatment for patients with non-healing wounds or who are at risk for limb loss. A plan is developed after thorough assessment of factors that may impede healing including vascular insufficiency, infection, biomechanical forces, and physical and psychological needs. Interventions such as prevention/protection, debridement, grafts, or hyperbaric oxygen are implemented and reassessment/updating of the plan occurs at least weekly and as needed. Wound volume is tracked to assure anticipated healing trajectories are met. The patient, family and significant others, as well as a multidisciplinary Wound Team, are involved in the plan of care.

B. Areas where Nursing Care is delivered, not under the Division of Nursing:
1. Nursing care departments not specifically reporting to the chief nurse executive are overseen by the chief nurse executive via a dotted line relationship, ongoing meetings, regular communication opportunities, review and oversight of nursing practice issues, and approval of policies and procedures.
2. Cardiac Catheterization Lab:
    a. The purpose of the Cardiac Catheterization Laboratory is to diagnose the exact nature, extent and severity of a patient's heart disease to determine the correct therapeutic approach. Patient's needs are met through individualized and specialized nursing care coordinated through the interdisciplinary team approach for care.
3. Cardiac Rehabilitation:
    a. The purpose of the Cardiac Rehabilitation department is to evaluate, monitor, and educate patients on the importance of risk factor modification and lifestyle changes necessary to improve quality of life and overall cardiovascular health and to avoid any further complications or events pertaining to heart health. Patient treatment plans are developed by a multidisciplinary staff based on individual patient needs, medical history, and goals. The main foci are the ECG monitored exercise training session, medication understanding and compliance, diabetes management, and weight management.
4. Cardiovascular Health Institute:
    a. The Cardiovascular Health Institute focus is disease prevention, education, and treatment through a multidisciplinary approach of Cardiology, Interventional Radiology, Cardiac and Vascular Surgery and through cardiovascular screenings. Patient's needs are met through a Nursing Clinical Care Coordinator who coordinates and manages patient-focused care, communicates openly with the patient's physicians, and simplifies and streamlines the experience.
5. Neurovascular Institute:
    a. The Neuroscience Institute is a co-management collaborative between Tri-City Healthcare District and physicians who practice within all domains of neurological and neurosurgical health. The objective is to provide high quality, seamless care for all patients who receive care from the most basic screening to most complex neurosurgical procedures. The multi-disciplinary approach is aimed at achieving the highest quality patient outcome of care that is delivered in the most efficient manner.

6. Orthopaedic Institute:
   a. The Orthopaedic and Spine Institute is a co-management collaborative between Tri-City Healthcare District and physicians who practice within all domains of orthopedic and spine services. The objective is to provide high quality, seamless care for all patients who receive care from the most basic musculoskeletal screening to most complex joint and spinal procedures. The multi-disciplinary approach is aimed at achieving the highest quality patient outcome of care that is delivered in the most efficient manner.
7. Interventional Radiology:
   a. Interventional Radiology is a sub-specialty of Diagnostic Radiology that has evolved over the past 25 years to become an integral part of comprehensive nursing care, providing alternatives to surgery for a broad range of health problems. Patient's needs are met through individualized and specialized nursing care coordinated through the interdisciplinary team approach for care.

XIII. INTEGRATION OF PATIENT CARE AND SUPPORT SERVICES

A. A collaborative multidisciplinary team approach, which takes into account the unique knowledge, judgment and skills of a variety of disciplines in achieving desired patient outcomes, serves as a foundation for integration. Open lines of communication exist between departments providing patient care, patient services and support services within the hospital, and as appropriate with community agencies to ensure efficient, effective and continuous patient care.

B. To facilitate effective interdepartmental relationships, problem-solving and shared decision making is encouraged at the point of service within the organization. Staff is encouraged to address one another's issues and concerns and seek mutually acceptable solutions. Supervisors and managers have the authority to solve problems and seek solutions within their span of control. Positive interdepartmental communications are strongly expected as part of our service standards.

C. When problems/issues identified involve two or more areas providing patient care, patient services or support services, supervisors or managers may elect to establish an interdepartmental work group of the personnel from the areas involved for the purpose of identifying mutually acceptable solutions. Other options would include nursing professional practice or operations. Leaders have several options for solutions to interdepartmental issues. Some of these options include: establishing interdepartmental work groups/committees (ad hoc or permanent); referring to the Performance Improvement Committee for consideration in forming a Rapid Improvement Event; and addressing issues in staff meetings.

XIV. REPORTING RELATIONSHIPS

A. The clinical practice departments are organized and grouped according to services offered and are under the management of a Director/Manager. Each Director/Manager is accountable to the Chief Nurse Executive (CNE) for patient care and services provided in their areas.
   1. Staff meetings shall be conducted by the Director/Clinical Manager or designee with a mechanism established for all staff members' participation.
   2. The Manager/ANM shall meet with their assigned Director/CNE at least monthly.
   3. Directors/Managers shall ensure staff communication meetings are held at least monthly.
   4. Directors/ /Managers may attend the Medical Staff Division Meetings when appropriate.

B. The Chief Nurse Executive (CNE):
   1. Assures that the clinical departments are organized consistently with the variety and complexity of patient care service and the scope of clinical activities.
   2. Is responsible and accountable for the daily operations of the PCS units and is a member of the Senior Leadership Team and participates in Board meetings as a C-Suite member.
   3. Reports the status of the plan for Nursing Services to the Clinical Quality Committee, and to Board of Directors.

4. Attends Medical Executive as the representative for the Department of Nursing.

C. Patient Care Services Councils communicate with medical staff committees in the following way:
   1. Quality reports to the Medical Quality/Peer Review Committee and QAPI.
   2. CNE sits on the Medical Executive Committee (MEC) as a non -voting member.
   3. Medical Executive Committee reports to the Board of Directors (BOD)

XV. QUALITY

A. Each Nursing area has developed a plan for patient care with metrics for quality and performance improvement. These are measured at least monthly and reported to the through QAPI and the Board annually. Areas of monitoring include but are not limited to:
   1. Comprehensive unit-based safety program (CUSP) Projects
   2. Catheter-associated urinary tract infection (CAUTI)
   3. Central line-associated bloodstream infection (CLABSI)
   4. Falls
   5. Hand washing
   6. Hospital acquired condition (HAC)
   7. Medication Administration
   8. Skin Care

B. Task forces, teams, committees and councils with staff participation as appropriate, shall be utilized to address issues identified through the Performance Improvement process.

XVI. BUDGET

A. The plan for the provision of patient services includes the hospital's budget process and considers the following:
   1. Patient requirements and their implications for staffing;
   2. The hospital's ability to attract and develop staff;
   3. Relevant information from performance improvement, risk management, utilization review, and other evaluation activities pertaining to unit, area, or departmental staffing;
   4. Feedback and specific concerns raised by patients, staff, and physicians.

B. In preparation for each fiscal year, the Department Director and/or Manager develop an operating and capital budget for each respective cost center and it is then submitted to the executive team and Board of Directors for final approval. Actual performance compared to the budget is reviewed regularly during the course of the fiscal year and is distributed to the department Director and/or Manager. A formal annual review of the effectiveness of the budgetary plan is made following the close of each fiscal year. Requests for capital equipment expenditures are initiated within each department/unit and are forwarded to the vice presidents, Chief Executive Officer, Chief Operating Office, Chief Nurse Executive, Chief Financial Officer, Chief Human Resources Officer, Chief Compliance Officer; for certain capital items, referral to the Board of Directors for final approval is required.

XVII. NURSING LEADERSHIP

A. To maintain a working environment that encourages professional growth through practice, education and research, peer review, resulting in quality nursing care and satisfaction.

B. The Role of Nursing Leadership in Facilitating Excellent Nursing Care
   1. We recognize the excellence delivered by our staff. As nurse leaders, we believe our critical role is making this excellence possible.
   2. We believe nurses who provide direct patient care provide invaluable direction, information and insight into the delivery of patient care and nursing practice, therefore; every attempt to ensure their attendance at Shared Decision-Making Council meetings is made.
   3. Nursing is a profound partnership between nurses and patients. Nurses help patients to achieve their potential for health and to cope with their illness/injury. The professional nurse combines superb technical skill with an expert knowledge base. The professional

nurse then needs an outstanding knack for communication-ease to achieve the best patient outcomes.

XVIII. NURSING SHARED-DECISION MAKING STRUCTURE

A. The Shared-Decision Making (SDM) structure shall be clearly defined through which the nursing staff will coordinate and integrate the delivery of nursing care. The SDM structure will recognize participation from all nursing staff members and will give evidence of shared decision making within the formal structure of the nursing staff.

B. The Purpose of SDM:

1. To provide a structure that supports the point of care and sustains ownership and accountability at the point of service. This structure builds a culture for people to be together, to tell the story. It creates: shared meaning and purpose in work, healthy relationships and meaningful conversations. All staff is encouraged to begin to participate at the level that they are most comfortable with, and then to "spread their wings" as they become more familiar with the concept of SDM, feeling empowered to contribute to decisions and trust that the community of nursing embraces their contributions, it will flourish. Decisions are made through consensus. Proposed decisions are brought to the various nursing committees for discussion, revisions, approval or disapproval. Final decisions are based on research, evidence, regulations and/or best practices.

XIX. SHARED DECISION MAKING COMMITTEES

A. Patient Care Services (PCS) is managed through application of Interdisciplinary Shared Leadership.

1. The councils of the PCS areas operate under Shared Leadership.
   a. A staff and management representative of the unit-based committees may participate in the councils
   b. Staff members/Assistant Nurse Managers (ANM) shall participate in committees/councils as assigned and shall be provided time for attendance when on duty. (See Professional Nursing Governance Bylaws for detail).

XX. RELATED DOCUMENT(S):

A. Patient Care Services: Chemotherapy Administration Procedure
B. Telemetry: Admission and Discharge Criteria Policy

XXI. REFERENCES:

A. American Nurses Association. (2015) *Code of Ethics for Nurses with Interpretive Statements.* Washington, D.C.: American Nurses Publishing.
B. American Nurses Association. (2015) *Nursing: Scope and Standards of Practice.*
C. California Nurse Practice Act (2016)
D. O'Grady, T. P. (1999) *Leading the Revolution in Health Care.* 164.

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**RIGID LARYNGOSCOPE REPROCESSING PROCEDURE**
Purpose:	Establish a standard practice for reprocessing of contaminated **reusable** rigid laryngoscope handles and blades after use during intubations.
Supportive Data:	~~Department of Health Services recommendations for reprocessing of semi-critical instruments such as rigid laryngoscopes dated April 30, 2007, AFL 07-09.~~ ~~Infection Control Policy, IC.5 – *Standard and Transmission Based Precautions*~~ ~~Infection Control Policy, IC.8 – *Hand Hygiene*~~
Equipment:	~~1. Intubation Trays~~ ~~2. Rigid Laryngoscope handle & blades~~ ~~3.~~1. Plastic Ziplock bag ~~4.~~2. Personal Protective Equipment (PPE)

A. **DEFINITION(S):**

1. Semi-Critical Medical Instruments: Instruments that contact mucous membranes or non-intact skin, but are not intended to penetrate sterile tissue. Items directly attached to instruments that contact mucous membranes, such as the handles of rigid laryngoscopes, should be considered semi-critical instruments.
2. Intubation Trays: Specially prepared trays with all necessary emergency equipment needed for intubation prepared by the Sterile Processing Department (SPD).
3. Laryngoscope: Any of several types of tubes, equipped with electrical lighting, used in examining or operating upon the interior of the larynx through the mouth.
4. Laryngoscope handles: Handheld battery-powered, fiber-optic light source for use in intubation.
5. Laryngoscope blades: Assorted size laryngoscope blades that attach to the Laryngoscope handles for use during intubation.

B. **PROCEDURE:**

1. Contaminated **reusable** rigid laryngoscope~~s~~ **handles and blades** shall be processed as soon as possible after use.
   a. Prolonged delay between use of the laryngoscope and reprocessing may result in the drying and hardening of debris on the laryngoscope's surfaces.
   b. Designated personnel are responsible to return and exchange trays in SPD.
2. The handle and blade shall be transported in an enclosed zip-lock bag or plastic container to the dedicated decontamination area for reprocessing.
3. The designated transporter delivers the tray to the processing area for decontamination.
4. The tray is checked for contamination and is cleaned using **hospital approved disinfectant**~~Sani-clothes~~.
5. Sterile items on the tray are inspected for package integrity. Items suspected of possible contamination shall be disposed.
6. Remove batteries and bulb from the laryngoscope handle.
7. Clean the blade and handle using an enzymatic cleaner.
   a. Blades and handles must undergo a minimum of high-level disinfection. The reprocessing of the device must take into consideration the manufacturer's recommendation, the type of material (if it is able to withstand the reprocessing method), and the infection risk to the patient.
8. **Place reusable laryngoscope handles and blades in a basket**
~~a.~~9. **Place basket in the washer/disinfector and run at the pre-set cycle for instruments**
~~8.~~10. **For**~~If~~ steam sterilization ~~is used~~, place the **reusable laryngoscope handles and blades** ~~blade and the handle~~ in individual peel packs **and run the cycle following the manufacturer's recommendations.**~~:~~

Department Review	Clinical Policies & Procedures	~~Operations~~ Nurse Executive Council	Pharmacy & Therapeutics Committee	Infection Control Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
12/07, 10/10; 01/15	10/10; 02/15, 11/16	11/10, 01/17	n/a	03/17	11/10, 05/17, 08/17	01/11	01/11

~~9.~~**11.** The bulb and batteries are reinstalled **into the laryngoscope handle** and ~~the blades are~~ tested before placing ~~back~~ **into a peel pack and placed** in the tray.

a. This process is performed using clean technique to avoid recontamination of equipment.

~~10.~~**12. Single-use disposable handles and blades will be disposed of at point-of-use following the manufacturer's recommendations.**

C. **RELATED DOCUMENT(S):**

1. **Infection Control Policy: Hand Hygiene - IC.8**
2. **Infection Control Policy: Standard and Transmission Based Precautions - IC.5**

D. **REFERENCES:**

1. **Association for the Advancement of Medical Instrumentation. ST79**
2. **Department of Health Services Recommendations for Reprocessing of Semi-Critical Instruments Such as Rigid Laryngoscopes. April, 30th 2007. AFL 07-09**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 07/11	**SUBJECT:** Skin Preparation, Surgical/Procedural
REVISION DATE: ~~12/13~~02/17	**POLICY NUMBER:** IV.V

Department Approval:	03/17
Clinical Policies and Procedures Approval:	~~12/13~~03/17
Nurse Executive Committee Approval:	~~12/13~~03/17
Operating Room Committee Approval:	04/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~02/14~~05/17~~08~~/17
Professional Affairs Committee Approval:	03/14
Board of Directors Approval:	03/14

A. **PURPOSE:**
1. To provide guidelines for surgical/procedural site skin antisepsis.

B. **POLICY:**
1. The surgical/procedural site and the surrounding area shall be free of dirt, ~~and~~ debris, **emollients, and cosmetics** before surgical preparation.
2. The surgical/procedural site shall be assessed before skin preparation.
   a. Presence of lesions, rashes, warts or other skin conditions at the surgical/procedural site shall be documented and the surgeon shall be notified.
   b. Jewelry or body piercings should be removed before skin preparation.
3. Hair at the surgical site should be left in place whenever possible. If the presence of hair will interfere with the surgical procedure and removal is necessary, the following precautions shall be taken:
   a. Hair removal shall be performed as close to the time of surgery as possible.
   b. Hair removal at the surgical/procedural site shall be performed according to physician orders.
   c. Hair removal shall be done in a manner that preserves skin integrity.
      i. Electric or battery-powered clippers with a disposable or reusable head that can be disinfected between patients is preferred.
      ii. Razor use is strongly discouraged, but if used wet shaving is preferable to dry shaving.
      ~~ii.~~iii. **A sterile razor may be used by the surgeon to remove hair from the scrotum for scrotal procedures and implant cases involving the scrotum. The surgeon shall be provided a sterile razor and supplies to complete a wet shave.**
4. The surgical/procedural site and surrounding area shall be prepared with a Food & Drug Administration (FDA)-approved antimicrobial agent in accordance with manufacturer's written instructions.
   a. Selection of antimicrobial agents shall be based on patient allergy or sensitivity, incision location, skin condition, and physician preference.
   b. Skin antiseptics shall be used in the full concentration as packaged by the manufacturer; do not dilute skin antiseptics prior to use.
   ~~b.~~**c.** The surgical/procedural site shall be prepared by personnel who are knowledgeable about the patient and have demonstrated competency in skin preparation techniques.

i. Preps shall be performed by a Registered Nurse (RN) or Physician/**Allied Health Professional (AHP)**.

~~ii.~~**I.** Advanced Care Technicians (ACTs), ~~n~~**N**ursing ~~a~~**A**ssistants, ~~a~~**A**nesthesia ~~t~~**T**echnicians or ~~s~~**S**urgical ~~t~~**T**echnicians may prep under the direct supervision of an RN or ~~p~~**P**hysician/**AHP**.

d. Personnel performing surgical skin antisepsis shall wear sterile gloves and use sterile supplies to apply antiseptic agents.

~~c.~~**e.** Anti~~microbial~~**septic** agents shall be applied using aseptic technique and proceeding from the incision site to the periphery.

i. Highly contaminated areas (eg, anus, colostomy) near the surgical site should be isolated with a sterile barrier drape.

~~i.~~**ii.** If a highly contaminated area is part of the procedure, the area with a lower bacterial count is prepped first, followed by the area of higher contamination.

~~ii.~~**iii.** An intestinal or urinary stoma within the surgical field should be cleansed gently and separately from the rest of the prepped area.

~~iii.~~**iv.** When prepping the anus, vagina, or a stoma, sinus, ulcer, or open wound, the sponge should be applied once to the area and then discarded.

~~iv.~~**v.** Vaginal preps for procedures that include the abdomen should be performed in a manner to prevent splashing of antiseptic agent expelled from the vagina onto the prepped abdomen.

I. Vaginal preps, inclusive or exclusive of Foley catheter insertion, are started and finished by the same RN. The vaginal prep sponges are removed from the vagina prior to disposal of prep supplies/~~f~~**F**oley catheter supplies, to prevent unintentional retention of the vaginal prep sponges.

5. Skin preparation shall be done in a manner that preserves skin integrity and prevents injury.
   a. Antimicrobial agents shall not be allowed to pool beneath the patient, tourniquets, **electrocardiography (ECG) electrodes,** positioning equipment, or electrosurgical dispersive pad.

6. Skin antiseptics shall be stored in the original, single-use container.

~~6.~~**7.** Special Considerations for Alcohol Based Prep solutions:
   a. Sufficient time must be allowed for the solution to dry and vapors to dissipate before the surgical drapes are applied and any heat source is used.
      i. ~~H~~Heat sources include: Electrosurgery, cautery, laser, burrs, drills, defibrillators, and light cords.
      ii. Verify in a "time out" before starting the procedure to assure the above condition is met.

~~7.~~**8.** Skin preparation agents shall not be warmed prior to application.

~~8.~~**9.** Patient skin preparation and skin condition shall be documented in the Perioperative/Procedural record.

C. **REFERENCE(S):**

1. ~~AORN Perioperative Standards and Recommended Practices, 2011 Edition.~~**AORN Guidelines for Perioperative Practice, 2016 Edition.**

~~1.~~**2. Patient Care Services: Sterile Technique**

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**UNIVERSAL PROTOCOL**
Purpose:	To outline the requirements and the process of Universal Protocol for surgical and invasive procedures. This procedure is designed to enhance patient safety by ensuring proper identification of the patient and that the correct invasive or surgical procedure is performed on the correct side and at the correct site. Procedures that place the patient at the most risk include those that involve general anesthesia or deep sedation.

A. **DEFINITION(S):**

1. Invasive Procedure: The puncture or the incision of the skin, insertion of an instrument or insertion of foreign material into the body for diagnostic or treatment-related purposes. For purposes of this policy, excluded as invasive procedures are~~:~~ venipuncture, **arterial puncture for lab draw,** nasogastric tube **placement,** ~~and~~ uretheral catheter placement, **and** peripheral IV.
2. Patient Safety: In all cases the goal of the Universal Protocol is patient safety. To that end, the site marking or time out may be deferred if the risk outweighs the benefit to the patient in a life-threatening situation.
3. Pre-Procedural Verification: The process of assuring ~~that~~ all relevant and needed documents (e.g. history and physical, signed procedure consent form, informed consent documented by physician, physicians orders, surgery/procedure schedule, nursing assessment, pre-anesthesia assessment, labeled diagnostic and radiology test results, scans, ~~and/or~~ pathology and biopsy reports, and any required blood products, implants, devices, and/or special equipment for procedure), information and equipment are available prior to the start of the procedure, correctly identified, labeled and matched to the patient's identifiers, and are reviewed and consistent with the patient's expectations and team's understanding of the intended patient, procedure, site and side.
4. Site Marking: For purposes of this procedure, site marking is when the ~~Licensed Independent Practitioner (LIP)~~ **physician/Allied Health Professional (AHP)** who has been granted privileges to perform the procedure and will be directly involved in the procedure places his/her initials at the intended site of the procedure. Marking the site may also be done by use of a special purpose armband when it is not possible/feasible to mark the actual site.
5. Time Out: For purposes of this procedure, the Time Out means that after the induction of anesthesia or administration of any pre-procedure medication (as applicable), ~~and~~ completion of prepping and draping, **and** just prior to the start of the procedure (injection of local anesthesia, insertion of instrument or device, **and/or** incision), the staff involved with the procedure cease all other noise and activities (to the extent possible without compromising patient safety) and conduct the final assessment that the correct patient, site and procedure are identified.

B. **POLICY:**

1. The pre-~~-~~operative/pre-procedure verification process occurs with the patient **is** awake and aware if possible (as applicable):
   a. At the time the surgery/procedure is scheduled
   b. At the time of preadmission testing/assessment~~.~~
   c. At the time of admission
   d. Before the patient leaves the unit/floor
   e. In Pre-Op Hold/pre-procedure area
   f. Prior to transporting the patient to the operating/procedural room
   g. Anytime the responsibility for care of the patient is transferred to another member of the surgical/procedural care team (including anesthesia providers), at the time of and during the surgery/procedure

Department Review	Operating Room Committee	Clinical Policies & Procedures	Nursing Executive Council	Medical Executive Committee	Professional Affairs Committee	Board of Directors
10/08, 01/09, 09/09, 06/10, 07/12, 03/13, 09/14, **02/17**	**10/14, 05/17**	08/12, 07/13, 04/14, 10/14, **06/17**	08/12, 04/14, 10/14, **07/17**	10/12, 06/14, 11/14, **08/17**	11/12,07/14, 01/15	12/12, 07/14, 01/15

2. A Time Out is performed for every surgery and invasive procedure, regardless of laterality, levels, structure, location, or setting within the hospital, including bedside procedures. Any discrepancy discovered during the time out must be resolved before **proceeding with** the invasive procedure/surgery ~~to proceed~~.
3. Any discrepancies identified during the pre-procedure verification process shall require a "hard stop" and a "huddle" to be called at the patient's bedside to resolve the discrepancy.
   a. Discrepancies include any difference between the patient's verbal confirmation of the surgery/procedure to be performed, the H&P, order for consent, surgery/procedural schedule, consent and imaging studies.
   b. Members of the huddle may include, but are not limited to:
      i. ~~LIP~~ **Physician/AHP** performing the procedure
      ii. Anesthesiologist
      iii. Radiologist/Radiology Physician's Assistant
      iv. Circulating Registered Nurse (RN)
      v. Scrub RN or Operating Room (OR) Technician
      vi. RN caring for the patient in the pre-procedural area
      vii. Primary RN
      viii. Patient/patient representative
      ix. OR/Pre-procedural area charge nurse
      x. Imaging technologist
      xi. ~~Or~~ Other healthcare provider (HCP) involved **in** the procedure
   c. The following documents are reviewed in the huddle:
      i. H&P
      ii. Order for consent
      iii. Surgery/procedural schedule (if add on for the same day, no printed schedule is required)
      iv. Consent form
      v. Radiologic studies as ordered
   d. The procedure shall not progress until all discrepancies are resolved.
   e. The discussion resolving the discrepancy and the final result of the decision shall be documented in the medical record by one of the following:
      i. ~~LIP~~ **Physician/AHP** performing the procedure
      ii. RN/Healthcare Provider
      iii. Anesthesiologist (as applicable)

C. **SITE MARKING:**

1. Process:
   a. Prior to leaving Pre-Op Hold or the pre-procedure area, the intended surgical site is marked by the ~~LIP~~ **physician/AHP** performing the procedure. Site marking must be legible, unambiguous, used consistently throughout hospital, and be visible once the patient is prepped and draped.
      i. Outpatient areas without pre-procedure areas will perform site marking in the procedure room.
   b. Site marking is required for all surgeries and invasive procedures except:
      i. Emergency situations where any delay in initiating the surgery or invasive procedure would compromise the safety of the patient or outcome of the procedure.
      ii. Single organ procedures without intended laterality.
      iii. Procedures that are intended to be bilateral and no laterality-based choice is involved.
      iv. There is no pre-determined site of insertion (i.e. cardiac catheterization, Interventional Radiology procedures).
      v. The site is so clearly evident (i.e. open fracture, laceration, cast) that it cannot be confused.

vi. The ~~LIP~~ **physician/AHP** performing the procedure is in continuous attendance of the patient from the point of decision to perform the procedure through the completion of the procedure.
vii. Endoscopic procedures and Bronchoscopies.

c. Site marking takes into consideration laterality, surface (i.e. flexor/extensor), level (spine) or specific lesion/digit to be treated.
d. The mark is made using a marker that is sufficiently permanent to remain visible after skin prep and the mark is to be placed such that it is visible after the patient is prepped and draped.
e. The mark is made using the **physician/AHP**~~LIP~~'s initials.
i. First and last initials are used. If the first and last initials are "N.O." a third initial is used.
ii. The ~~LIP~~ **physician/AHP** may choose to also draw a line at the proposed incision site.
f. In the event of multiple primary procedures by different ~~LIP~~ **physician/AHP**'s, each site must be marked prior to admission to the OR/Procedural area.
g. The site marking should be done with the patient/family awake and involved, to the extent possible.
h. For minimal access procedures intended to treat a lateralized internal organ, the intended side is indicated by a mark at or near the insertion site.
i. Marking for procedures performed at the patient's bedside will occur prior to prepping/draping or starting the procedure.

2. For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative radiographic techniques may be used for marking the exact vertebral level.
3. Dental Procedures: The operative tooth name(s), ~~and~~ number(s) **and**/or letter(s) are indicated on the documentation (OR schedule, **H&P/P**~~P~~**p**lan for ~~S~~**s**urgery, ~~O~~**o**rder for ~~C~~**c**onsent) and the operative tooth/teeth are marked with the surgeon's initials on the dental radiographs or dental diagrams. The radiograph/diagram is posted in the procedure room prior to start of the procedure.
4. Nerve blocks: Anesthesia shall confirm the surgical/procedure site, through a comparison of the patient's verbal response and a review of the medical record and ~~P~~**p**rocedural ~~C~~**c**onsent form, prior to the administration of sedation and/or initiation of a nerve block. The Anesthesiologist may place a pre-surgical nerve block only after the surgical site has been marked by the ~~LIP~~ **physician/AHP**.
5. Special Use Armband:
a. A special use armband is used when the surgical site is required to be marked, but cannot be marked because of one of the following situations:
i. The patient refuses~~.~~
ii. The patient is a neonate~~.~~
iii. The proposed site is technically or anatomically difficult to mark (e.g., perineum)
iv. Movement of the patient to mark could compromise the safety of the patient or outcome of the procedure (e.g. patient with unstable spine fracture)~~.~~
b. The first and last name of the patient, a second patient identifier, and the planned procedure, including site and side, are written on the armband. In the event of laterality, the armband is applied on the side of the intended procedure.
c. The ~~LIP~~ **physician/AHP** must initial the armband.
d. The armband is removed at the conclusion of the procedure or immediately prior to prepping if necessary to perform the surgical/procedural prep on the banded limb.

D. **SCHEDULING:**
1. Scheduling for the procedure must include the following information:

a. Patient name and second patient identifier (DOB, MRN, or FIN). Cases cannot be scheduled unless this information is available (with the exception of an emergency, when a delay procuring information could adversely affect the patient).
b. Entire procedure, exact site, level, digit and side/ laterality. No abbreviations may be used.
c. See department specific scheduling procedures for additional scheduling requirements.

E. **PRE-PROCEDURE VERIFICATION PROCESS:**

1. Upon admission, the patient's identity is verified by the person admitting the patient. An appropriate identification band is affixed to the patient's arm (or leg). See Patient Care Services Policy Identification, Patient.
2. Before the patient leaves the unit/floor the Registered Nurse (RN):
   a. Reviews the medical record to verify the following items are available, accurately matched to the patient and are all in agreement for the procedure/site/side to be performed:
      i. H&P – plan for surgery
      ii. Orders for consent
      iii. Consent form
      iv. Surgery/procedural schedule
      v. Radiologic studies report (as applicable)
   b. Completes the pre-operative/pre-procedure checklist (as applicable).
   c. Ensures site marking is completed if patient is going directly to the operating room.
   d. Any discrepancies identified during the pre-procedure verification process shall require a "hard stop" and a "huddle" to be called at the patient's bedside to resolve the discrepancy.
3. In Pre-Op Hold/pre-procedure area the **pre-procedural** RN/HCP:
   a. Reviews the medical record to verify the following items are available, accurately matched to the patient and are all in agreement for the procedure/site/side to be performed:
      i. H&P – plan for surgery
      ii. Orders for consent
      iii. Consent form
      iv. Surgery/procedural schedule
      v. Radiologic report and images, as ordered~~.~~
   b. Reviews the Pre-Operative Checklist to ensure accuracy and completeness.
   ~~c. Ensures necessary implants or special equipment is available.~~
   ~~d.~~**c.** Ensures site marking is completed.
   ~~e.~~**d.** Any discrepancies identified during the pre-procedure verification process, shall require a "hard stop" and a "huddle" to be called at the patient's bedside to resolve the discrepancy.
4. Prior to transferring the patient to the operating room/procedural area the OR/Procedural RN:
   a. Reviews the medical record to verify the following items are available, accurately matched to the patient and are all in agreement for the procedure/site/side to be performed:
      i. H&P – plan for surgery
      ii. Orders for consent
      iii. Consent form
      iv. Surgery/procedural schedule
      v. Radiologic report and images, as ordered~~.~~ (
   b. Reviews the Pre-Operative Checklist to ensure accuracy and completeness.
   c. Ensures necessary implants or special equipment ~~is~~**are** available.
   d. Ensures site marking is completed.