TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE PROFESSIONAL AFFAIRS COMMITTEE
OF THE BOARD OF DIRECTORS
March 8, 2018, 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 February 2018 Meeting	3-8	2 min.	Committee
5.	New Business			
a.	Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures** 1. Release of Deceased to a Family Member Policy 2. Safe Medical Device Act Tracking and Reporting Policy 3. Safe Surrender 4. Sponge, Sharps and Instrument Counts - Prevention of Retained Surgical Items **Unit Specific** **Administrative** 1. Success Service Recovery Program (SSRP) (Formerly Star Service Plan) **Behavioral Health Services** 1. Approved Abbreviations- Clean Copy Approved Abbreviations- Tracked Changes 2. Assisting MediCal Recipients with Grievances and Appeals 3. Behavioral Health Unit Visiting Policy 4. BHU Multidisciplinary Treatment Plan 5. Clinical Assessment 6. Community Meeting 7. Conducting Searches Patient Room Patient Belongings 8. Confidentiality 9. Cleaning and Changing of BHU/ CSU Bathroom Curtains 10. Daily Environmental Safety Rounds 11. Daily Schedule 12. Direct Admissions to BHU 13. Discharge Planning 14. Dress Code for Patients	9-10 11-12 13-14 15-16 17-21 22-25 26 27-28 29-30 31 32 33-35 36 37-38 39-40 41-42 43-44 45 46-47 48 49		Committee

	15. Elopement Precautions 16. Environmental Safety Standards in BHU 17. Exclusionary Criteria 18. Family Involvement in Treatment 19. Food for the Unit 20. Freedom of Movement 21. General Supervision of patients: Patient Rounds 22. Hose Use During Garden Activity 23. Inpatient Unit Admission Criteria 24. Involuntary Hold Patients 25. Management of Aggressive and Assaultive Behavior **Food and Nutrition** 1. Clinical Nutrition Dietitian Staffing 2. Nutrition Assessment and Care for Adult Geriatric Patients Protocol **NICU** 1. Admission and Discharge Criteria for the NICU- Clean Copy Admission and Discharge Criteria for the NICU- Tracked Changes 2. Ordering of Durable Medical Equipment 3. Patient Assignment in NICU 4. Patient Classification (Acuity) in the NICU **Outpatient Infusion Center** 1. Infection Prevention and Control Activities **Pharmacy** 1. Automated Dispensing Machine 2. Licensure and Professional Standards 3. Medication Preparation 4. Receiving and Tracking Narcotic Pump Refills Prepared by Outside Vendors **Progressive Care Unit** 1. Custody Awareness Safety Guidelines 2. Hunger Strike, CDCR 3. Release of A Deceased- Justice Involved Patient	50-52 53-55 56 57-58 59 60-61 62-63 64 65-69 70 71-72 73 74-79 80-82 83-86 87 88-89 90-93 94-95 96-104 105-106 107-108 109 110-114 115-123 124-125		
6.	Motion to go into Closed Session		2 min.	Committee
7.	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
8.	Reports from the Committee Chairperson of any Action Taken in Closed Session (Government Code, Section 54957.1)		10 min.	Chair
9.	Comments from Members of the Committee		5 min.	Committee
10.	The next meeting of the Professional Affairs Committee of the Board is on April 12, 2018 .		1 min.	Chair
11.	Adjournment		1 min.	Chair

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
February 8, 2018

Members Present: Director Laura Mitchell (Acting Chair), Director Larrty Schallock, Dr. Contardo, Dr. Souza and Dr. Ma

Non-Voting Members Present: Steve Dietlin, CEO, Scott Livingstone, COO , Sharon Schultz, CNE/ Sr. VP , Carlos Cruz, Chief Compliance Officer, Susan Bond, Director of Legal Services Marcia Cavanaugh, Sr. Director for Risk Management and Jami Piearson, Director of Quality and Regulatory.

Others Present: Sharon Davies, Jeremy Raimo, Merebeth Richins, Stephen Chavez-Matzel, Lisa Mattia Debra mendez, Joy Melhado, Oska Lawrence, Jeff Surowiec, Dino Cinquemani, Charlene carty, Colleen Thompson, Thomas Moore, Sherry Miller, Nancy Myers, Priya Joshi, Ann Palimisano, Patricia Guerra and Karren Hertz.

Members Absent: Director Leigh Anne Grass (Chair), Dr. Johnson.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell called the meeting to order at 12:06 PM in Assembly Room 1. Director Mitchell is sitting in as the Committee Chair for this month as Director Grass is out on a conference.		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 Schallock and seconded by Dr. Ma.	Director Mitchell
3. Comments by members of the public on any item of interest to the public before committee's consideration of	Director Mitchell read the paragraph regarding comments from members of the public.		Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
the item.			
4. Ratification of minutes of January 2018.	Director Mitchell called for a motion to approve the minutes from January 11, 2018.	The minutes were ratified after making a couple of corrections from Director Schallock. Director Schallock and Dr. Souza seconded the motion to approve the minutes from January 2018.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures** 1. Code STEMI Policy 2. CONSTAVAC, Reinfusion of Blood 3. Duty to Warn Potential Victims Policy 4. Minors Attempting to Leave Without a Parent / Legal Guardian	 There was a recommendation to change the date on the graph describing the pre-hospital STEMI algorithm. There was no discussion on this policy. This policy is now a hospital-wide policy so the unit specific ones are being deleted from the other departments. The minors that are being referred to in this policy are the unmarried minors.	 **ACTION:** The Patient Care policies and procedures were approved. Dr. Souza moved and Dr. Ma seconded the motion to approve the policies moving forward for Board approval.	 Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
5. Privacy Code Policy	There is no discussion on this policy.		
6. Special Order Durable Medical Equipment and Specialty Beds	There is no discussion on this policy.		
Unit Specific Administrative Policies			
1. Decision Making for Unrepresented Patients	Decision making for unrepresented patients does not apply to urgent matters as the physician will make the decision in urgent cases.	**ACTION:** The Administrative policies were approved. Director Schallock moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Designation of Authority in Temporary and Voluntary Absence of Chief Executive officer	There is no discussion on this policy.		
Behavioral Health Services			
1. Duty to Warn Potential Victims Policy	This is a policy deletion.	**ACTION:** The Behavioral Health policy was approved. Dr. Souza moved and Director Schallock seconded the motion to approve the policy moving forward for Board approval.	Patricia Guerra
Infection Control			
1. Aerosol Transmissible Diseases and Tuberculosis Control Plan	Dr. Contardo mentioned that this policy has numerous pages of very long information. He inquired if there is a "Quick Reference" that the units can have as a summary so they don't have to go throught the whole policy all the time.	**ACTION:** Lisa Mattia mentioned that there is a Quick Reference Summary in the units for easy reference for the staff.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
2. Required Reporting	It was clarified the State reports to the Feds but the hospital does not.	The Infection Control policies were approved. Dr. Souza moved and Director Schallock seconded the motion to approve the policies moving forward for Board approval.	
3. Risk and Assessment and Surveillance Plan	There was no discussion on this policy.		
Medical Staff			
1. Medical Record Documentation Requirements	There was no discussion on this policy.	**ACTION:** The Medical Staff policy was approved. Dr. Souza moved and Dr. Contardo seconded the motion to approve the policy moving forward for Board approval.	Patricia Guerra
Outpatient Behavioral Health			
1. Duty to Warn Potential Victims Policy	There was no discussion on this policy.	**ACTION:** The Outpatient Behavioral Health policy was approved. Directoir Schallock moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Pharmacy			
1. Patient Specific Information	There was no discussion on this policy.	**ACTION:** The Pharmacy policy was approved. Dr. Ma moved and Dr. Souza seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Rehabilitation			
1. Job Site Assessment	Priya made a clarification that the job site assessment is free for staff but there is a charge for community members.	**ACTION:** The Rehabilitation policies were approved. Dr. Contardo moved and Director	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
2. Occupational Therpay Assistant Supervision 3. Therapy Pool Dress Code **Forms** 1. Notice of Privacy Practices **Pre-printed Orders** 1. Physician Orders 2. Remicade (Infliximab) Administration **Formulary Requests** 1. Topical Epinephrine Monograph	Priya stated the the Rehabilitation department tries to hire internal employees for this position. There was no discussion on this policy. There was no discussion on this policy. There was no discussion on the pre-printed orders. This topical is fairly new as it is only used for plastic surgery cases.	Schallock seconded the motion to approve the policies moving forward for Board approval. **ACTION:** The notice of privacy practice was approved to move forward to Board approval as moved by Dr. Contardo and seconded by Director Schallock. **ACTION:** The pre-printed orders were approved to move forward to Board approval as moved by Dr. Souza and seconded by Director Schallock. **ACTION:** The formulary request was approved to move forward to Board approval as moved by Director Schallock and seconded by Dr. Souza.	Patricia Guerra Patricia Guerra Patricia Guerra
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Dr. Contardo moved, Director Schallock seconded and it was unanimously approved to go into closed session at 1:10 PM.	Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
8. Return to Open Session	The Committee return to Open Session at 2:15 PM.		Director Mitchell
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Mitchell
10. Comments from Members of the Committee	No comments.		Director Mitchell
11. Adjournment	Meeting adjourned at 1:35PM.		Director Mitchell

PROFESSIONAL AFFAIRS COMMITTEE
March 8th, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
<u>Patient Care Services</u>		
1. Release of Deceased to a Family Member Policy	3 Year Review	
2. Safe Medical Device Act Tracking and Reporting Policy	3 Year Review, Practice Change	
3. Safe Surrender	3 Year Review, Practice Change	
4. Sponge, Sharps and Instrument Counts - Prevention of Retained Surgical Objects	Practice Change	
<u>Administrative</u>		
1. Success Service Recovery Program (SSRP) 272 (Formerly Star Service Plan)	3 Year Review	
<u>Unit Specific</u>		
Behavioral Health Services		
1. Approved Abbreviations – **Clean Copy** Approved Abbreviations – **Tracked Changes**	3 Year Review, Practice Change	
2. Assisting MediCal Recipients with Grievances and Appeals	3 Year Review, Practice Change	
3. Behavioral Health Unit Visiting Policy	DELETE	
4. BHU Multidisciplinary Treatment Plan	3 Year Review	
5. Clinical Assessment	3 Year Review	
6. Community Meeting	3 Year Review	
7. Conducting Searches Patient Room Patient Belongings	3 Year Review, Practice Change	
8. Confidentiality	3 Year Review	
9. Cleaning and Changing of BHU/ CSU Bathroom Curtains	NEW	
10. Daily Environmental Safety Rounds	3 Year Review, Practice Change	
11. Daily Schedule	3 Year Review, Practice Change	
12. Direct Admissions to the BHU	3 Year Review, Practice Change	
13. Discharge Planning	3 Year Review	
14. Dress Code for Patients	3 Year Review	
15. Elopement Precautions	3 Year Review, Practice Change	
16. Environmental Safety Standards in BHU	3 Year Review, Practice Change	
17. Exclusionary Criteria	DELETE	
18. Family Involvement in Treatment	3 Year Review	
19. Food on the Unit	3 Year Review, Practice Change	

PROFESSIONAL AFFAIRS COMMITTEE
March 8th, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
20. Freedom of Movement	3 Year Review	
21. General Supervision of Patients Patient Rounds	3 Year Review, Practice Change	
22. Hose Use During Garden Activity	NEW	
23. Inpatient Unit Admission Criteria	3 Year Review, Practice Change	
24. Involuntary Hold Patients	DELETE	
25. Management of Aggressive and Assaultive Behavior	3 Year Review, Practice Change	
Food & Nutrition		
1. Clinical Nutrition Dietitian Staffing	3 Year Review	
2. Nutrition Assessment and Care for Adult Geriatric Patients Protocol	3 Year Review, Practice Change	
NICU		
1. Admission and Discharge Criteria for the NICU- Clean Copy Admission and Discharge Criteria for the NICU- Tracked Changes	3 Year Review, Practice Change	
2. Ordering of DME Equipment	DELETE	
3. Patient Assignment NICU	3 Year Review, Practice Change	
4. Patient Classification (Acuity) in the NICU	3 Year Review, Practice Change	
Outpatient Infusion Center		
1. Infection Control and Prevention	DELETE	
Pharmacy		
1. Automated Dispensing Machine	3 Year Review, Practice Change	
2. Licensure and Professional Standards	3 Year Review, Practice Change	
3. Medication Preparation	3 Year Review, Practice Change	
4. Receiving and Tracking Narcotic Pump Refills Prepared by Outside Vendors	3 Year Review	
Progressive Care Unit		
1. Custody Awareness Safety Guidelines	3 Year Review, Practice Change	
2. Hunger Strike, CDCR	NEW	
3. Release of A Deceased -Justice Involved Patient	NEW	

Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE:	07/93	SUBJECT:	RELEASE OF DECEASED TO A FAMILY MEMBER
REVISION DATE:	06/03, 08/07, ~~07~~08/13	POLICY NUMBER:	IV.P.1

Department Review:	11/17
Clinical Policies & Procedures Committee Approval:	~~07/13~~11/17
~~Patient Care Quality Committee Approval:~~	~~07/13~~
Nurse Executive Committee Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	02/18
Professional Affairs Committee Approval:	08/13
Board of Directors Approval:	08/13

A. POLICY:

~~A.~~1. A decedent may be released for transportation by a family member only after the family has provided the following:
   - ~~1.~~a. Death certificate
   - ~~2.~~b. Burial permit
   - ~~3.~~c. Valid transportation

~~B.~~2. Death Certificate: A death certificate must be obtained (blank form from a mortuary or other facility), properly completed by the attending physician, filed with Department of Health by the family member and presented to Tri-City ~~Medical Center~~**Healthcare District (TCHD)**.

~~C.~~3. Burial Permit: The family member must obtain and present to ~~Tri-City Medical Center~~**TCHD** a burial permit from the mortuary or cemetery at the point of destination, stating that said mortuary or cemetery will accept delivery of the decedent by the family member.

~~D.~~4. Valid Transportation: The family member must provide proof to the Department of Health that the decedent was properly embalmed and/or placed in a hermetically sealed coffin. The decedent cannot be transported in an airplane or across state lines without proof of a hermetically sealed coffin.

5. The family member shall sign the **Authority for** ~~"~~Release of Deceased~~"~~ Report in place of mortuary at time of pick-up.

~~1.~~6. **Exclusions: Justice Involved Patients.**

B. FORM(S):

~~2.~~1. **Authority for Release of Deceased Report – Sample**

Authority for Release of Deceased Report – Sample

Test, Fred | **MR#** 00000547 | **FIN#** 6002100724

2 | **SSN** 487-66-5555 | **Room #** 516

Oceanside CA 92056

Next of kin: Test, Fred **Relation:** Pt **Phone Number:** (111) 111-1111

Patient a donor: Yes

Attending Physician: Test, DME Physician

Pronounced Time: 04/04/2016 14:56 **Medical Examiner Notified:** Yes **Waive No.:** 55555

I acknowledge the receipt of personal effects (Acuso recibo de los efectos personales)

Date (Fecha) ______ Signature of next to kin (Firma del Paciente mas cercano) ______ Relationship (Parentesco) ______

I hereby authorize Tri—City Medical Center to release the remains of (Por medio del presente documento, authoriza a Tri—City Medical Center liberar los restos de) Test, Fred

Patient (Pacienta)

To (Al):

Mortuary/Procurement Agency funeral home

(Nombre del Mortuario)

(Codigo de Area o # de Telefono) Phone No 5555555

Date (Fecha) ______ Signature of next to kin (Firma del Paciente mas cercano) ______ Relationship (Parentesco con el Difunto) ______ Phone Number (Codigo de Area o # de Telefono) ______

Physician to sign Death Certificate: Test, DME Physician **Phone:** ( ) –

Mortuary Notified Date & Time: ______ **By** ______

Received from Tri—City Medical Center the remains of patient listed above

Date/Time ______ Signature of Medical Examiner/Lifesharing ______ Release by ______

Returned By: ______ Medical Examiner/Lifesharing Agent ______ Accepted by ______ Date/Time ______

Received from Tri—City Medical Center

Date/Time ______ Mortuary/Procurement Agency ______ Release by ______

Public Administrator Notified ______ Date/Time ______

0

Tri-City Medical Center

Authority for Release of Deceased

00000547
Test, Fred
02/02/1954 / 62 Years/Male
TCMC/Inpatient/6002100724

PLEASE MAKE COPY OF ORIGINAL WITH FAMILY SIGNATURES FOR MORTUARY PICK UP SERVICE

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE:	**~~06~~08/12**	**SUBJECT:**	**Safe Medical Device Act~~:~~ Tracking ~~& Reporting~~**
REVISION DATE:			**~~POLICY NUMBER: XI.M~~**

Department Review:	**11/17**
Clinical Policies & Procedures Committee Approval:	**~~06/12~~12/17**
Nurse Executive Council Approval:	**~~06/12~~01/18**
Pharmacy and Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/12~~02/18**
Professional Affairs Committee Approval:	**08/12**
Board of Directors Approval:	**08/12**

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

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

C. **PROCEDURE:**
1. Examples of devices for tracking, including but not limited to:
    a. Permanently implantable devices:
        i. Abdominal Aortic Aneury~~sum~~sm (AAA) stent grafts
        ii. Automatic implantable cardioverter/defibrillator
        iii. Implantable pacemaker pulse generator
        iv. Cardiovascular permanent implantable pacemaker electrode
        v. Silicone gel-filled breast implants
        vi. Replacement heart valve (mechanical only)
        vii. Automatic implantable cardioverter/defibrillator
        viii. Cultured epidermal autographs
        ix. Implanted cerebellar stimulator
        x. Implanted diaphragmatic/phrenic nerve stimulator
        xi. Implantable infusion pumps
        xii. Temporomandibular Joint (TMJ) prosthesis
        xiii. Glenoid fossa prosthesis
        xiv. Mandibular condyle prosthesis
        xv. Throacic Aortic Aneurysm (TAA) stent graphs
        xvi. Transcatherter Pulmonary Valve (TPV) Prothesis
    b. Life-sustaining or life-supporting devices used outside device user facilities:

i. Breathing frequency monitors
ii. Continuous ventilator
iii. Ventricular bypass (assist) device
iv. **Direct current** (DC) defibrillator and paddles

2. Documentation of Implants (on Implant Record) must include:
   a. Name, address, telephone number and Social Security number of patient
   b. Name/type of implant, size if applicable
   c. Site of implantation
   d. Manufacturer of implant
   e. Catalog number of implant if available
   f. Serial, batch, model, lot number, or other identifier necessary to track device~~.~~
   g. Expiration date if noted on packaging
   h. Date of implantation
   i. Name, address and phone number of the surgeon implanting the device
3. If an implantable device has patient user information included in the packaging, this must be labeled with the patient's name and sent with the patient.
4. If the packaging includes a manufacturer tracking device form this must be completed and mailed back to the company for their records.
5. Documentation of explanted items must include:
   a. The date the device was explanted
   b. Name, mailing address, and telephone number of the explanting physician
   c. The date of the patient's death (if applicable)
   d. The date the device was returned to the manufacturer or distributor, permanently retired from use, or otherwise permanently disposed of.
6. Device Tracking Records:
   a. Device tracking records must be maintained for the useful life of the tracked device.
   b. Records required for the device **are documented in the patient's electronic ~~medical~~health record (EHR).**~~tracking law must be kept in a centralized location.~~

D. REFERENCE(S):

1. **The Safe Medical Device Act 1990 (SMDA), Medical Device Reporting for User Facilities. Retrieved from:** https://www.fda.gov/downloads/MedicalDevices/.../UCM095266.pdf

Tri-City Health Care District
Oceanside, California

Patient Care Services

ISSUE DATE: 02/01	**SUBJECT:** Safe Surrender
REVISION DATE(S): 05/02, 05/03, 04/04, 12/05, 09/06, 11/09, 02/13	~~**POLICY NUMBER: 380**~~
Department Approval:	**11/17**
Clinical Policies & Procedures Committee Approval:	~~**02/14**~~**12/17**
Nursing Executive Committee:	~~**02/14**~~**01/18**
Pharmacy and Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**02/18**
Professional Affairs Committee Approval:	**04/14**
Board of Directors Approval:	**04/14**

A. **PURPOSE:**
1. To provide guidance for Tri-City Healthcare District (TCHD) employees accepting custody of newborns up to 72 hours old who are voluntarily surrendered by a parent or other person with legal custody.
2. To implement the requirements of the **Safely Surrendered Baby Law**~~Newborn Abandonment Law. (Senate Bill 1368)~~

B. **POLICY:**
1. In compliance with Senate Bill 1368, TCHD has designated the Emergency Department (ED) as the safe surrender site within the facility and the employees on duty in the ~~Emergency Department (~~ED~~)~~ to receive abandoned newborns.
2. Any officer, employee or medical staff member on duty at the hospital must accept physical custody of an abandoned newborn up to 72 hours old ~~(H & S Code Section 1255.7)~~.
3. No person or entity that accepts a surrendered newborn will be subject to civil, criminal, or administrative liability for accepting and caring for the child in the good faith belief that action is required or authorized by this law. This includes situations where the child may actually be older than 72 hours, or where the surrendering person did not have lawful physical custody of the infant.
4. Notify ~~Emergency Department~~**ED** registration **to provide confidential ID number**.
   ~~5.~~**a.** The coded, confidential ID number should not be a Medical Record number.

~~6.~~**5.** The consent of the parent or other relative surrendering the newborn is not required for the Medical Screening Exam (MSE).

~~7.~~**6.** Newborns abandoned in accordance with law are eligible for MediCal coverage.

~~8.~~**7.** When a newborn is surrendered, the **registered nurse** (RN) ~~or LVN~~ will:
   a. Follow ED Standard for triage of patients. A MSE and any necessary medical care must be provided. (See **Administrative Policy:** EMTALA: Emergency Medical Screening~~, Administrative Policy #~~ 506)
   b. Access an abandoned newborn packet (Stored in the ED Triage**, Charge Desk, and Radio Room.)** ~~area).~~
      i. Contents of the packet must include a coded, confidential identification (ID) ankle bracelet; a matching coded arm ID bracelet; a coded, confidentially identified family medical history questionnaire (English and Spanish versions); ~~Letter to the Mother,~~**campaign brochure and law fast facts sheet** (English and Spanish) and a stamped envelope addressed to TCHD.
   ~~b.~~**c.** Place the coded ID bracelet on the newborn.
   ~~c.~~**d.** Make a good faith effort to give the matching coded ID arm bracelet to the person

surrendering the newborn. This will facilitate reclaiming the infant later.

~~d.~~**e.** Make a good faith effort to give the person surrendering the newborn a coded, confidential family medical history questionnaire, **campaign brochure, law fast facts sheet**~~Letter to the Mother~~, and a stamped addressed envelope.

~~e.~~**f.** Notify Child Protective Services (CPS) of the surrender as soon as possible and in no event later than 48 hours. CPS must assume temporary custody of the newborn immediately on receipt of notification, and must investigate.

~~f.~~**g.** Notify Social Services Department. Send appropriate paperwork for processing and keeping statistics.

~~9.~~**8.** If a person surrendering a newborn request that TCHD returns the newborn to her/him, the hospital must do so if it still has custody and if the dependency petition has not been filed. Contact Administration or Legal Services prior to returning newborn.

~~10.~~**9.** If a health practitioner at TCHD reasonably suspects that the child has been the victim of abuse or neglect, he/she must notify CPS rather than returning the child. Voluntary surrender of a newborn in accordance with law is not in and of itself a basis for reporting abuse or neglect. The statute does not provide immunity from personal injury or wrongful death, including malpractice claims. Legal counsel should be consulted immediately with questions.

~~11.~~**10.** If a dependency petition has already been filed through ~~Child Protective Services (~~CPS~~)~~, the person surrendering the newborn may reclaim the child within **fourteen (**14**)** days of the surrender. If TCHD still has physical custody of the newborn, a copy of the court order should be obtained, reviewed, and referred to legal counsel before releasing the child.

~~12.~~**11.** Any identifying information that pertains to a parent or individual who surrenders a newborn pursuant to the **Safely Surrendered Baby Law**~~Safe Surrender law,~~ that is obtained as a result of the questionnaire or in any other matter, must not be disclosed by any personnel of a Safe Surrender site that accepts custody of an infant.

~~C. LOCATED IN PATIENT CARE SERVICES FORMS/RELATED DOCUMENTS:~~
~~1. Newborn Family Medical History Questionnaire (English/Spanish)~~
~~2. Letter to the Mother from the Safe Arms Program (English/Spanish)~~

C. EXTERNAL LINK(S):

1. **Safely Surrendered Baby Medical Questionnaire – English: http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC861.pdf**
2. **Safely Surrendered Baby Medical Questionnaire – Spanish http://www.cdss.ca.gov/cdssweb/entres/forms/Spanish/SOC861SP.pdf**
3. **Safely Surrendered Baby Campaign Brochure http://www.cdss.ca.gov/Portals/9/FMUForms/M-P/PUB400.pdf?ver=2017-10-26-110106-193**
4. **Safely Surrendered Baby Law Fast Facts – English http://www.cdss.ca.gov/Portals/9/OCAP/PDFs/Fact%20Sheets/2_ENG_SSBFactSheet.pdf?ver=2017-09-05-161625-780**
5. **afely Surrendered Baby Law Fast Facts – Spanish http://www.cdss.ca.gov/Portals/9/OCAP/PDFs/Fact%20Sheets/Fast%20Facts%20SP.pdf?ver=2017-09-05-161628-437**

D. RELATED DOCUMENT(S):

~~3.~~**1. Administrative Policy: EMTALA: Emergency Medical Screening 506**

~~D.~~**E. REFERENCE(S):**

1. California ~~Healthcare~~ **Hospital** Association **(2017). *California Hospital*~~,~~** *Consent Manual.* **Sacramento, CA: California Hospital Association.** ~~2009~~
2. **Safely Surrendered Baby Law;** Senate Bill No. 1368, Chapter 824
3. ~~California~~ **Cal.** Health ~~&~~**and** Safety Code **(HSC)**~~.~~ §~~Section~~ 1255.7 **(1973).**

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**SPONGE,SHARPS & INSTRUMENT COUNTS, PREVENTION OF RETAINED SURGICAL ITEMS**
Purpose:	To outline nursing responsibilities and accountability regarding sponges sharps, and instrument counts in the surgical/procedural areas.
Supportive Data:	Sponges, sharps, and instrument counts are performed during surgery/invasive procedures to provide for safe patient care and prevent retained surgical items. Counts for sponges/soft goods, sharps, and instruments are performed to account for all items used on the surgical field and to lessen the potential for injury to the patient as a result of a retained surgical item. All items are to be counted except those used for storage or disposal of items.
Equipment:	White Board, White Board Marker, Count Sheet(s), Sponge holders

A. **POLICY:**

1. Sponges, sharps, and miscellaneous item counts are required on all procedures except eyes and cystoscopies.
2. All counts shall be conducted both audibly and visually.
    a. Counted items shall be visualized by both the scrub person and circulator/designee~~, one of whom must be a Registered Nurse (RN)~~.
    b. At time of permanent relief of either the scrub or circulating **Registered Nurse** (RN), direct visualization may not be possible; the team shall account for all items.

~~b.~~**3.** **In surgery/obstetric operating room (OB-OR), one of the counting team members must be an RN.**

~~3.~~**4.** A count may be initiated by any member of the perioperative team.

~~4.~~**5.** Unnecessary activity and distractions should be omitted during the counting process.

~~5.~~**6.** To the extent possible, the initial count shall be completed before the patient is brought into the OR.

~~6.~~**7.** Counts may be omitted in an emergency.
    a. The emergent nature of a procedure or an unexpected change in the condition of the patient may necessitate omission of counts to preserve patient life or limb. In such cases, counts may be waived on order of the surgeon. The surgeon will document the omission of the count and rationale for the practice variation in the medical record.
    b. If counts were omitted due to an emergency, x-ray shall be performed and read prior to the completion of skin closure.
        i. Document events regarding the nature of the emergency.
        ii. Document the name of physician reading the x-ray and the x-ray results.
        iii. Complete an incident report.

~~7.~~**8.** If a patient is transferred to another department for completion of the procedure (i.e., transferred from OR to Interventional Radiology or transferred from Labor and Delivery to OR), an x-ray must be performed and read for retained surgical items prior to the completion of skin closure.

9. Sponge, sharps, and miscellaneous item counts shall be written on the white board. Instrument counts shall be recorded on the instrument count sheet(s).

B. **PROCEDURE:**

1. Surgical counts are classified as:
    a. ~~Baseline~~**Initial** count: count before the procedure begins to establish the baseline and identify manufacturer packaging errors.
    b. ~~New item~~ **Add** count: count new items added to the field after the baseline count is complete.
    c. Relief count: count at the time of permanent relief of the scrub or RN circulator.

Revision Dates	Operating Room Committee	Clinical Policies & Procedures	Nursing Executive Council	Medical Executive Committee	Professional Affairs Committee	Board of Directors
03/03, 04/06, 08/09, 05/12, 01/13, 05/14, 04/15, 09/15, **10/17**	**06/14, 01/16, 12/17**	06/12, 07/13: 05/14, 11/15, 02/16, **01/18**	06/12, 02/13, 05/14, 02/16, **01/18**	07/12, 07/14, 09/16, **02/18**	08/12, 10/14, 10/16	08/12, 11/14, 11/16

        i. The relief count is performed by the incoming scrub and/or circulator who are assuming responsibility for the count as it stands at the time of relief.
    d. Cavity count: count before closure of a cavity (e.g., uterus, bladder, stomach, peritoneum, placement of mesh to close a space).
    e. Closing count: count before wound closure begins.
    f. Final count: count after skin closure or end of procedure, when surgical items are no longer in use and all sponges (used and unused) are passed off the field, separated into sponge holders and confirmed by the surgical team.
2. Count in the following order:
    a. Sponges
    b. Needles
    c. Other sharps and miscellaneous items
    d. Instruments
3. Count items in the following sequence:
    a. Operative field
    b. Mayo stand
    c. Back table
    d. Items off field
4. Items passed off or dropped from the sterile field shall be retrieved by the circulating nurse, isolated from the field, and included in the final count. Countable items must never be subtracted from the count or removed from the operating room.
5. Members of the surgical team shall account for broken or separated instruments/items within the surgical field.
6. Multi-part items shall be counted as one unit (e.g., hypo and cap is counted as one unit), unless otherwise specified on the count sheet/whiteboard. Account for all individual pieces of multi-part items.
7. Items added to the field need to be recorded at the time they are added.
    a. Once the count has begun, recalled memory and/or counting packages cannot be used to reconcile a count.
    b. The number on the whiteboard/count sheets must match the number of items on the field at the time of the count, or the count is considered incorrect.
8. The count is to be recorded on the count board using a horizontal superscript running total format (i.e., $10^{10}20^{10}30^{10}40$). No additional slashes, initials, equal signs, or extraneous marks are to be made.
9. The person adding countable items to the field is responsible for recording the items on the count board.
    a. If items are added by anyone other than the primary RN circulator, the person adding the items shall verbally report the additions to the primary RN circulator.
10. Inform primary surgeon of the count outcomes.
11. Incorrect Counts:
    a. Inform primary surgeon of count discrepancies.
    b. The surgeon should perform a methodical wound examination, and a thorough search of all areas should be completed by the surgical scrub and circulating nurse.
    c. Search the total room including floor, trash and linen:
        i. If item is not found, an X-ray of the patient must be taken prior to patient leaving the operating room.
            1) X-ray is not required if the missing item is not X-ray detectable.
        ii. If item missing is micro or CV needle (C-1 or smaller), X-ray is not needed.
        iii. Complete an incident report.
    d. Ensure sterile field remains sterile until item is found or x-ray is read
    e. Inform Assistant Nurse Manager (ANM)/charge nurse/designee of count discrepancies.
12. X-ray interpretation for incorrect counts, emergencies, and X-ray in lieu instrument counts:
    a. When possible, it is highly recommended that a radiologist read the X-ray before the skin is closed and the results of the reading, along with the name of the person who read the

X-ray, are documented.

b. At a minimum, the surgeon must interpret the film intraoperatively.

13. If an item is used to occlude the colpotomy during a da Vinci hysterectomy (i.e., asepto or glove), it becomes a countable item and must be accounted for at the end of the case.

C. **SPONGES/SOFT GOODS COUNT:**

1. Sponges (laps, baby laps, raytex) are issued in groups of ten.
2. The following counts are required for sponges/soft goods:
   a. ~~Baseline~~ **Initial** count
   b. ~~New item~~**Add** count
   c. Relief count
   d. Cavity count
   e. Closing count
   f. Final count
3. ~~Baseline~~**Initial** sponge counts shall be performed in the quantity as packaged by the manufacturer in order to identify manufacturer packaging errors (i.e., laps are counted in multiples of five and raytex are counted in multiples of ten), total count in multiples of ten.
4. If a package of sponges/soft goods is found to be defective when opened (e.g., wrong number, damaged, contaminated), the package and its contents will be removed immediately from the field, placed in a plastic bag, labeled, and removed from the operating room.
5. Sponges shall be counted in order from largest sponge to smallest sponge (e.g., laps then baby laps, then raytex).
6. All sponges shall be X-ray detectable.
   a. Never use X-ray detectable sponges for wound dressings.
7. Count each sponge and separate from other sponges during the count.
8. Remove all packing and wrapping materials and promptly discard in the trash.
9. All sponges must be opened and visualized during closing counts and separated into sponge holders.
   a. At the end of skin closure, ALL sponges are passed off the field, separated, opened to full length, and placed in sponge holders.
   b. Use a separate sponge holder for each sponge type (i.e., one for laps, one for raytex).
   c. Only one sponge should be placed in each pocket of the sponge holder.
   d. Load the sponge holder horizontally from the bottom row to the top row, filling first the bottom two pockets and continuing upwards. This process will make visual determination of the filled holder easier to see from the OR table so empty pockets will be clearly visible to all in the room.
   e. Place the sponge inside the pocket with the blue tag or blue stripe visible.
   f. Place one sponge per pocket, two sponges per row, and 10 sponges per sponge holder.
   g. When a holder has 10 sponges, there will be no empty pockets.
   h. The final sponge count CANNOT be considered completed until ALL sponges opened during the case are bagged and visualized by the surgical team.
   i. The sponge holders are not disposed of until the patient leaves the OR.
10. Towels used in an open wound shall be x-ray detectable and shall be included in the count as miscellaneous items.
    a. Scrub person shall notify the circulating RN when a towel is placed in a wound/cavity and when it has been removed.

D. **SHARPS AND MISCELLANEOUS ITEMS COUNTS:**

1. The following counts are required for sharps and miscellaneous items:
   a. ~~Baseline~~**Initial** count
   b. ~~New item~~**Add** count
   c. Relief count
   d. Cavity count
   e. Closing count

f. Final count
2. Packaged needles containing an incorrect number shall be removed from the room.
3. All used needles are to be placed in a puncture-proof needle counter box.
   a. Place one needle in each numbered slot; do not double-up needles in a numbered slot.
   b. Obtain an additional needle counter box if the initial needle counter box is full.
4. Counting number of needle packages may not be used to reconcile an incorrect needle count.

E. **INSTRUMENT COUNTS:**
1. The following counts are required for instruments:
   a. ~~Baseline~~**Initial** count
   ~~a.~~**b. Add count**
   ~~b.~~**c.** Relief count
   ~~c.~~**d.** Closing count
2. The instrument count is driven by the instrument count sheet, used as a checklist. The circulating nurse/designee directs the instrument count by reading off the instrument count sheet and visualizing the counted instruments with the scrub.
   a. All instruments shall remain within the OR during the procedure until all counts are completed and resolved.
      i. Individual pieces of assembled instruments shall be accounted for within the instrument count (e.g., suction tips, wingnuts, blades, sheaths).
3. Instrument counts are required for cases entering the abdominal, thoracic, mediastinal, and retroperitoneal cavities.
   a. Instrument counts are required for any procedure where the incision is large enough for an instrument (including instrumentation, such as screws) to pass through.
   b. Instruments shall be counted at the start of all hernia repairs, laparoscopy, thoracoscopy, and robotic procedures since the possibility of converting to an open procedure or extending the incision exists.
      i. If the procedure does not convert to an open procedure or the incision is not extended to be larger than the smallest instrument used on the case, the closing instrument count may be waived.
   c. Closing instrument counts are required for vaginal hysterectomies and laparoscopic assisted vaginal hysterectomies. For all other vaginal procedures, the surgeon is to perform a methodical wound examination of the vaginal cavity at the conclusion of the procedure to ensure items are not retained in the vagina.
   d. Instrument counts may be omitted in certain cases with numerous and/or complex instruments or instrumentation. An X-ray is taken before the completion of skin closure to confirm instruments are not left in the wound. The following cases shall use an X-ray in lieu of instrument count:
      i. All anterior, posterior, and lateral spine cases.
      ii. Cervical spine cases.
      iii. Total joint replacements (hips, knees and shoulders).
      iv. Any orthopedic case using trays of screws, wires, or other complex instrumentation.
      v. Any case using loaner trays or large numbers of instruments which is prohibitive of completing an accurate instrument count.
      vi. If fluoroscopy is being used on the case, a fluoroscopic image may substitute for an X-ray if a permanent copy of the image can be recorded and retained.
      vii. When possible, it is highly recommended that a radiologist read the X-ray before the patient leaves the OR and the results of the reading, along with the name of the person who read the X-ray, are documented. At a minimum, the surgeon must interpret the film intraoperatively.
   e. Reverse total shoulder replacements: the surgeon shall announce when the humeral protector is placed into the wound and when it is removed and the RN circulator shall record it on the whiteboard.

F. **DOCUMENTATION:**

1. Document verification of all counts in the OR record.
   - a. Types of counts (sponges, sharps, and instruments).
   - ~~b. Cavity count must be written as a count.~~
   - ~~c.~~**b.** **Initial count, relief count and** ~~T~~the number of ~~d~~**closing** counts.
   - ~~d.~~**c.** Names and titles of persons performing counts.
   - ~~e.~~**d.** Results of counts
     - i. Actions taken if count discrepancies occur.
     - ii. Rationale if counts are not performed or completed.
   - ~~f.~~**e.** Complete an incident report for all incorrect counts or waiver of counts in the event of an emergency.

G. **REFERENCE(S):**

1. AORN Guidelines for Perioperative Practice, 201~~5~~**7** Edition.
2. Verna Gibbs, MD. NoThing Left Behind®: Prevention of Retained Surgical Items Multi-Stakeholder Policy (2015).

Tri-City Health Care District
Oceanside, California

Administrative Policy
District Operations

ISSUE DATE:	**07/02**	**SUBJECT:**	**SUCCESS SERVICE RECOVERY PROGRAM (SSRP)**
REVISION DATE:	**12/02, 04/09, 09/10, 12/10**	**POLICY NUMBER:**	**8610-272**

Department Approval:	**02/18**
Administrative Policies & Procedures Committee Approval:	**~~06/14~~02/18**
Professional Affairs Committee Approval:	**02/15**
Board of Directors Approval:	**02/15**

A. **PURPOSE:**
1. The Purpose of the Success Service Recovery Program (SSRP)~~I~~ is:
    a. To promote guest satisfaction.
    b. To provide a mechanism that empowers staff to implement immediate Service Resolution or Recovery measures.
    c. To be used by employees to proactively intervene on behalf of guests to create a positive perception of Tri-City ~~Medical Center~~**Healthcare District** (TC~~MC~~**HD**).

B. **PHILOSOPHY:**
1. TC~~MC~~**HD** staff is encouraged to practice TC~~MC~~**HD**'s Service Standards.
2. Positive management of expectations should be the first response to each guest's concerns.
3. The SSRP may be utilized at any time if other interventions have been unsuccessful.

C. **DEFINITION(S):**
1. Guest: Inpatient, outpatient, or visitor.
2. Positive Intervention: Actions taken by an employee to promote guest satisfaction; not to be used for employee recognition.
3. Service Resolution: The process used to satisfy an unhappy guest in circumstances where other measures, e.g. initial service resolution steps, have been ineffective. Examples possibly requiring service resolution are: long wait times for procedures, cancelled procedure that inconvenienced the customer, inadequate explanations from staff, or dissatisfaction with TCMC's service from the guest's perspective.
4. LAST Approach: An initial process service for resolution steps. Initial Service Resolution steps include using the method of customer complaint resolution defined below:
    a. 'L' is for listening: Do not argue with a guest. Do not feel it is necessary to defend yourself. Use good eye contact. Consider summarizing to clarify what the customer is concerned about.
    b. 'A' is for apologizing: Remember, an apology does not mean an admission of guilt. It is an expression that you are personally sorry your guest is unhappy with his/her service.
    c. 'S' is for solving: Tell your customer you are going to take care of his/her problem. Ask them "What can I do to make it better for you?" If you are unable to change the outcome consider a gift from the SSRP P as an expression of an apology.
    d. 'T' is for thanking: Thank the guest for taking the time to tell you about his/her experience and giving you the opportunity to make a change.
5. SSRP Voucher: A voucher is a three-part form to be used in the Service Resolution process.
    a. Vouchers can be used at the following locations: Cafeteria, Gift Shop, and Coffee Cart.
    b. Vouchers can also be used by Administrative Supervisors, Managers, and Assistant Nurse Managers and above for purchased items in the form of flowers or plants.

c. Vouchers will be maintained in each department and restocked by unit secretaries, with oversight provided by the Quality Performance Improvement/Risk Management (QPI/RM) Department.

6. Petty Cash: Monies available to reimburse for personal expenses used in Service Resolution and not to exceed a maximum of $50 ~~(Administrative Policy # 208)~~.

D. **POLICY:**

1. TC~~MC~~**HD** encourages all of its employees to identify opportunities to demonstrate Service Excellence "above and beyond the call of duty."
2. Employees are empowered to proactively intervene and create positive perceptions of TC~~MC~~**HD**, its services, and its employees.
3. Resources such as vouchers and managerial support will always be available to respond to guest issues and concerns.
4. TC~~MC~~**HD** encourages guests to express issues/concerns so they may be addressed promptly to prevent future dissatisfaction.
5. Guest dissatisfaction issues are dealt with at the point of contact and are referred to management staff only when unresolved or when deemed necessary.
6. Any employee who encounters a guest complaint uses the LAST approach as the first line of intervention.
7. If this approach is unsuccessful, and the complaint is not resolved, an employee may resolve the complaint independently using vouchers from the SSRP Service.
8. All Employee interventions requiring use of a voucher are to be recorded on said voucher and brought to the attention of acting management at the time of service intervention/resolution. (This will be done to track trends and provide a means of resolving recurrent problems.)
9. Presentation of a complaint will not compromise a guest's access to care.
10. Each Unit/Department's ~~"~~SSRP vouchers are to be kept in the SSRP Logbook. Vouchers are to be readily available to all employees. The QPI/RM department will maintain a backup supply of vouchers.
11. The employee selects the most appropriate intervention based on the nature of the circumstance.
12. To use the SSRP Service Plan:
    a. Employee provides selection from coffee cart, cafeteria, or gift shop.
        i. Voucher completed and White copy of voucher given to guest.
        ii. Guest or employee takes Voucher to provider of service.
        iii. Yellow copy placed in SSRP Logbook
        iv. Pink copy forwarded to SSRP Excellence Coordinator
    b. Employee purchases and presents gift less than $50 to guest.
        i. Voucher completed.
        ii. Employee submits White copy of voucher and petty cash form to Business Office ~~(Administrative Policy # 208)~~.
        iii. Yellow copy placed in SSRP Logbook
        iv. Pink copy forwarded to QPI/RM
    c. Employee purchases and presents $50 - $150 gift to guest.
        i. Voucher completed (Manager/Director approval required)
        ii. Employee submits White and Pink copy of voucher and receipt to OISE Department.
        iii. QPI/RM Department submits a Non-Stock Purchase Requisition Form, receipt and White copy of voucher to Materials ~~(~~**per** Administrative Policy: #~~-~~214 **Accounts Payable Check Processing**~~)~~.
13. Yellow Copy of Voucher placed in STAR Service Plan Logbook If a guest complaint is not resolved, the employee will forward the concern to the Department Director, Patient Representative, QPI/RM, and/or Administrative Supervisor ~~(refer to~~**per** ~~Administrative~~ **Patient Care Services** Policy:~~-#~~ ~~318~~**Patient Complaints and Grievances**~~)~~.

14. Administrative Supervisors, Managers, Assistant Nurse Managers, unit secretaries and the QPI/RM Department will maintain a supply of SSRP. White and yellow copies are to be collected and sent to the QPI/RM Department by the 5th of each month.

E. **FORM(S):**

1. Success Service Recovery Program Voucher

F. **RELATED DOCUMENT(S)**

1. Administrative Policy: 214 Accounts Payable Check Processing

~~1.~~**2. Patient Care Services Policy: Patient Complaints and Grievances**

Success Service Recovery Program Voucher

"SUCCESS is in our hands"
Service Recovery Program

Service Voucher

A sincere Thank You for choosing Tri-City Medical Center!

Date/Time______________________________

Name of Recipient (print)______________________________

Gift given______________________________

Amount of Gift ______________________________

Name of employee giving gift (Print) ______________________________

Department ______________________________

____

Reason for Intervention/Service Resolution______________________________

____

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____

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Follow-Up Requested: Yes____ No______

Reason______________________________

____

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Cost Center: 8742

[3 Copies: Original (white copy) to Guest/Provider of Service; Second copy (yellow copy) to "SUCCESS Service Recovery Program" Logbook; Third copy (pink copy) to Service Excellence Coordinator.]

6/9/14

Tri-City Medical Center
Oceanside, California

Clean Copy

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: Approved Abbreviations, BHU and CSU Specific

ISSUE DATE: 03/08 **POLICY NUMBER:** 300
REVISION DATE(S): 08/09, 04/10, 03/13

Department Approval: 09/17
Division of Psychiatry Approval: n/a
Pharmacy and Therapeutics Approval: n/a
Medical Executive Committee Approval: n/a
Professional Affairs Committee Approval:
Board of Directors Approval:

A. **PURPOSE:**
1. To define the list abbreviations applicable to the Behavioral Health Unit (BHU) and Crises Stabilization Unit (CSU).

B. **POLICY:**
1. When documenting in the patient medical record clinical staff may use the following program and hospital approved abbreviations.
2. Other abbreviations are not acceptable and are not to be used in medical records.

C. **ABBREVIATIONS:**

BHOS	Behavioral Health Outpatient Services
CA	Cocaine Anonymous
O/H	Olfactory Hallucinations
PHP	Partial Hospitalization Program
PMR	Psychomotor Retardation
Q15	Every 15 minutes
Q30	Every 30 minutes
RI	Resulting In
RCF	Residential Care Facility
S/A	Suicide Attempt
S/I	Suicidal Ideation
S/R	Support and Reassurance
Th	Therapist
TPR	Treatment Plan Review

D. **EXTERNAL LINK(S):**
1. Neil-Davis Medical Abbreviation - MedAbbrev.com

E. **RELATED DOCUMENT(S):**
1. Patient Care Services: Abbreviations, Use of

Tri-City Medical Center
Oceanside, California

Tracked Change Copy

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Approved Abbreviations, BHU and CSU Specific**

ISSUE DATE: **03/08** **POLICY NUMBER:** **300**
REVISION DATE(S): **08/09, 04/10, 03/13**

Department Approval: **09/17**
Division of Psychiatry Approval: **n/a**
Pharmacy and Therapeutics Approval: **n/a**
Medical Executive Committee Approval: **n/a**
Professional Affairs Committee Approval:
Board of Directors Approval:

A. **PURPOSE:**
1. To define the list abbreviations applicable to **the Behavioral Health Unit** (BHU) **and Crises Stabilization Unit (CSU).**

B. **POLICY:**
1. When documenting in the patient medical record clinical staff may use the following program and hospital approved abbreviations.
2. Other abbreviations are not acceptable and are not to be used in medical records.

C. **~~PROCEDURE~~ABBREVIATIONS:**

~~1:1~~	~~One-to-One Supervision of the patient or Individual encounter with the patient~~
~~ADR~~	~~Adverse Drug Reaction~~
~~A/H~~	~~Auditory Hallucinations~~
~~AA~~	~~Alcoholics Anonymous~~
~~ADD~~	~~Attention Deficit Disorder~~
~~ADL~~	~~Activities of Daily Living~~
~~AKA~~	~~Also Known As~~
~~AE~~	~~Adverse Effect~~
~~AEB~~	~~As Evidenced By~~
~~AMB~~	~~As Manifested By~~
~~B & C~~	~~Board and Care~~
~~BHU~~	~~Behavioral Health Unit~~
~~BIB~~	~~Brought In By~~
BHOS	Behavioral Health Outpatient Services
~~Bx~~	~~Behavior~~
~~C~~	~~With~~
~~CD~~	~~Chemical Dependence~~
~~C/O~~	~~Complaining Of~~
CA	Cocaine Anonymous
~~CC~~	~~Clinical Coordinator~~
~~CLC~~	~~Community Liaison Director~~
~~CMHC~~	~~Community Mental Health Center~~

~~CPS~~	~~Chronic Paranoid Schizophrenia~~
~~CQI~~	~~Clinical **Continuous** Quality Improvement~~
~~D/C~~	~~Discharge~~
~~DC~~	~~Discontinue~~
~~DD~~	~~Developmentally disabled~~
~~Dx~~	~~Diagnosis~~
~~G/H~~	~~Gustatory Hallucinations**Grooming and Hygiene**~~
~~H/I~~	~~Homicidal Ideation~~
~~IOP~~	~~Intensive Outpatient Program~~
~~IP~~	~~Inpatient~~
~~ITP~~**ITP**	**Interim Treatment Plan**~~Initial Treatment Plan~~
~~LOS~~	~~Length of Stay~~
~~LTG~~	~~Long Term Goal~~
~~MDD~~	~~Major Depressive Disorder~~
~~Med~~	~~Medication~~
~~MICA~~	~~Mentally Ill Chemical Abuser~~
~~MJ~~	~~Marijuana~~
~~MSE~~	~~Mental Status Exam~~
~~MTP~~	~~Master Treatment Plan~~
~~NA~~	~~Narcotics Anonymous~~
~~OA~~	~~Overeaters Anonymous~~
O/H	Olfactory Hallucinations
PHP	Partial Hospitalization Program
PMR	Psychomotor Retardation
~~PRN~~	~~As needed~~
Q15	Every 15 minutes
Q30	Every 30 minutes
RI	Resulting In
~~R/O~~	~~Rule Out or Reality Orientation~~
RCF	Residential Care Facility
~~Rx~~	~~Prescription~~
~~S~~	~~Without~~
~~SAD~~	~~Schizoaffective Disorder~~
S/A	Suicide Attempt
~~Sib~~	~~Siblings~~
S/I	Suicidal Ideation
~~SCUT~~	~~Schizophrenia, Chronic Undifferentiated Type~~
~~SNF~~	~~Skilled Nursing Facility~~
S/R	Support and Reassurance
~~Sx~~	~~Symptoms~~
Th	Therapist
TPR	Treatment Plan Review
~~Tx~~	~~Treatment~~
~~V/H~~	~~Visual Hallucinations~~

D. EXTERNAL LINK(S):

1. **Neil-Davis Medical Abbreviation - MedAbbrev.com**

E. RELATED DOCUMENT(S):

~~D.~~1. **Patient Care Services: Use of Abbreviations**

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Assisting Medi-Cal Recipients with Grievance and Appeals Processes**

ISSUE DATE: **03/08** **POLICY NUMBER:** **510**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **DEFINITION(S):**
~~A.~~**1.** ~~MHP:~~ **Mental Health Plan (MHP): Mental Health services are available to people on Medi-Cal in San Diego. Sometimes they are provided by a specialist and called "specialty" mental health services. These are provided through the San Diego** ~~Mental Health Plan (MHP)~~**, which is separate from the patient's attending psychiatrist on the Behavioral Health Unit (BHU). The San Diego County MHP operates under rules set by the State of California and the federal government. Each county in California has its own MHP. Patients can use the San Diego MHP Access and Crisis Line (888)-724-7240 24 hours a day, seven days a week to obtain written and verbal interpretation of their rights, benefits, and treatments. The information will be made available in the patient's language of choice.**

B. **PURPOSE:**
1. To provide a mechanism by which Tri-City ~~Medical Center~~**Healthcare District (TCHD)** ~~Behavioral Health Unit~~**BHU** provides assistance to Medi-Cal recipients with grievances or appeals.

C. **POLICY:**
1. The ~~assigned Social Work~~ staff will be responsible to ensure that Medi-Cal recipients receive assistance in accordance with any grievances or appeals that they initiate while hospitalized on the inpatient ~~Behavioral Health Unit~~**BHU** at ~~Tri-City Medical Center~~**TCHD.**

D. **GUIDELINES:**
~~1. Definitions:~~
~~a. MHP: Mental Health Plan: Mental Health services are available to people on Medi-Cal in San Diego. Sometimes they are provided by a specialist and called "specialty" mental health services. These are provided through the San Diego Mental Health Plan (MHP), which is separate from the patient's attending psychiatrist on the Behavioral Health Unit.~~
~~b. The San Diego County MHP operates under rules set by the State of California and the federal government. Each county in California has its own MHP.~~
~~c. Patients can use the San Diego MHP Access and Crisis Line (800) 479-3339 24 hours a day, seven days a week to obtain written and verbal interpretation of their rights, benefits, and treatments. The information will be made available in the patient's language of choice.~~

~~2.~~**1.** The ~~Behavioral Health Unit~~**BHU** will maintain Grievance and Appeals forms and self-addressed envelopes on both units where patients have reasonable access without having to request them.

~~3.~~**2.** ~~The Unit~~**BHU** will post notices explaining the Grievance and Appeals process in both units and will make language interpreting services available at not charge, along with toll-free numbers to help patients during normal business hours.

~~4.~~**3.** ~~The Social Work s~~**S**taff will provide information to patients, upon their request, related to an "expedited" grievance or appeal process, which means that the matter is reviewed more quickly because the patient's health or stability is at risk.

~~5.~~**4.** The patient has the right to authorize another person to act on his or her behalf during the grievance or appeal process, including the San Diego County MHP.

~~6.~~**5.** The patient will be assisted to contact the Mental Health Ombudsman Services Program if it appears that he or she needs additional information, direction or assistance getting services.

~~7.~~**6.** The patient will be permitted to request a review of a decision that was made about services that were provided through either the standard appeals process or the expedited appeals process.

a. The Standard Appeals process is a request for a review of a problem the patient has had with their MHP or their provider (TC~~MC~~**HD**) that involves denial or changes to services the patient believes he or she needs.

b. The Standard Appeals process may take up to 45 days for disposition.

c. The Standard Appeals process allows the patient to file in person, on the phone, or in writing.

d. The patient may authorize another person to act on his or her behalf in the appeal process, including the MHP. If the patient authorizes another person he/she will be asked to sign a form authorizing TC~~MC~~**HD** to release information to that person.

e. The patient or his or her representative will be allowed to examine his/her case file, including the medical record or other documents that will be considered during the Appeal process both before and during the appeal process.

f. The patient will be provided with opportunities to present evidence and allegations of fact or law either in person or in writing as part of the Appeals Process.

E. RELATED DOCUMENT(S):

1. Patient Care Services Policy: Patient Complaints & Grievances

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health U
Crisis Stabilization Unit

DELETION: duplicate policy of Behavioral Health Services: Visiting in Behavioral Health Unit

ISSUE DATE: 04/84

SUBJECT: Behavioral Health Unit Visiting Policy

REVISION DATE(S): 07/85, 02/87, 09/91, 06/94, 05/97, 06/99, 05/03, 04/05, 03/13

POLICY NUMBER: 6340-014

Department Approval:	09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. ~~**Behavioral Health Unit Visiting Guides**~~
   1. ~~The following criteria outline safety standards for visitors to the Behavioral Health Unit. The treatment team encourages family and friends to visit.~~

B. ~~**POLICY:**~~
   1. ~~**Hours:**~~
      a. ~~Visiting hours have been established to limit interference with treatment activities/groups.~~
         i. ~~Weekdays 12:00PM to 1:00PM 5:00PM to 7:00~~
         ii. ~~Weekends/Holidays 12:00PM to 2:00PM 5:00PM to 7:00~~
      b. ~~Nursing staff may limit the number of visitors and/or length of visit based upon the patient's condition.~~
      c. ~~An overhead page shall remind visitors when visiting hours are concluded.~~
   2. ~~**Visiting Locations and Exclusions:**~~
      a. ~~Visiting may be conducted in the patio area, dayroom, and the dining room.~~
      b. ~~Visiting is discouraged in the patient's room as they are made for double occupancy, and~~
         i. ~~visitors for one person may be disruptive to the other occupant.~~
      c. ~~Children under 16 years of age may not visit.~~
   3. ~~**Packages:**~~
      a. ~~The nursing staff shall inspect all packages brought to patients as no sharp objects or other contraband is allowed on the unit.~~
   4. ~~**Behavior Guidelines:**~~
      a. ~~Visitors are expected to behave in a manner appropriate to the hospital environment. Visitors may be requested to leave by hospital or security personnel if their behavior is disturbing the unit.~~
   5. ~~**Former Behavioral Health Unit Patients:**~~
      a. ~~Former Behavioral Health Unit patients, 30 days post discharge, may visit by invitation of a current patient.~~
   6. ~~**Denial of Rights:**~~
      a. ~~If it necessary to deny a patient the rights to receive a visitor, an order and the reason shall be obtained from the physician. A denial shall then be completed.~~

Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **BHU Multidisciplinary Treatment Plan**

ISSUE DATE: **03/08** **POLICY NUMBER:** **726**
REVISION DATE(S): **08/09, 06/10, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/13**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**
1. To have consistent guidelines for development of multidisciplinary plan of care for all patients admitted to the Behavioral Health Unit **(BHU)**.

B. **PROCEDURE:**
1. Every patient admitted to the BHU shall have a Multidisciplinary Plan of Care developed for every admission:
    a. Upon assessment the admitting **registered nurse** (RN) will begin to document identified problems in the patient treatment plan within 24 hour of admission.
    b. Each discipline will complete an admission evaluation and identify specify individualized treatment plan.
        i. Nursing
        ii. Psychiatrist
        iii. Social Work/Discharge Planner
        iv. Recreational Therapist
        v. Utilization Reviewer
    c. The Multidisciplinary Team will meet to discuss the treatment plan within 72 hours of the Patient's admission.
2. Nursing is responsible to meet with the patient to present the written treatment plan to dialogue about the goals and obtain the patients signature.
3. All treatment disciplines are responsible to review the patient's treatment plan and strive to assist the patient to meet their goals.
4. Every problem listed on the treatment plan will be addressed in the patient's chart at least once every 24 hours.
5. Every patients treatment plan will be reviewed weekly and as needed as the patient's condition warrants.

Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **Clinical Assessment**

ISSUE DATE: **03/08** **POLICY NUMBER:** **301**
REVISION DATE(S): **~~08~~09/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/13**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. To identify the core assessments that must be completed for all patients entering the program and to identify optional assessments that are completed, as necessary or clinically indicated.

B. **POLICY:**

1. All patients who are admitted to the program will routinely have an Admission Psychiatric Assessment, Physical assessment, Nursing Assessment, Psychosocial Assessment, and Activity Therapy Assessment.
2. Patients are considered members of the treatment team and will be asked to provide information regarding their concerns, needs, limitations, physical health needs, pre-existing conditions and preferences as part of the assessment process.
3. Information from all assessments, including input from the patient, will be used in the formulation of the patient's individualized treatment plan that includes provision for ensuring the patient's safety when there are co-morbid medical conditions, physical limitations, or other safety issues.
4. Room placement in relation to the nurse's station, type of bed, and whether or not the patient will be placed with a roommate will be made based on the initial nursing assessment; these decisions may be modified as ongoing assessment continues throughout the hospital stay.

C. **PROCEDURE:**

1. All core assessments will be completed by appropriately licensed and qualified clinical personnel using Tri-City ~~Medical Center~~**Healthcare District (TCHD)** approved medical records forms.
2. Diagnostic formulation, problem identification, and treatment planning are dependent upon a thorough and on-going assessment of the patient.
3. The Interdisciplinary Treatment Plan is formulated and altered based on the assessment data collected by each member of the treatment team.
4. The clinician will use all available clinical resources to gather assessment data including but not limited to the patient's subjective report, objective observations, written information from laboratory and diagnostic testing, past medical record information, and information from family and significant others.
5. Types of core initial assessments and time frames for completion
   a. Psychiatric Assessment: The psychiatrist is consulted at the time the patient is evaluated by the Psychiatric Liaison and, in collaboration with the Psychiatric Liaison and other involved clinicians, performs an initial preliminary telephonic assessment to determine

that the patient meets criteria for inpatient hospitalization. The attending psychiatrist performs the initial face-to-face psychiatric examination of the patient, within 24 hours of the patient's admission to the unit. The assessment includes psychiatric history, presenting complaint (s) and a complete mental status examination. The psychiatrist formulates a DSM-V diagnostic statement and initial plan that will be brought forward to the Treatment Team meeting at the conclusion of the initial assessment.

b. Nursing Assessment: The Registered Nurse **(RN)** is responsible to begin an initial nursing assessment at the time of admission and by the end of the shift on which the patient was admitted. The assessment includes a system review, suicide risk, elopement risk, health history, co-morbid substance abuse history fall risk and psychiatric history. The ~~Registered Nurse~~**RN** identifies patient problems and establishes an initial treatment plan that will be brought forward to the Treatment Team meeting based on the Initial Nursing Assessment.

c. Psychosocial Assessment: The purpose of the Psychosocial assessment is to identify psychosocial and discharge planning needs of the patient and family in order to develop a plan to meet those needs. A psychosocial evaluation will be initiated within 24 hours of admission unless the patient is too medically or psychiatrically compromised for this evaluation to be initiated. The Initial Psychosocial Assessment will be completed within 72 hours of the patient's admission to the unit. The Social Worker or Marriage and Family Therapist formulates a preliminary discharge plan that will be brought forward to the Treatment Team meeting based on the Psychosocial Assessment.

d. Activity Therapy Assessment: The Activity Therapist (either Occupational Therapist or Recreational Therapist) initiates an evaluation of the patient within 24 hours of admission unless the patient is too medically or psychiatrically compromised for this evaluation to be done. The Initial Assessment will be completed within 72 hours of the patient's admission to the unit. The Activity Therapist formulates problems and goals that will be brought forward to the Treatment Team meeting based on the Activity Therapy Assessment.

e. History and Physical Examination: A physician/**Allied Health Professional (AHP)** will perform a history and physical examination on the patient within 24 hours of the patient's admission and will order additional evaluations as are clinically indicated.

6. Ongoing Assessment:

a. The Attending Psychiatrist will meet with and perform an assessment a minimal of five **(5)** days of every seven **(7)** days during which the patient is hospitalized and will document the results of that assessment and the plan for continued care in the medical record and will bring ongoing assessment information forward to the Treatment Team Review.

b. The ~~Registered Nurse~~**RN** will perform an assessment of the patient each shift. These assessments will be documented on hospital forms designed for this purpose in the patient's medical record and the RN will bring ongoing assessment information forward to the Treatment Team Review.

c. This assessment includes but is not limited to:

i. System review
ii. Update on co-morbid medical conditions
iii. Suicide risk
iv. Elopement risk
v. Fall risk
vi. Tobacco Use
vii. Audit-C and CIWA assessment for Alcohol Use
viii. Method of Communication
ix. Response to interventions that have been provided for treatment of identified problems
x. Nutrition
xi. Mobility

xii. Vital signs

d. The Social Worker/Marriage and Family Therapist will meet with and perform ongoing assessment as is clinically indicated but at least three of every seven days during which the patient remains hospitalized. The Social Worker/Marriage and Family Therapist will document in a clinical note in the patient's medical record each contact with the patient or made on the patient's behalf with either family, significant others, referral resources, or community agencies and will bring ongoing assessment information forward to the Treatment Team Review.

e. The Activity Therapist will meet with and perform ongoing assessment as is clinically indicated and at least three of every seven days during which the patient remains hospitalized. The Activity therapist will document a clinical note in the patient's medical record at each individual or group contact with the patient and will bring ongoing assessment information forward to the Treatment Team Review.

7. Other assessments will be performed based upon the patient's clinical presentation. These may include but are not limited to, nutritional assessments, physical therapy, respiration therapy, medical specialists, obstetrical assessments and others.

8. Upon the patient's request, a chaplain or clergyman may visit the patient to assess and tend to the patient's spiritual needs.

Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **Community Meeting**

ISSUE DATE: **03/08** **POLICY NUMBER:** **701**
REVISION DATE(S): **08/09, 06/10, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/13**
Board of Directors Approval:	**03/13**

A. **DEFINITION(S):**
1. To identify the forum for patients to discuss milieu issues, to identify daily goals, and to make announcements that affect the entire milieu.

B. **POLICY:**
1. Patients will be given the opportunity to increase their involvement in the therapeutic milieu and to discuss their issues and concerns in a daily meeting that includes other patients and members of the treatment team.

C. **PROCEDURE:**
1. A community meeting will be held in the patient day room every day at the beginning of both shifts. The evening meeting will be a wrap-up meeting to review patient daily goals and accomplishments.
2. Every patient on the unit will be invited and encouraged to attend.
3. The beginning of the meeting will be announced over the public address system.
4. All the common areas not being used for groups are closed during the Community Meeting.
5. All available staff will be encouraged to attend the daily Community Meeting.
6. The community meeting will follow a prescribed format
   a. The leader of the meeting is a patient who volunteers each day to conduct the meeting with the assistance of a designated staff member.
   b. Patients will be asked to volunteer for task related duties for the day; volunteers' names will be written on the chalk board in the day room.
   c. The president follows the meeting agenda and asks for patient and staff discussion on each agenda item.
   d. The daily schedule is discussed.
   e. Staff and patient announcements are made.
   f. New patients are introduced.
   g. Patients who will be discharged are introduced.
7. The role of the clinical staff who attends the Community Meeting is to help patients to establish communication within the group, maintain order, help patients identify daily goals, and assist the group in problem solving.
8. Emergency Community meetings may be called for specific reasons such as natural disasters, or unusual unit occurrences of an upsetting nature.

Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Conducting Searches: Patient Room/Patient Belongings**

ISSUE DATE: **03/08** **POLICY NUMBER:** **101**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/13**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. To provide guidelines for clinical staff who conduct searches of patients' rooms or personal belongings.

B. **POLICY:**

1. For the safety and protection of both patients and staff, a search of a patient's room and or his/her personal belongings may be conducted when there is reason to believe that the patient is in possession of illicit drugs, alcohol, and/or weapons, or when a theft has occurred on the unit.

C. **PROCEDURE:**

1. Patients will be informed at the time of their admission that drugs, alcohol, weapons, or other items that might inflict injury on the patient or others are not allowed on the **Inpatient Behavioral Health** Unit **(BHU)**. This statement will be presented to all patients, in writing, in the Unit Rules book at the time of their admission as well.

2. If it becomes necessary to conduct a search of a patient's room and/or his belongings, the patient will be provided with an explanation of the rationale for the search.

~~2.~~**3.** If the circumstances are such that a general search of all rooms is indicated the clinical staff, or a representative thereof, will meet with all patients in a special Community Meeting to provide an explanation of the rationale for the search.

~~3.~~**4.** When a patient's room or belongings are searched, the patient will always be afforded an opportunity to be present. All other patients will remain in the Community Meeting area until such time as their individual room is searched.

~~4.~~**5.** Two **(2)** members of the clinical staff will conduct the search. When it is advisable to do so a member of the Security Department will be asked to participate as well.

~~5.~~**6.** If a patient refuses to cooperate in the search a written physician order may be obtained~~,~~ (e.g. ~~"~~Have **two [2]** staff search patient's room for unsafe contraband).~~"~~

~~6.~~**7.** After a search is conducted there will be a patient debriefing meeting in which patient questions will be answered and concerns and comments will be addressed.

~~7.~~**8.** If contraband is found in a patient's room, a note describing the nature of the contraband will be entered into a clinical note in the patient's medical record.

~~8.~~**9.** If weapons are confiscated and the patient is on a 72-hour or 14 day hold, the weapons will not be returned to the patient at time of discharge. Security will be notified and will confiscate and store any/all weapons found during a patient search.

~~9.~~**10.** If illegal contraband is found during a search, i.e. crack pipes, drug paraphernalia, or illicit drugs, these will be given to Security for disposal and will not be returned to the patient at time of discharge.

~~10. Patients authorized to use medical marijuana will be asked to produce the appropriate documentation or have a medical order to return any marijuana or related equipment to have these items returned by Security at the time of patient discharge.~~

D. REFERENCE(S):

1. **~~In-Patient~~ Behavioral Health Unit Policy: ~~#6340-402~~ Patient Belongings**
2. **Administrative Policy: ~~8610~~-217- Disposal of Drugs ~~&~~and Drug Paraphernalia**

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Confidentiality**

ISSUE DATE: **03/08** **POLICY NUMBER:** **505**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/13**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**
1. To provide guidelines to staff to ensure that they identify and respond appropriately to the importance of patient confidentiality.

B. **POLICY:**
1. The ~~Inpatient Behavioral Health~~**Behavioral Health Unit (BHU) and Crisis Stabilization Unit (CSU)** staff will keep all patient information confidential and will engage in interactions with others in compliance with ~~all TCMC~~**Administrative** Polic~~iesy:~~ ~~related to~~ **455** Confidentiality.

C. **PROCEDURE:**
1. Both written and verbal information will remain confidential between the patient and the staff. It is the responsibility of the staff to emphasize the importance of patient confidentiality.
2. At admission all patients will be given a notice of Privacy Practices for Tri-City ~~Medical Center~~**Healthcare District (TCHD)** in accordance with HIPAA regulations.
3. Patients will be asked to sign a written Release of Information to allow staff to communicate with persons other than those who are currently providing mental health services to the patient. This includes but is not limited to family members.
4. Confidentiality also applies to telephone conversations and inquiries from the family and the public. Unless disclosure is authorized there will be no information given regarding patients' presence or treatment in the Inpatient ~~Behavioral Health Unit~~**BHU**.
5. Violation of patient confidentiality constitutes a breach of the patients' rights and will result in formal disciplinary action ranging from verbal warning up to and including possible termination. A privacy breach of Public Health Information (PHI) is reported to **California Department of Public Health** (CDPH) and the office of Civil Rights. The regulatory departments within these agencies request the name of the person at the facility that was responsible for the breach. The person responsible for the breach will be held liable for the fine.
6. Exceptions to this policy include incidents when the patient is threatening to harm an identified third party. In this case the staff must comply with the **Patient Care Services Policy:**~~Tarasoff responsibility of~~ Duty to Warn **Potential Victims**~~in compliance with the provisions of that policy~~. Other exceptions include reportable incidents such as child abuse, elder abuse, or domestic violence.

D. **RELATED DOCUMENT(S):**
1. **Administrative Policy: 455 Confidentiality**

~~7.~~2. Patient Care Services Policy: Duty to Warn Potential Victims

Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Cleaning and Changing BHU/CSU Bathroom Curtains**

ISSUE DATE: **NEW** **POLICY NUMBER:** **407**
REVISION DATE(S):

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **POLICY:**
1. T~~his Policy~~**o** provide~~s~~ guidelines for the cleaning and changing of curtains to prevent and control of infections.
2. Ensuring best practices to protect the patient, staff and visitors in the healthcare facility by minimizing the possible spread of infections in the facility.

B. **PROCEDURE:**
1. Replace a patient's bathroom curtain anytime it becomes soiled, or soiled after isolation to prevent cross contamination.
2. Wear gloves ~~&~~**and** Personal Protective Equipment (PPE) appropriate for a surface decontamination and cleaning task. Discard used PPE by using routine disposal procedures.
3. Soiled curtains should be handled with minimum agitation to prevent gross microbial contamination of the air and of persons handling the linen.
4. Bag or contain contaminated items in containers at the location where it last used and have them washed with detergent in hot water at a temperature of at least 160^{0} F (71°C) for a minimum of 25 minutes for an effective means of destroying microorganisms. If low temperature (<160^{0}F /~~[~~<71^{0}C~~]~~) laundry cycles are used, use the hospital provided soap only for each load. This detergent has activated oxygen enzyme bleach for wash/disinfection. This will help prevent accidental cross contamination and the spread of bacteria from one wash load to another.
5. Prior to laundering the curtains, run a full wash cycle using only bleach.
6. Machine dry curtains completely. Do not leave damp curtains in machines overnight.
7. Perform hand hygiene after removing gloves.
8. Wipe the track or ledges with the PDI Super Sani Cloth (~~"~~Purple Top~~"~~) disinfectant prior to hanging the new curtain.
9. Night shift Assistant Nurse Managers (ANMs) to ensure quarterly cleaning, disinfection, and inspection for damage of curtains. If they are visibly soiled or soiled after isolation then they should be replaced before admitting a new patient into the room.
10. Curtains should be replaced when torn or damaged. Soiled curtains that need to be repaired should be cleaned first and tagged as "Clean".
11. Staff to perform Environmental Safety Audit twice per day on both main ~~&~~**and psychiatric intensive care unit** (PICU) areas to monitor environmental cleanliness and safety, and to ensure curtains are intact.
12. The Infection Prevention and Control Coordinator should be consulted if there is any question related to the disinfecting of the item.

C. **FORM(S):**
1. **BHU Environmental Safety Audit**
2. **Quarterly Cleaning of Bath Curtains Log**

D. **REFERENCE LIST:**
1. Guidelines for Environmental Infection Control in Health-Care Facilities (June 6, 2003). Retrieved from http://www.cdc.gov/hicpac/pdf/guidelines/eic_in_HCF_03.pdf

Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **Daily Environmental Safety Rounds**

ISSUE DATE: 03/08 **POLICY NUMBER:** 400
REVISION DATE(S): 08/09, 03/13

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/13**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**
1. To provide guidelines for staff who will be expected to conduct environmental safety rounds on each shift.

B. **POLICY:**
1. Safety rounds will be conducted on each shift to ensure that the milieu is free from hazards that could compromise patient or unit safety.

C. **PROCEDURE:**
1. A member of the outgoing shift and a member of the oncoming shift will conduct unit safety rounds every day.
2. During the rounds the staff will enter each patient's room to:
   ~~2.~~**a.** **D**~~d~~etermine whether there are items present that have been determined to be contraband. Contraband includes but isn't limited to:
      ~~a.~~**i.** Food (attracts insects and vermin)
      ~~b.~~**ii.** Unopened beverages with the exception of water
      ~~c.~~**iii.** Items that might be used to inflict injury as indicated in **Behavioral Health** ~~U~~ **Services** Policy:~~,~~ ~~"~~Personal ~~Property"~~**Belongings.**
      ~~d.~~**iv.** Items that might have been brought in by visitors during the shift including plastic bags, plants, or sharp objects
      v. Any other items of suspicion **(e.g. broken tooth brush or comb)**~~.~~
   ~~e.~~**b.** **Inspect bathroom curtains to ensure they are not soiled and the Velcro stays in place. If they need to be replaced, follow the** ~~procedure outlined in the~~ **Behavioral Health Services Policy:** ~~"~~**Cleaning and Changing BHU** ~~and~~ **/CSU Bathroom Curtains**~~" policy~~**.**
3. Each patient will be afforded an opportunity to accompany the staff to their room during the safety rounds and will be given an explanation of the rationale for the removal of items from their room.
4. While in the room staff will check wastebaskets, under mattresses, desktops, and drawers for contraband items. They will also assess the room for environmental safety hazards such as burned out lights, sharp corners, broken equipment as well as for general care and appearance.
5. Patients will be reminded daily in Community Meeting about the purpose and procedure for daily safety rounds.

6. If~~/when~~ items are found in a patient's room that should not be kept there, the~~se~~ items will be removed from the room. If they are patient belongings, the items will be placed in the patient's personal property on the unit. If they are food or beverages they will be disposed of.
7. If items are found that appear to have been purposefully hidden for the purpose of inflicting self - injury, the items will be removed, the psychiatrist will be notified, and the patient will be thoroughly assessed for level of suicidal intent. Clinical interventions will occur as are deemed necessary to ensure patient safety and may include ~~transfer from the main unit to the PICU,~~ assignment to a higher level of supervision (~~e.g. Q 15-minute checks or~~**such as** one-to-one supervision).
8. The Registered Nurse **(RN)** will be responsible to document significant findings uncovered during safety rounds in the patient's medical record and will communicate these findings to the oncoming shift.

D. <u>RELATED DOCUMENT(S):</u>

1. **Behavioral Health Services Policy: Personal Belongings**
2. **Behavioral Health Services Policy: Cleaning and Changing BHU /CSU Bathroom Curtains**

Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: Daily Schedule

ISSUE DATE: 03/08 **POLICY NUMBER:** 702
REVISION DATE(S): 08/09, 03/13

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/13**
Board of Directors Approval:	**03/13**

A. **DEFINITION(S):**
   1. To organize and outline the various groups and activities offered in the Inpatient Behavioral Health Unit **(BHU)** and to assist patients in achieving their treatment goals.

B. **POLICY:**
   1. A daily group schedule will be developed and arranged to address the treatment needs of the patient population served.

C. **PROCEDURE:**
   1. A group schedule will be posted in the Dayroom~~ in both units (PICU and main unit)~~.
   2. Group sessions will be offered ~~6 hours each day~~**throughout the day**, seven **(7)** days a week.
   3. The schedule will be revised as is clinically indicated.
   4. Each discipline~~,~~ **(**i.e. nursing, social work, activity therapy, and psychology**)**~~,~~ will provide group interventions. Individual groups will be led by clinical staff who are appropriately credentialed to lead that particular type of group.
   5. To the extent that it is possible each therapy group will have a therapist and co-therapist.
   6. Changes in daily group schedules will be discussed in the Community Meeting.
   7. Patients will be told, upon admission, and throughout their hospitalization, that they are expected to attend and participate in group activities since these are considered to be a vital part of their treatment program.

Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **Direct Admissions to the Behavioral Health Unit**

ISSUE DATE: **03/08** **POLICY NUMBER:** **201**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/13**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**
1. To reduce waiting times for patients meeting admission criteria who are known to the medical staff.
2. To help improve patient flow through the emergency department.

B. **POLICY:**
1. Patients known to the medical staff may be admitted directly to the Behavioral Health Unit **(BHU)** if they meet criteria for inpatient care.
2. The referring psychiatrist **or** ~~**physician's designee**~~**Allied Health Professional (AHP)** must be affiliated with Tri-City ~~Medical Center~~**Healthcare District (TCHD)** but is not required to be the attending psychiatrist.

C. **PROCEDURE:**
1. The referring physician**/AHP** ~~or the physician's designee~~ will notify the ~~Psychiatric Liaison Supervisor~~, Assistant Nurse Manager **(ANM)** or designee directly**, and the Medical Director BHU**.
2. The attending psychiatrist will be advised of the admission.
   a. If the referring physician**/AHP** will be the attending physician, the on-call psychiatrist does not need notification~~,~~ ~~**but**~~**and the referring physician/AHP will have to follow the patient throughout their duration of the hospital stay**.
   ~~2.~~**b.** If the referring physician**/AHP** will not be the attending physician, the on-call psychiatrist must accept the patient after consultation with the referring physician**/AHP**.
3. The physician**/AHP** who will be attending the patient on the unit must ~~call orders~~**enter admitting orders and notify** ~~to~~ the ~~Assistant Nurse Manager~~**ANM** or another registered nurse. In addition to orders, the referring physician**/AHP** ~~or his designee~~ should fax the following information to the inpatient unit:
   a. The patient's name and medical record number, if known.
   b. The patient's date of birth and social security number.
   c. The type of insurance and copies of any insurance cards.
   d. Current symptoms requiring hospitalization.
   e. Axis I through V diagnoses.
   f. ~~Whether the admission is for the PICU or the main locked unit, and~~ **The** legal status of **the** patient.
4. If pre-authorization is required by the patient's insurance, the referring physician**/AHP** ~~or his designee~~ is responsible for obtaining such authorization. In the event the referring

physician/**AHP**~~ or his designee~~ cannot obtain pre-authorization, the Psychiatric Liaison Supervisor, ~~Assistant Nurse Manager~~**ANM** or designee is responsible for obtaining such authorization.~~.~~

5. ~~An assessment will be performed by the on-duty behavioral health liaison as soon as possible after admission.~~The admitting **registered nurse (**RN**)**, mental health worker, and security officer, if needed, will complete a safety assessment of patient and personal property. All contraband will be secured in the appropriate storage area ~~[Refer to~~**per Behavioral Health Services** Policy:~~ 6340--502~~ **402** Patient Belongings~~]~~.

D. <u>RELATED DOCUMENT(S):</u>

~~6.~~**1. Behavioral Health Services Policy: 6340--502 402 Patient Belongings**

Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **Discharge Planning**

ISSUE DATE: **03/08** **POLICY NUMBER: 703**
REVISION DATE(S): 08/09, 03/13

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/13**
Board of Directors Approval:	**03/13**

A. **~~DEFINITION(S)~~PURPOSE:**
1. To ensure that patient discharge occurs when treatment goals are met and the patient no longer meets criteria for inpatient hospitalization.
2. To provide assistance for each patient upon discharge in order to optimize the transition to the next level of care.

B. **POLICY:**
1. A social worker/discharge planner will be assigned to each patient for the purpose of assisting in discharge planning efforts.

C. **PROCEDURE:**
1. Each patient will be assigned to a social worker~~/discharge planner~~ upon admission based on past relationship, current caseload, and, in some instances, professional preference.
2. Discharge planning will begin on admission as a collaborative effort between the psychiatrist, ~~the~~ psychiatric liaison, ~~the~~ **nurse,** ~~the~~ social worker, ~~the~~ conservator, and the patient, all of whom provide information that will be utilized to plan a reasonable and optimal disposition.
3. The assigned **s**~~S~~ocial **w**~~W~~orker~~/Discharge Planner~~ will include the patient and support system (as consented to by the patient). The support system may include case managers, clinics, family, and/or significant others.
4. The **s**~~S~~ocial **w**~~W~~orker~~/discharge planner~~ will utilize objective and subjective data in developing a discharge plan.
   a. The initial discharge plan may change as additional assessment data becomes available.
   b. Patient preferences will be considered as is reasonable and clinically appropriate.
5. The discharge plan will be reviewed and discussed by the team daily in the interdisciplinary team meetings, and more formally, in treatment plan review sessions.
6. Upon discharge each patient will have an appointment that is documented in the discharge plan. The plan will be reviewed with the patient at the time of discharge and the patient will be educated about the importance of adherence with the plan.

Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **Dress Code for Patients**

ISSUE DATE: **03/08** **POLICY NUMBER:** **705**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/13**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**
1. To define appropriate dress for patients hospitalized on the inpatient Behavioral Health Unit **(BHU)**.

B. **POLICY:**
1. To the extent that their clinical condition allows, patients will be expected to dress in a socially acceptable manner.
2. Staff members will assist patients to maintain appropriate dress as is clinically indicated.

C. **PROCEDURE:**
1. Patients will be given the following general guidelines at time of admission and during community meeting:
    a. All clothing should be age appropriate and clean.
    b. No tube tops, short shorts, bareback dresses or tank tops are to be worn.
    c. No bare torsos for either gender will be allowed.
    d. Clothing with profane or suggestive writing will not be allowed.
    e. Patients will be expected to bathe or shower regularly such that personal hygiene is maintained.
    f. Patients will be expected to wear footwear at all times on the unit when they are walking about. No bare feet or excessively high heels that could reduce mobility or increase fall risk will be permitted.
2. Problems with clothing that is assessed to be inappropriate will be addressed with the patient as a treatment issue.
3. For those situations in which a patient does not have clothing or if the patient has a medical condition that necessitates it, the patient will be provided with a hospital gown and slippers. If the patient is wearing hospital attire, the patient will be encouraged and or assisted to wear it such that modesty is preserved.
4. ~~An assigned s~~**S**taff member**s** will assist patients with laundry and personal hygiene as is clinically indicated.
5. A patient will be asked to change clothing if/when it does not comply with minimum standards of modesty or good taste.
6. Family members will be asked to bring appropriate clothing from home as is indicated. In the absence of family involvement, patients will be given clean clothing from the clothing storage area of the unit.

Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Elopement Precautions**

ISSUE DATE: **03/08** **POLICY NUMBER: 601**
REVISION DATE(S): 08/09, 06/10, 03/13

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/13**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**
1. To provide guidelines for the management of a patient who is at risk for leaving the unit in an unauthorized manner.

B. **POLICY:**
1. Each patient who is admitted to the **Crisis Stabilization Unit (CSU) or** ~~inpatient psychiatric~~**Behavioral Health U**~~u~~nit **(BHU)** will be assessed for elopement potential upon admission and throughout his or her hospital stay.
2. The clinical staff will make every effort to prevent patients from leaving the unit without authorization and, if a patient does leave, will make reasonable efforts to return the patient to the unit safely.

C. **PROCEDURE:**
1. Common indicators of risk for elopement include**,** but are not limited to:
   a. History of elopement from previous treatment facilities
   b. Symptoms of restlessness, agitation, wandering
   c. Patient is frequently checking exits and doors; p**atien**t is testing door knobs and locked exits
   d. Verbalizations of intent to leave the unit
   e. Confusion
   f. Purposeful wandering
   g. Family or friends are not supportive of hospitalization and are encouraging patient to leave
2. Staff will engage in activities to discourage elopements from the unit including**,** but not limited to:
   a. Conducting patient rounds every **fifteen** (15) minutes in ~~the PICU and the main unit~~**BHU**~~,~~ at staggered times, to determine and accurately document the location of each patient.
   ~~a.~~**b.** **Conducting patient comfort rounds every 60 minutes in the CSU~~,~~ and monitoring patients in assigned chairs and unit surroundings~~,~~ (including patio)~~,~~ via ongoing camera monitor in nursing station.**
   ~~b.~~**c.** Conducting safety rounds on the unit at each change of shift to assure that all exits are secured.
   ~~c.~~**d.** Assessing each patient for elopement risk and documenting changes in risk in the medical record; sharing risk information during change of shift report.

~~d.~~**e.** Maintaining a clinical person in the ~~PICU dayroom and in the main~~**BHU** ~~unit~~ hallways **and CSU**.

f. Staying in communication with the security officer ~~who will be~~ **posted in the CSU and making rounds in both the CSU and BHU.**

~~e.~~**g.** Communicating clearly with each other when a need arises for any staff member to leave the unit; obtaining coverage for absences as clinically appropriate.

~~f.~~**h.** Discussing patients at risk for elopement at daily treatment plan review sessions.

~~f.~~**i.** Exercising care when leaving and entering the ~~PICU and main unit~~**BHU and CSU.**

~~i.~~**j.** ~~Avoiding the door that opens to the main hallway, from the PICU~~

~~ii.~~**k.** Observing the exit closely when visitors enter and exit ~~**(No visitors in CSU)**~~.

~~iii.~~**l.** Observing the exit closely when dietary or other departments enter and exit.

~~iv.~~**m.** Posting signs on the entry way doors when elopement risk is high.

~~h.~~**n.** Monitoring patients closely on the ~~PICU and main unit~~**BHU and CSU** patios during **fresh air**~~smoking~~ breaks.

   i. One clinical staff member will be on the patio with patients during **fresh air**~~g smoking~~ breaks at all times **(-BHU only)**.

   ii. Cameras in the nursing station will be used to visualize **the outside**~~smoking~~ patio.

   iii. After ~~smoking~~ **fresh air** breaks a clinical staff will ensure that all patients have returned to the unit and that the patio door is locked **(BHU only)**.

~~i.~~**o.** Carefully assessing patients for psychiatric stability prior to allowing them to leave the unit for medical testing.

   i. The **registered nurse** (RN) and physician**/Allied Health Professional (AHP)** will determine, collaboratively, when it is psychiatrically safe to allow a patient to leave the unit for diagnostic testing or treatment. Testing and treatment will be delayed, within safe limits, until the patient is determined to be stable enough to tolerate the procedure or test without risk of injury or elopement.

   ii. When the patient is allowed to leave the unit, he ~~or~~ /she will be placed in a patient gown and **non-slip socks. In CSU the patient will be placed in scrub top, bottom, and non-slip socks.** ~~slippers.~~

   iii. A staff member will accompany all patients who leave the BHU. In addition, Security will accompany all patients who are on involuntary legal status.

   iv. The Assistant Nurse Manager **(ANM)** or charge nurse will be responsible for determining if voluntary patients will require staff or security accompaniment for diagnostic testing or procedures.

3. The ~~Registered Nurse~~**RN** may initiate elopement precautions if he ~~or~~ /she assesses the clinical necessity to do so based on the patient's history and current behavior. The RN will notify the physician**/AHP** as soon ~~i~~as practicable to obtain a written order that will be entered in the medical record. Only the physician**/AHP** may discontinue elopement precautions.

4. When it is discovered or reported that a patient has left the unit without authorization the ~~Assistant Nurse Manager~~**ANM** will:

   a. Notify Security immediately, give a report to the Security Officer that indicates:
      i. Patient name
      ii. Gender
      iii. Age
      iv. Description, including clothing
      v. Time patient left (approximate)
      vi. Patient's last known whereabouts
      vii. Patient's home address
      viii. Reason for hospitalization and major concerns (i.e. danger to self, danger to a specific other, indication of weapons in the home, restraining orders, etc.)

   b. Notify the treating physician**/AHP** of the event and surrounding circumstances.

   c. Refrain from chasing the patient or engaging in physically restraining a patient who has left the unit.

d. Notify the Clinical Nurse Manager and Risk Management Department.
e. Notify the patient's family and/or friend (as indicated if the release of information consent is signed).
f. Ensure that the Oceanside Police Department has been notified (for LPS involuntary hold or conservatorship patients only). Involuntary patients only.
g. Ensure that an accurate QRR/RL Solutions is completed that provides a detailed time-line of the event.
h. Ensure that a clinical note is completed that provides a detailed time-line of the event.
    i. Time, and method of departure
    ii. Time and names of staff, family members, police officers who were notified
    iii. Time of patient return to the unit

5. If the patient returns to the unit the clinical staff will:
    a. Carefully check the patient's clothing and other belongings for contraband items.
    b. Observe patient for signs of illicit drug use and, as indicated, follow-up with attending physician/**AHP** for further assessment.
    c. Evaluate patient's current mental status, reason for leaving, and level of continued elopement risk.
    d. Document all assessments and follow-up in a clinical note
    e. Provide clinical care as indicated by patient's presenting symptoms and concerns
6. If the patient does not return to the **BHU**~~unit~~ the clinical staff will:
    a. Hold the bed open until at least midnight of the day of the event.
    b. Obtain a physician order to discharge the patient if the patient is absent beyond midnight of the day of the event.
7. **If the patient does not return to the CSU the staff will:**
    a. Notify NP or on-call physician/AHP.
    ~~c.~~**b. Consider patient left without treatment.**

Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **Environmental Safety Standards in BHU**

ISSUE DATE: **03/08** **POLICY NUMBER:** **6340-401**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Professional Affairs Committee Approval:	**03/13**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**
   1. To provide guidelines for maintaining the safety of the unit, staff, and patients.

B. **POLICY:**
   1. All clinical staff will be responsible for maintaining a therapeutic milieu that provides for the safety, health, and comfort of patients.

C. **PROCEDURE:**
   1. Clothing and Personal Items:
      a. On admission each patient's belongings will be searched, in the presence of the patient or witnessed by another staff member if the patient is unable to be present.
      b. All patients will be transported from the Emergency Department **(ED)** to the **Behavioral Health Unit** (BHU**)** in a patient gown and will have their clothing searched in the ED for contraband items.
      c. All patients who are admitted directly to the unit and who arrive in street clothing will be asked to empty their pockets. A belonging search shall include a search of the patient's luggage, purse, or other items carried into the facility by the patient and/or family. This also includes checking electrical items/appliances for safety and contraband. Building Engineering staff shall inspect all electrical hygiene appliances for safety before they can be used. An inspection sticker shall be placed on the electrical appliance with date and initials of inspector if safe for use in the hospital.
      d. Staff will check patient billfolds and/or purses for contraband items.
      e. Ask the patient to remove his/her shoes and socks and all garments such as coats, sweaters, or jackets. All items shall be searched thoroughly including checking all pockets, rolled up cuffs or sleeves, hems and waistbands. Staff shall check the patient's pockets by asking the patient to empty pockets and turn the pockets inside out.
      f. Instruct the patient to put on a hospital gown, remove all clothing with the exception of undergarments. Once the hospital gown is on, the patient shall be requested to remove all undergarments (including bra for female patient). This shall be done under the supervision of the staff member in attendance.
      g. After all clothing is removed; carefully search the patient's personal clothing. Staff shall include pockets, hems, inside shoes and socks; and other places where items may be hidden. For new patients, the Skin Assessment is conducted at this time by the **Registered Nurse** (RN**)** and documented in Cerner.
      h. Invasive body searches are not conducted at Tri-City ~~Medical Center~~**Healthcare District (TCHD)**~~,~~ ~~Behavioral Health Unit~~**BHU**.

i. All items considered contraband such as glass, compacts, perfume bottles, sharp objects, hairspray, pen, pencil, etc. will be secured in a non-patient area.
j. Glass flower vases will not be permitted in patient care areas or patient rooms.
k. Clinical staff will monitor use of razors.
l. Cellular phones are not permitted on the unit.
m. Shoelaces are not permitted on the unit.

2. Food:
a. Food items will not be allowed in patient rooms due to the possibility of insect infestation.
b. Dietary trays will be permitted in the dining room and patio. Dietary trays are to contain plastic-ware only. Plastic knifes are not permitted.
c. ~~No~~ **Food ~~allowed~~ from outside hospital is not allowed~~,~~ unless physician/Allied Health Professional (AHP)~~doctor has~~ ordered~~.~~.** ~~Visitors will be asked to check with staff before bringing in food and beverages to the patient.~~
d. No beverages with caffeine will be permitted on the unit except with a written order by the physician/**AHP**.
e. The kitchen will be kept locked when not in use.
f. Snacks will be available between meals and in the evening at scheduled times
g. No cans will be permitted on the unit.

3. Environment:
a. A staff member will be in patient care areas at all times to observe the milieu and to monitor patients' whereabouts. An assignment sheet will be kept to indicate which staff member is assigned to unit observation and in what time periods.
b. Staff will closely monitor the use of supportive aids such as walkers, canes, and crutches.
c. The patient admission process will take place in a patient care area that affords privacy but that can be observed by other staff members.
d. When a patient is placed on one-to-one supervision and the patient is in his or her room, the door to the room will remain open at all times.
e. The medication room will be kept closed at all times when not in use.
f. Doors to the nurse's station will be closed and locked when not occupied.
g. Any craft items brought in by or for the patient will be first approved by the nursing staff and will be maintained for the patient in the belongings area.
h. Patients may work on approved craft items only in patient care areas and not in patient rooms. Patients must be supervised with craft items.
i. Patients will not be permitted to enter other patient's rooms under any circumstances.
j. Environmental safety checks will be conducted twice daily at change of shift by nursing staff.
k. Regularly scheduled environmental safety rounds will be conducted by hospital safety department personnel in the company of a clinical staff member from the BHU staff.
l. Staff will regularly report environmental safety concerns to the Assistant Nurse Manager **(ANM)** who will be responsible for initiating work orders for needed repairs and following up to ensure that needed work is completed.
m. The patio door ~~on the PICU~~ will be kept locked except when a clinical staff is present for direct and continuous observation.
n. The patio door ~~on the main locked unit~~ has a delayed egress door that will activate alarm after **fifteen (15)** seconds. Clinical staff must be present for direct and continuous observation when patients are on the patio.
o. During fire alarm, or testing of hospital generator (done monthly), the ANM/Charge RN will assign a staff member to monitor the main unit delayed egress door and the double door adjacent to the RT room, near back hallway of main unit.
p. At least one staff member will be present on the patio during ~~smoking breaks~~ **fresh air breaks** ~~on the PICU and the main unit~~.

4. Patient Rules Related to Environmental Safety:

a. Patients will be instructed not to borrow from each other or to give their personal possessions to other patients.
b. Patients will be required to wear footwear at all times.
c. Patients will be reminded in daily Community Meeting to wash their hands frequently throughout the day and in particular before all meals. Alcohol based gel will be made available for this purpose by nursing staff.
d. Physical and sexual contact between patients will not be permitted.
e. Visitors will not be permitted to visit in patient rooms.
f. Patients will be expected to maintain at least minimum standards of hygiene. Nursing staff will assist patients who are unable to maintain these standards independently.

~~g.~~**D. RELATED DOCUMENT(S):**
1. Behavioral Health Services: Dress Code for Patients
~~5.~~**2. Behavioral Health Services: Patient Belongings**

Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

DELETE: Information incorporated into BHS Policy Inpatient Admission Criteria 202.

SUBJECT: Exclusionary Criteria

ISSUE DATE: 03/08
REVISION DATE(S): 08/09, 3/10, 03/13

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/13**
Board of Directors Approval:	**03/13**

~~A. **PURPOSE:**~~
~~To provide guidelines for admission to the inpatient psychiatric unit by defining those conditions which preclude acceptance into either the locked or main unit.~~

~~B. **POLICY:**~~
~~1. Adults who are referred for admission to the Inpatient Behavioral Health unit must meet DSM IV R Severity of Illness criteria, have a primary psychiatric diagnosis, and be able to derive benefit from the therapeutic milieu. Patients will be considered inappropriate for admission if they meet *any* of the following exclusionary criteria:~~
~~a. Under age 18.~~
~~b. Primary Substance abuse diagnosis~~
~~c. Primary dementia diagnoses~~
~~d. Co-existing medical condition(s) requiring care by nursing staff with specific medical-surgical nursing competencies including but not limited to:~~
~~i. Intravenous medication~~
~~ii. Indwelling catheter~~
~~iii. Tracheostomy~~
~~e. Individuals with developmental disabilities of such a degree that they are unable to participate in daily unit activities~~
~~f. Unstable medical condition, i.e. chest pain, acute infectious disease, uncontrolled hypertension or blood glucose levels.~~

~~2. **PROCEDURE:**~~
~~a. The Assistant Nurse Manager will collaborate with the Psychiatric Liaison and Attending Psychiatrist regarding patients who may or may not be deemed appropriate for BHU admission.~~
~~b. When a patient cannot be admitted to the BHU because of a coexisting medical condition, that patient may be admitted to another unit in the hospital for treatment.~~
~~1. The nursing staff of the medical unit will initiate a request for a psychiatrist consult when the patient's medical condition has been stabilized.~~
~~2. The Psychiatric Liaison will collaborate with the staff of the medical unit to facilitate interim psychiatric treatment and admission to the BHU as is clinically appropriate.~~
~~3. The Psychiatric Liaison is responsible to notify the nurse practitioner or on-call Psychiatrist to consult with patient on the medical floor.~~

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Family Involvement in Treatment**

ISSUE DATE: 03/08 **POLICY NUMBER:** 707
REVISION DATE(S): 08/09, 03/13

Department Approval:	09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	03/13
Board of Directors Approval:	03/13

A. **PURPOSE:**
   1. To identify the role of the family in the patient's treatment.

B. **POLICY:**
   1. When appropriate and with the patient's consent, the family or significant others will be involved in the patient's treatment.

C. **PROCEDURE:**
   1. At the time of admission to the **B**~~b~~ehavioral **H**~~h~~ealth **U**~~u~~nit **(BHU) or Crisis Stabilization Unit (CSU)** the clinical staff will assess the opportunities for family participation in the patient's treatment.
   2. With the patient's written consent, family members will be encouraged to participate in treatment planning, discharge planning and family therapy sessions as are clinically indicated.
   3. The patient must sign a **Patient Consent Visitation and/or Telephone Calls** ~~Release of Information~~ Form before any interaction is initiated with the family or significant other and before any information can be provided to them.

D. **FORM(S):**
   ~~1~~**1.** **Patient Consent Visitation and/or Telephone Calls 6340-1009**

Patient Consent Visitation and/or Telephone Calls 6340-1009

Your presence here is confidential and cannot be disclosed by staff without your permission. Please list the people you do not want to hear from or see while on the unit.

Do you wish to receive phone calls and/or have visitors? ☐ Yes ☐ No

Do we have permission to talk to your family, friends or significant other? ☐ Yes ☐ No

Please indicate whom we have permission to talk to regarding your care.

Date	Patient Initial	Name		
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.

I DO NOT wish to have my presence here known or receive telephone calls and/or visitation from the following people:

Date	Patient Initial	Name		
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.

__________ __________ ___/___/___ ___:___ AM/PM

Name: Patient/Representative **Signature:** Patient/Representative **Date** **Time**

If signed by a person other than the patient, indicate relationship to patient: __________

Examples: Spouse, Partner, Legal Guardian

If patient is unable to sign, state reason: __________

__________ __________ ___/___/___ ___:___ AM/PM

Witness – TCHD Representative **(print name)** **Signature** **Date** **Time**

INTERPRETATION / INTERPRETER'S STATEMENT

Interpretation provided in preferred language: __________ ☐ Telephonic ☐ VRI ☐ Face-to-face: ☐ I have accurately and completely reviewed this document in patient/patient's legal representative preferred language with: __________ ☐ Patient ☐ Patient's legal representative

__________ __________ ___/___/___ ___:___ AM/PM

Interpreter ID number or Name Interpreter Signature (if present) Date Time

☐ Patient refuses TCHD's interpretation services and selects as interpreter: __________

Name and relationship to patient

Note: Changes can be made to the above list adding or crossing out names. Please sign and date each change.

Affix Patient Label

Tri-City Medical Center

4002 Vista Way • Oceanside • CA • 92056

PATIENT CONSENT VISITATION AND/OR TELEPHONE CALLS

6340-1009
(Rev. 3/17)

Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Food on the Unit**

ISSUE DATE: **03/08** **POLICY NUMBER:** **403**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/13**
Board of Directors Approval:	**03/13**

A. PURPOSE:
1. To reduce occupational exposure and transmission of pathogens and discourage insects and vermin on the Behavioral Health Unit **(BHU) and Crisis Stabilization Unit (CSU)**.
2. To ensure compliance with the Occupational Safety and Health Administration (OSHA) and Joint Commission regulations.

B. POLICY:
1. Food and beverages will be managed in such a manner as to minimize health risk and to maintain the unit in accordance with regulatory guidelines.

C. PROCEDURE:
1. Food and beverages will not be kept in refrigerators, freezers, on countertops or in other storage areas where blood or other potentially infectious materials are present.
2. Staff food and beverages will not be intermingled with food and beverages for the use of patients. A separate staff refrigerator will be maintained in the staff lounge for employee use.
3. Beverages will be permitted in nurse's station in a sealed container in designated area. Food is not permitted in nurse's station.
4. **In the Inpatient ~~Behavioral Health Unit~~BHU, patients are encouraged to consume food and beverages in the dining room~~,~~ but they may eat in other designated areas, such as the patio, if staff(s) are present.**
5. **In the ~~Crisis Stabilization Unit (~~CSU~~)~~, food and beverages will be permitted in the patient care areas, as defined by CSU staff.**

~~4. Food and beverages will not be kept on patient bedside table, or places where specimens, or dirty instruments/devices might have been previously placed.~~

~~5. Patient food and beverages other than water are permitted in the patient dining area and on the patio. Patients may have food in the patient lounge only for movie night and other special occasions as determined by Recreational Therapy.~~

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Freedom of Movement**

ISSUE DATE: **03/08** **POLICY NUMBER:** **508**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/13**
Board of Directors Approval:	**03/13**

A. **DEFINITION(S):**
   1. Limitation: The constraint of a right for an individual recipient of services.
   ~~A.~~**2. Restriction: General constraint of a right for all or a group of recipients.**

B. **PURPOSE:**
   1. To ~~e~~insure that each patient's freedom of movement is not restricted more than is clinically necessary.

C. **POLICY:**
   1. Patients who receive behavioral health services in the Behavioral Health Units **(BHU)** are entitled to freedom of movement. Limitations and/or restrictions will be imposed only to achieve a therapeutic milieu and to safeguard the safety of the patient, other individuals in the environment, or property.

D. **PROCEDURE:**
   ~~1. Definitions~~
      ~~a. Limitation: The constraint of a right for an individual recipient of services~~
      ~~b. Restriction: General constraint of a right for all or a group of recipients~~
   ~~2.~~**1.** At the time of admission the patient will be informed of his/her right to freedom of movement, of those areas where patients may gather, and of those areas from which patient movement is restricted.
      a. The patient will be informed of areas that have been designated as off-limits for reasons of safety or that might impair the effectiveness of program operations with patients present.
      b. They will be informed of areas of usual access and the program schedule that describes the activities occurring in treatment areas throughout the day.
   ~~3.~~**2.** Every patient will be permitted access to areas designated for treatment, recreation, or vocational activities, eating, and social interaction activities in accordance with program scheduling unless a limitation is clinically indicated.
   ~~4.~~**3.** The rationale for implementing a restriction or a limitation will be limited to the following:
      a. The achievement of a treatment goal.
      b. The maintenance of a therapeutic milieu and to facilitate effective program operations.
      c. The protection of the patient or others from harm.
      d. The prevention of property damage.

~~5.~~4. In the event a limitation is imposed on a patient's right to freedom of movement, a staff member will explain the rationale, the time frame for the limitation, and the right of the patient to appeal the decision including discussion of the proposed action and consensus of the treatment team and the initiation of a Rights Advocate complaint.

a. All limitations will be documented in the clinical record and will include the rationale for imposing the limitation.

b. The limitation or restriction will be removed when the circumstances that justified its adoption cease to exist.

Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **General Supervision of Patients: Patient Rounds**

ISSUE DATE: **03/08** **POLICY NUMBER:** **708**
REVISION DATE(S): **08/09, 06/10, 03/11, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/13**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**
1. To provide guidelines for maintaining a system of observing patient behavior and location.

B. **POLICY:**
1. Each unit and each shift will maintain a rounds board that will be used to document rounds on all patients. Documentation will include the unit name ~~(PICU/Main Unit)~~, date, patient name, room number, and activity and any precautions. Each shift will document patient behavior and location every **fifteen** (15) minutes ~~on the PICU and every 15 minutes on the Main Unit~~, although individual patients on each unit may be monitored more frequently if clinically indicated and written as a physician order.

C. **PROCEDURE:**
1. The Assistant Nurse Manager (ANM) or Charge Nurse will assign rounds every shift. The person who is assigned to initial rounds on each shift will prepare the rounds sheet for that shift. The outgoing and incoming staff personnel will conduct a unit environmental safety check and will document its completion on the rounds sheet including his or her signature.
2. All staff assigned to rounds during a shift will update the rounds sheets to reflect changes in individual patient precaution level, room or bed changes, new admissions and/or discharges as they occur.
   a. The rounds sheet for each unit will include space for the staff member to document the patient's legal status. The staff will indicate changes in the status as they occur during the shift.
   b. The rounds sheet for each unit will include provision for documenting a patient's time in the quiet room either for time-out, seclusion, or restraint.
3. A staff initial at the bottom of each time block will indicate the completion of all rounds for that time increment. Staff initials must be legible. Staff initialing the round sheet will include their name and title in the appropriate section on each form.
4. The purpose of rounds is to check all aspects of security and safety while monitoring patient behavior and location.
   a. All patient accessible areas will be checked to see that patients are safe and behavior is appropriate. All patient accessible areas are also visually checked for contraband items or for damages. Contraband, damage or unsafe situations will be reported to the shift supervisor at once.
   b. Rounds will not be done in such a predictable manner that patients will have an opportunity to plan acting out in between checks. Staff will, at all times, conduct rounds

so that safety and supervision are maximized. Although all patients must be checked at least every **fifteen (15)** minutes (as ordered) the rounds will be performed at staggered intervals and in a varying pattern or sequence throughout the unit to minimize planned acting-out opportunities.

c. All doors that are to be locked will be checked to see that they are locked.

d. All areas will be checked visually for fire hazards, contraband and all other safety hazards.

5. Rounds will be made at the ordered frequency on both shifts. Any concerns regarding safety, security, whereabouts or behavior of a patient will be reported immediately to the shift supervisor or charge nurse.
6. Staff will be assigned to monitoring patient areas and being available on the floor at all times.
   a. It is critical having staff purposefully out in the milieu, posting at different areas on the floor, creating a caring and more secure environment.
   b. Ensuring that patients are not entering into rooms not assigned to them.
   c. Particular attention must be paid to supervising showers and bathrooms for patients who are on fall precautions.
   ~~d. Staff must be present in tub room with patient at all times. No supplies, food, or drinks are to be stored in the tub room. The tub room is to be cleaned between patient use with hospital approved disinfectant by Environmental Services.~~
   d. High risk times for patient acting out generally include changes of shifts, crisis de-escalation, meal times, visiting hours and during staff meetings. Staff will be vigilant and maintain a constant awareness of unit diversions and provide constant supervision during these high-risk times.
7. During the night or whenever patients are in bed, rounds will be made at the ordered intervals to be sure that the patient is in bed and safe. Staff is required to ensure that patients are breathing.
8. Every effort will be made to respect the patients' right to privacy during rounds. However, safety for the patient and staff is always the prevailing priority. Bedroom doors may be left open except while a patient is dressing or undressing if the patients' behavior or precaution level warrants.
9. Supervision and rounds extends to the patio areas.
   a. Staff will accompany patients to the ~~smoking area on both the PICU and the Main Unit~~**patio**.
   b. Patients will not be left unattended on the ~~smoking~~ patio ~~on both units~~ at any time.
10. Staff conducting rounds must verify ~~that~~ they are checking the correct patient~~. This can be done~~ by:
    a. Checking ID bands
    b. Asking the patient to state their first and last names
    c. Asking another staff member to verify the patient's identity.
11. When staff assigned to patient rounds must leave the unit for any reason that prevents them from doing rounds as ordered, it will be their responsibility to inform the shift supervisor or charge nurse so that another staff member can perform the rounds for that period.
12. Any errors in location or behavior should be circled. On the back of the rounds sheet the staff will write the correct patient, behavior, and location and will sign the correction with name, title, date and time.
13. When a patient is on 1:1 observation an additional observation record will be maintained.
14. All rounds sheets will be maintained as a permanent record but will not be a part of the patient's medical record. The original copy of each rounds sheet may be kept on the rounds board for up to one week after which the sheets will be filed in a binder that is kept expressly for this purpose.
15. The Night shift ANM will review the rounds sheets for the previous 24 hours for any missing entries. Missing entries will be noted on the chart deficiency list and reported to the oncoming ~~shift supervisor~~**ANM/Charge Nurse**.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **Hose Use During Garden Activity**

ISSUE DATE: **NEW**
REVISION DATE(S):

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**
1. The opportunity will be provided for patients to use a hose to water the garden during Recreation Therapy activity on the patio.

B. **POLICY:**
1. Patients on the Behavioral Health Unit **(BHU)** are eligible to participate in Recreation Therapy activities, specifically gardening. This includes using a hose to adequately water the plants, flowers, vegetables in the gardening boxes and planters on the patio.

C. **PROCEDURE:**
1. During Recreation Therapy held on the patio, patients under supervision of staff will have access to a garden hose to water the plants in the garden boxes and planters. Staff will use the water key to turn on the faucet while the assigned patient uses the hose to water the plants.
2. The hose will kept locked in the Recreation Therapy closet when not in use. The hose may only be used under staff supervision.

Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **Inpatient Unit Admission Criteria**

ISSUE DATE: **03/08** **POLICY NUMBER:** **202**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/13**
Board of Directors Approval:	**03/13**

A. <u>DEFINITION(S):</u>

1. **Functional Impairment: This refers to the degree to which an individual is unable or has difficulty attending to one or more self-care needs, basic physical needs (nutrition, shelter, etc) to familial or social role expectations and/or to vocational or educational responsibilities due to impaired judgment, cognition, affective regulation, or impulse control related to a mental disorder.**
2. **Intensity of Service: The setting of care that usually corresponds to the types and frequency of needed services and supports to the degree of restrictiveness necessary to safely and effectively treat the individual.**
3. **Least Restrictive Environment: The least intensive/restrictive setting of care that is sufficient to effectively, safely, and appropriately treat the individual's condition and to achieve the purposes of treatment and/or rehabilitation.**
4. **Risk Estimation/Clinical Stability: The degree to which an individual is at risk of injury due to self/other harm inclinations, reckless activities (not arising from antisocial behavior or related traits) loss of ability to perform activities for daily living due to severely impaired judgment, impulse control, cognition or affective regulation, or due to lack of necessary skills or environmental supports.**
5. **Severity of Illness: Refers to the nature and severity of the signs, symptoms, functional impairments and risk potential related to the individual's disorder. It is assumed that as the severity of illness increases, the level of care needed to treat the individual will increase in restrictiveness**

~~A.~~**B.** <u>PURPOSE:</u>

1. To provide guidelines for determining the appropriateness of admission for inpatient psychiatric treatment. To ensure that care is delivered in the least restrictive environment and that it is based on established severity of illness criteria.

~~B.~~**C.** <u>POLICY:</u>

1. Individuals who are admitted to Inpatient ~~psychiatric services~~**Behavioral Health Unit (BHU)** will be screened to ensure that they meet predetermined criteria. The severity of illness and intensity of service criteria for admission are based on the assumption that the patient is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairment, and manifesting a level of clinical risk that either individually or collectively are of such severity that treatment in a less restrictive environment would be unsafe and/or ineffective and that the patient has the psychological and cognitive capacity or potential capacity to

respond to the inpatient program. It is expected that active treatment provided at the medically necessary level of care will reasonably result in improvement in the patient's condition.

~~1.Definitions:~~

~~a.Functional Impairment: This refers to the degree to which an individual is unable or has difficulty attending to one or more self-care needs, basic physical needs (nutrition, shelter, etc) to familial or social role expectations and/or to vocational or educational responsibilities due to impaired judgment, cognition, affective regulation, or impulse control related to a mental disorder.~~

~~b.Intensity of Service: The setting of care that usually corresponds to the types and frequency of needed services and supports to the degree of restrictiveness necessary to safely and effectively treat the individual.~~

~~c.Least Restrictive Environment: The least intensive/restrictive setting of care that is sufficient to effectively, safely, and appropriately treat the individual's condition and to achieve the purposes of treatment and/or rehabilitation.~~

~~d.Risk Estimation/Clinical Stability: The degree to which an individual is at risk of injury due to self/other harm inclinations, reckless activities (not arising from antisocial behavior or related traits) loss of ability to perform activities for daily living due to severely impaired judgment, impulse control, cognition or affective regulation, or due to lack of necessary skills or environmental supports.~~

~~e.Severity of Illness: Refers to the nature and severity of the signs, symptoms, functional impairments and risk potential related to the individual's disorder. It is assumed that as the severity of illness increases, the level of care needed to treat the individual will increase in restrictiveness~~

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

~~2.~~1. All candidates for admission will be screened by an appropriately credentialed clinician to determine suitability for admission using the following criteria:

a. Availability of a suitable bed.

b. The patient's assessed potential for response to the treatment services offered on ~~the unit~~**BHU**. Physical illness, developmental disability or organic impairment should not be of such severity that it precludes meaningful participation in the program.

i. It is expected that the patient will possess the potential to participate in and derive benefit from at least 50% of the program's scheduled activities.

ii. The patient's ability to adapt to the current milieu on ~~the unit~~**BHU** will be determined by the psychiatric liaison and/or the medical service director. In making this decision consideration will be given to the number and acuity of the patients already on ~~the unit~~**BHU**, the existing nurse to patient ratio, and the assessed needs of the patient being considered for admission.

iii. In all cases the safety of the patient and the milieu will be the determining factors in making a decision to deny an admission if the patient is clinically suitable for admission.

c. The patient must be medically stable as defined below:

i. The patient will have no condition that would prevent him/her from being able to be out of bed, with or without assistance, and have the capacity or potential capacity to participate in at least 50% of the unit scheduled activities.

ii. If the patient has a positive medical history for any major illnesses such as stroke, diabetes, hypertension, significant weight loss, etc. the patient will be medically cleared prior to inpatient admission.

d. Clinical presentation:

i. An individual will be considered for admission when it is determined that he/she is mentally ill and requires supervised care in a 24 hour protective setting.

ii. The severity of illness and intensity of service criteria will be based upon the judgment of the qualified screening clinician that the patient is displaying signs and symptoms of a serious psychiatric disorder.

iii. The decision to admit an individual under voluntary or involuntary status will be determined by the clinical presentation, i.e. whether the patient meets 5150

criteria regarding danger to self, danger to others, grave disability and if the patient is willing to consent to treatment. In those instances that the legal status is in question, the psychiatric liaison will collaborate with the attending psychiatrist in making the decision.

iv. Inpatient psychiatric hospitalization is indicated if it is determined that the patient is exhibiting functional impairments and demonstrating a level of clinical risk that are severe and it is determined that alternative treatment in a less structured and supervised setting would be unsafe and ineffective.

e. Diagnosis: The patient must be suffering from a major mental illness reflected in a primary validated DSM-5~~IV~~ Axis 1 diagnosis.

f. Severity of illness: The patient must exhibit at least one of the following manifestations with reasonable hope that inpatient therapy will relieve, retard, or reverse the active symptoms of the mental disorder:

i. Severe psychiatric signs and symptoms:

1) Thought disturbances including hallucinations, delusions and impaired perceptions.
2) Situational stress reactions that result in extensive interference with the individual's ability to perform activities of daily living and to function in daily routines in the community.
3) Demonstrations of disordered bizarre behavior or psychomotor retardation that prevent successful treatment at a lower level of care and interfere with the individual's ability to perform activities of daily living and to function in daily routines in the community.
4) Disorientation: A demonstration of memory impairment with impaired reality testing, poor judgment or impulse control problems that interfere with the individuals ability to perform activities of daily living and to function in daily routines in the community that are considered severe enough to endanger the welfare of the patient and/or others.
5) Mental disorders refractory to outpatient therapy such as a recurrent psychosis that is not response or a severe depression failing to respond to outpatient drug therapy.

ii. Clinical findings: Disruptions of self care and interpersonal functioning

1) The diagnosed mental illness is disabling the individual from independently attending to their basic self care needs such as food, clothing, shelter, transportation, and health care independently to the extent that it is severe enough to threaten life or vital bodily function (gravely disabled).
2) Severe impairments in interpersonal functioning such as severe social withdrawal are preventing the patient form meeting educational, occupational, legal, and recreational goals or expectations.
3) The individual is experiencing a recurrence of symptoms that are not responding to outpatient interventions and that are severely interfering with self care and/or interpersonal functioning.

iii. Clinical findings: Self harm

1) An attempt, plan, or ideation (such as depression with feelings of suicidal hopelessness) exists to engage in destructive behavior with the intent to inflict death upon him or herself. The severity of suicidality is collectively based on an assessment that includes:
    a) Seriousness of intent
    b) Degree of lethality
    c) Family history
    d) History of prior attempts
    e) Existence of a workable plan
    f) Level of impairment (intoxication or impaired rational thinking)

g) Current social support

iv. Self mutilation or reckless endangerment: The current behavior or a recent history provides evidence that there is a verbalized threat of a need/willingness to self-mutilate or become involved in other harmful high risk behaviors. The severity of self harm is determined by the following that together reveal an inability to maintain behavioral control:
1) Intent
2) Impulsivity
3) Judgment
4) Plan

v. Other self-injurious behavior: A suspicion of overdose is considered when the individual has a recent history of drug ingestion. Regardless of the need for detoxification, the individual could also require treatment of a substance induced psychiatric disorder.

vi. Clinical findings: harm to others
1) An attempt, plan, or ideation exists to engage in assaultive and destructive behavior with the intent to inflict harm upon another or others.
2) Serious assaultive behavior has occurred and there is a risk of escalation or repetition of this behavior in the immediate near future.
3) The intent to harm others is expressed and a plan is available to carry it out. The individual demonstrates an impaired level of impulse control such as might occur in response to command hallucinations, intoxication, impaired judgment, persecutory delusions, or paranoid ideation.
4) Significant destructive behavior toward property occurred in the recent past that endangered others.

vii. Clinical findings: drug/medication complications or co-existing general medical condition that requires care
1) The patient is experiencing significant side effects from prescribed psychotropic medication.
2) The patient is experiencing toxic effects from a prescribed psychotropic medication (e.g. Lithium level > 2.0 mEq/L).
3) The patient requires significant increases, decreases, or changes of psychotropic medication for stabilization and the adjustment or reinitiation of the medication requires close and continuous medical and nursing observation, supervision, or monitoring that cannot be accomplished at a less intense level of service based on the patient's condition.
4) There are concurrent physical symptoms or medical disorders that necessitate evaluation, intensive monitoring, and/or treatment, and inpatient hospitalization is recommended because the co-existing medical condition would hamper or complicate psychiatric treatment at a lower level of care.

~~3.~~**2.** Exclusion Criteria: An individual will not be considered appropriate for admission to the inpatient ~~psychiatric unit~~**BHU** if ~~one of the following is evident~~**they meet any of the following exclusionary criteria**:

a. Under age 18.
~~a.~~**b.** There is a primary substance abuse diagnosis or a dual diagnosis in which substance abuse is the primary problem at this presentation.
~~b.~~**c.** There is a primary dementia diagnosis.
~~c.~~**d.** There is a developmental disability of such an extent that the patient cannot actively participate in the therapeutic milieu.
~~d.~~**e.** The patient is not medically cleared.
f. Co-existing medical condition(s) requiring care by nursing staff with specific medical-surgical nursing competencies including but not limited to:
i. Intravenous medication

ii. **Indwelling catheter**
iii. **Tracheostomy**

g. **Unstable medical condition, i.e. chest pain, acute infectious disease, uncontrolled hypertension or blood glucose levels.**

h. **Unable to independently transfer from wheelchair or patient requiring electric wheelchair.**

~~a.~~i. There is lack of clinical evidence that would ordinarily indicate that the patient meets the severity of illness criteria.

Tri-City Medical Center
Oceanside, California

BEHAVIORAL HEALTH SERVICES

DELETE- Redundant policy, follow Patient Care Services: 72 Hour Hold, Evaluation and Treatment of the Involuntary Patient Policy

SUBJECT: Involuntary Hold Patients
POLICY NUMBER: 6340-004

ISSUE DATE: 6/97
REVISION DATE(S): 6/97, 7/00, 4/02, 8/03, 12/04, 1/05, 03/13

Department Approval:	09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	03/13
Board of Directors Approval:	03/13

~~A. Patients may be detained involuntarily for the purpose of evaluation and treatment when any person, as a result of a mental disorder, is a danger to others, to himself or herself, or gravely disabled, in accordance with the Welfare and Institutions Code, Division 5, the Lantenman-Petris-Short Act (LPS), section 5150. Only those individuals privileged to do so at Tri-City Medical Center and law enforcement official may put patients on involuntary holds. All patients being held involuntarily are afforded the same patient's rights as all other patients. According to the LPS Act, only the following functions related to the involuntary detainment of individuals are performed at Tri-City Medical Center:~~

1. ~~**72-HOUR HOLD (5150)**~~
    a. ~~Mental health professionals may detain patients on a 72-hour hold for the purpose of evaluation and treatment.~~
2. ~~**14-DAY HOLD (5250)**~~
    a. ~~After receiving an evaluation while on a 72-hour hold, individuals may be certified for not more than 14 days of intensive treatment. Individuals placed on a 14-day hold must have a second psychiatric consultation.~~
3. ~~**REISE HEARINGS**~~
    a. ~~Reise hearings may be held for any involuntary patient (either 72-hour or 14-day holds or temporary conservatorship) who may be incapable of, or resistant to giving informed consent for psychotropic medications. The hearings insure that the patient's rights are protected before receiving such medications.~~
4. ~~**WRITS OF HABEUS CORPUS**~~
    a. ~~All patients who are on legal holds (72-hour, 14-day or conservatorships) may request to leave the hospital. Upon such request, a Writ is filed on behalf of the patient and the Public Defender's office is notified. A hearing will be scheduled. At any time, the patient may withdraw their request to leave, and the Writ and hearing will be cancelled by notification to the Public Defender's office.~~

Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Management of Aggressive and Assaultive Behaviors**

ISSUE DATE: 03/08 **POLICY NUMBER:** 724
REVISION DATE(S): 08/09, 06/10, 03/13

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/13**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**
1. To provide guidelines for the management of aggressive and assaultive behavior in a careful and reflective manner that utilizes the least restrictive interventions possible in any given clinical situation.

B. **POLICY:**
1. On the occasions when a patient displays aggressive or assaultive behaviors that places him or herself, or other patients or staff in danger, the patient may require a physical intervention by the clinical staff to prevent such injury.

C. **PROCEDURE:**
1. All employees on the IInpatient BBehavioral HHealth UUnit **(BHU)** will be required to successfully complete Non--Violent Crisis Intervention (NVCI) training at the time of hire and annually thereafter as scheduled.
2. The program will also provide specific training which takes into consideration such factors as the program location, availability of staff, and proximity of assistance from outside sources.
3. An instructor who has completed a certification program in physical management or an instructor who has been trained by that individual will provide training.
4. The overall goal of physical management is to maintain the care, welfare, and safety of patients and staff as well as the integrity of the therapeutic milieu.
5. Techniques of non-violent crisis management will be employed in managing aggressive behaviors. Whenever possible, verbal interventions will occur first and these interventions will then follow the prescribed sequence form least to most restrictive.
6. When a staff member identifies a problematic circumstance, e.g. a situation that is escalating and could potentially result in injury or risk, he/she will communicate this immediately to other staff to obtain assistance and will implement the intervention most appropriate to the presenting situation.
7. All available staff, including Security Department personnel, will respond to a call for assistance by reporting to the location of the incident where they will await further instruction/assignment from the designated team leader.
8. A team leader will be identified and assignments will be made as soon as it is determined that the situation may result in a physical intervention.
    a. The team leader will be responsible to verbally direct the intervention and indicate the number of staff needed to safely manage the occurrence.

b. The team leader will communicate with other staff directly and will specifically indicate what he/she expects from each member present.

c. Staff who are not needed to safely control the patient will involve themselves, as assigned by the team leader, with removing and relocating other patients to a neutral location away from risk of injury.

9. Security officers will ~~be summoned to the program and~~ be available as a resource. Staff members will, however, make every reasonable effort to resolve the occurrence without the intervention of Security officers.

   a. When it is determined that Security may be needed, a designated staff member will ~~call and~~ provide the following information **to security**:

      i. A brief description of the patient (gender, age, height, weight), mental status as well as any other pertinent information such as pregnancy or physical infirmity.

      ii. The status of the present situation including its specific location, number of available staff and level of acuity.

      iii. The number of Security Officers it is estimated that will be needed to safely manage the situation.

      iv. The name of the team leader or an initial contact person.

   b. Officers will remove any articles that might inflict injury to self, other staff, or the patient, before responding.

   c. Officers will be given a brief update on the status of the situation upon arrival including the identified plan for intervention.

   d. The team leader will maintain responsibility for directing Security personnel and other staff members throughout the intervention and for requesting that specific interventions be utilized.

   e. If at any time during the intervention the team leader determines that the psychiatric staff cannot safely contain the situation he/she will specifically request that Security take control over the situation. At this point one Security Officer will assume the role of team leader and will direct the remainder of the intervention.

   ~~f. Chemical aerosol spray may not be used to subdue a patient.~~

10. Assigned staff will document an account of the physical management occurrence including the signs and symptoms of any significant clinical changes that may have occurred as a result of the physical management and follow up intervention to reduce or treat injury.

11. Staff will participate in a debriefing to discuss precipitants and to evaluate interventions as soon as possible after the occurrence.

12. **BHU** staff will also hold a patient debriefing session in a community meeting to allow patients who witnessed the occurrence to discuss it, ventilate their feelings and to restore an atmosphere of safety and security.

~~13. All episodes of physical intervention will be reported in accordance with the TCMC QRR process.~~

~~14.~~**13.** Any episodes that result in either patient or staff injury or a significant disruption in the milieu and those in which interventions that were used were in violation of this policy will be reported **in accordance with the Tri-City Healthcare District (TC~~MC~~HD) QRR process and** to the appropriate administrative personnel.

14. All episodes of physical intervention will require an entry in the patient's medical record. Seclusion/Restraint documentation will be completed in accordance with ~~policy as indicated~~**Patient Care Services Policy: Restraint-Seclusion for Violent-Self-Destructive Behavior**.

D. RELATED DOCUMENT(S):

~~15.~~**1. Patient Care Services Policy: Restraint-Seclusion for Violent-Self-Destructive Behavior**

Oceanside, California

Food and Nutrition Services

SUBJECT: Clinical Nutrition Dietitian Staffing

ISSUE DATE: 4/3/06
REVISION DATE(S): 10/11

Department Approval Date(s):	**02/17**
Medical Staff Department/Division Approval Date(s):	**n/a**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s): -	**n/a**
Professional Affairs Committee Approval Date(s)	
Board of Directors Approval Date(s):	

A. POLICY:
1. Clinical dietitians are scheduled to assure continuity and consistency of nutrition care provided to patients.
2. Clinical dietitians are scheduled daily to assure consistency of care to patients.
3. A dietitian is scheduled for coverage for every weekend.
4. A dietitian is scheduled for coverage for each holiday.
5. Clinical dietitians complete a nutrition assessment within 48 hours for patients identified at nutrition risk by nursing upon completion of initial admission assessment. Consults are completed by clinical dietitians within 48 hours of receipt of consult.
6. Staffing of clinical dietitians is adjusted to patient census and workload; i.e. staffing is increased on Mondays/Fridays and as needed with increase/decrease in patient census.

Oceanside, California

Food and Nutrition Services

SUBJECT:	**Nutrition Assessment ~~&~~and Care for Adult ~~&~~ Geriatric Patients**

ISSUE DATE: **03/88**
REVISION DATE(S): **06/08, 10/10, 11/11**

Department Approval:	**11/17**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**01/18**
Medical Executive Committee Approval:	**02/18**
Professional Affairs Committee Approval:	
Board of Directors Approval:	**02/12**

A. **POLICY:**

1. ~~Function:~~ A systematic method for the Registered Dietitian **(RD)** to collaborate with the physician/**Allied Health Professional (AHP)** in the assessment of nutrition status of patients, the education of patients regarding nutritional therapies, and the provision of appropriate medical nutrition therapy given the patient's medical diagnosis and assessed nutritional requirements **for patient age fourteen (14) years of age and older admitted to Tri-City** ~~Medical Center~~**Healthcare District**.
~~2. Circumstances:~~
~~3. Setting:All adult patients (age 14 years and older) admitted to or being treated at Tri City Medical Center~~
~~4. Supervision:None required~~
~~5.~~**2.** Referrals for a nutrition assessment are generated if certain criteria are met via the adult admission assessment in Compass Power Chart.
~~6.~~**3.** ~~Registered dietitians (~~RD~~)~~ will assess nutritional status of triggered patients within 48 hours of referral, considering age of patient, disease states, nutrition history, medical history, medical therapies/treatments and laboratory values.
~~7.~~**4.** ~~Registered dietitians (~~RD~~)~~ may assess nutrition status of any patient and implement an appropriate nutrition care plan, to include evaluation and recommendations for enteral and parenteral nutrition support, addition of supplements, modification of food texture, and education of patients/families regarding appropriate nutrition intervention for a particular disease state.

B. **PROCEDURE:**

1. Referrals for nutrition assessment are generated if any of the following criteria are met upon completion of the admission data base by nursing:
   a. **Greater than (>)** 75 years of age with abdominal or thoracic surgery
   b. Currently receiving **total parenteral nutrition** (TPN) or enteral feedings
   c. Unplanned weight loss of **greater than (>)** 10# in last month
   d. Hyperemesis with **greater than (>)** 10# weight loss
   e. Presence of pressure ulcer or skin breakdown
   f. Braden score of **greater than (<)** 15
   g. Eating disorder
   h. Impaired nutrient intake
   i. Nausea/vomiting/diarrhea
   j. Intake **greater than (<)** 50% of normal in the last **three (3)** days
   k. Aspiration risk
   l. **Gastrointestinal** (GI) problem other than constipation

2. ~~Registered Dietitian~~**RD** assesses all medical/surgical patients for nutrition risk upon referral. Upon completion of assessment, appropriate nutrition care plans are implemented.
3. ~~Registered Dietitian~~**RD** will review patient's medical history and current medical status.
4. ~~Registered Dietitian~~**RD** will assess patient's nutrition history, indicating patient's ability to tolerate various modes of feeding, recent intake, previous diet modification, food allergies or aversions, and appropriateness/adequacy of patient's current diet order.
5. ~~Registered Dietitian~~**RD** will document height/weight, **ideal body weight** (IBW), usual body weight and any other appropriate anthropometric measurements. Usual body weight is more useful than IBW in ill population.

Calculation of IBW	
1)	Males: 106# for first 5'; 6# for each inch over 5'
2)	Females: 100# for first 5'; 6# for each inch over 5"

   a. Body Mass Index (weight **[**~~(~~kg~~)~~**]**/height **[**~~(~~m2~~)~~**]** is determined to assess health and body fat).

Body Mass Index Body Size Classification Table	
Underweight	<18.5
Normal Weight	18.5 -24.9
Overweight	25 - 29.9
Obesity	>30
Extreme Obesity	>40

6. **Patient will be assessed for malnutrition based on current American Society of Parenteral and Enteral Nutrition (ASPEN) and Academy of Nutrition and Dietetics (AND) guidelines after assessment of weight history, appetite change, and nutrition focused physical assessment is completed.**
7. Dietitian will evaluate pertinent laboratory data to include: serum albumin, transferrin, **total iron-binding capacity** (TIBC), total lymphocyte count, hematocrit, hemoglobin, electrolytes, etc. Other pertinent laboratory data (i.e. BUN/CR, liver function tests, serum glucose levels, lipid levels) will be evaluated as necessary. ~~Causes of hypoalbuminemia include liver disease, infection, nephrotic syndrome, postoperative states, metabolic stress, inadequate protein intake, protein malnutrition, fluid imbalances, malabsorptive states, etc.~~

~~Albumin~~	
~~2.8-3.5g/dL~~	~~mild depletion~~
~~2.1-2.7g/dL~~	~~moderate depletion~~
~~<2.1g/dL~~	~~severe depletion~~

8. ~~Registered Dietitian~~**RD** will evaluate factors, which may affect nutrition intake, digestion, and absorption, including: medications, previous GI surgeries, on-going treatments, and chronic disease states, i.e. cancer or alcoholism.
9. ~~Registered Dietitian~~**RD** will confer with nursing, pharmacist, and physician/**AHP** regarding pertinent factors affecting nutrition status (medication, **intake and output** (I&O) intake, Braden Score, presence of decubitus ulcers, presence of diarrhea, vomiting, reduced oral intake, etc.).
10. ~~Registered dietitian~~**RD** will determine patients at nutrition risk based upon above assessment and to include, but not limited to, patients with actual or potential malnutrition, patients on altered diets or diet schedule, patients with inadequate nutrition intake, lactating and pregnant women, and geriatric surgical patients.
11. ~~Registered Dietitian~~**RD** will document protein/calorie and fluid requirements for patients as indicated. (See tables 1, 2, & 3).

Table 1 - Assessment of Energy Requirements		
(a)	Harris Benedict	
	Men:	66.5 + 13.75 (w) = 5.0 (h) - 6.76 (a)
	Women:	655 + 9.56 (w) = 1.85 (a) - 4.68 (a)
	Apply appropriate activity & stress factors	
(b)	20 Kcal/Kg to 25-30 Kcal/kg/d (disease specific guidelines follow)	

(c) Ireton-Jones Energy Equations:
EEE(V) = 1784- 11 (A) + 5 (W) + 244 (S) + 239 (T)
EEE(S) = 629 – 11 (A) + 25 (W) – 609 (O)
EEE = kcal/day
S = spontaneously breathing
V = ventilator dependent
A = age (years)
W = body weight (kg)
S = sex (male = 1, female = 0)
T = trauma
B = burn
O = obesity (if present = 1, absent = 0)

Table 2 - Assessment of Protein Requirements

RDA = 0.8gm/kg IBW or actual weight

*modified to reflect requirements for specific diseases and/or metabolic stress (refer to disease specific guidelines to follow and various references available in department)

Table 3 - Assessment of Fluid Requirements

30-35ml/kg (18 to 64 yrs. of age) or 1ml/Kcal

12. ~~Registered Dietitian~~**RD** will develop a nutrition care plan indicating type of nutritional support (i.e. oral, oral with supplements, appropriate enteral feeding, or suggestion of parenteral feeding) to be given and its implementation. Determination of care plan will be based on assessment. Care plan will be individualized to meet specific needs of each patient. Goals will be individually determined with delineation of methods of achievement of goals and time frames. ~~Dietitian~~ **RD** will confer with ~~MD~~ **physician** for appropriate ordering and intervention, with **register nurse (**RN) for delivery of nourishment, with pharmacy and nursing for TPN and Drug Nutrient Interaction.
13. ~~Registered Dietitian~~**RD** will monitor intake, input and output, weight, changes in medical condition and/or treatment and laboratory data and make recommendations as necessary. Intake may be monitored via calorie count. (Refer to Policy and Procedure for Calorie Count.)
14. ~~Registered Dietitian~~**RD** will document patient's reaction and tolerance to dietary regimen.
15. ~~Registered Dietitian~~**RD** will assess adequacy of enteral and parenteral feedings in relation to patient's nutritional requirements (see ~~Policy and Procedures for~~**Food & Nutrition Policies:** Enteral Feedings and **Nutrition Assessment of** TPN Patient~~s~~).
16. ~~Registered Dietitian~~**RD** may offer appropriate nutritional supplements to patients at any time when a patient is consuming less than 75% of assessed calories/protein requirements~~.~~ (see Table 1 and Table 2). Selection of appropriate supplement will be based upon assessment of patient's diagnosis, laboratory values, tolerance, and personal preference.
17. ~~Registered Dietitian~~**RD** may implement texture changes in foods when indicated based upon patient tolerance and or personal preference (i.e. regular to mechanical soft or pureed).
18. ~~Registered Dietitian~~**RD** will periodically reassess patient's nutritional status throughout hospital stay and document on Nutrition Reassessment form in Compass Power Chart every **one (1)- to seven (7)** days depending upon patient's status and individualized needs.
19. Obstetric patients will not be assessed unless ~~Registered Dietitian~~**RD** is requested to do so by Physician**/AHP/**Nurse or if patient has nutritional risk factors, i.e. "lying in" or gestational diabetes. (See **Food & Nutrition** Policy**: Nutrition Assessment of** ~~for~~ High Risk OB Patients~~.~~)

20. Behavioral Health patients will not be routinely assessed by the ~~Registered Dietitian~~**RD** unless requested to do so by Physician/**AHP**/Nurse or if patient has nutrition risk factors (see **Food & Nutrition** Policy: ~~for~~ Nutrition Assessment ~~of~~ BHU ~~patients~~).
21. Any significant change in the patient's condition, i.e. surgery, intubation, warrants a reassessment.
22. A significant change in diagnosis, i.e. cancer, warrants a reassessment.
23. Upon completion of the assessment, the dietitian will complete the initial nutrition assessment form. Additional documentation may be noted in the progress notes of the paper medical record

C. RELATED DOCUMENT(S):

1. Food & Nutrition Policies: Enteral Feedings and Nutrition Assessment of TPN Patient
~~24.~~**2. Food & Nutrition Policy: Nutrition Assessment BHU**
~~25.~~**3. Food & Nutrition Policy: Nutrition Assessment of High Risk OB Patient**
4. Nutrient Requirements for Specific Disease States

D. REFERENCE ~~LIST~~(S):

1. Gottlischlich, MM, ed in chief: *The Science and Practice of Nutrition Support: A Case Based Core Curriculum.* Kendall/Hunt Publishing Company, Dubuque, IA, 2001.
~~26.~~**2. *Manual of Clinical Dietetics*, online edition. Academy of Nutrition and Dietetics, Chicago, IL, 2017.**
3. *Manual of Clinical Dietetics*, online edition. American Dietetic Association, Chicago, IL, 2000
4. Mueller, Charles, ed in chief: *The A.S.P.E.N Adult Nutrition Support Core Curriculum.* American Society for Parenteral Enteral Nutrition; 2nd ed. edition (2012)
5. Shikora, SA, Martindale, RG, Schwaitzberg, SD, eds: *Nutritional Considerations in the Intensive Care Unit: Science, Rationale, and Practice.* Kendall/Hunt Publ Co, Dubuque, IA, 2002.

Nutrient Requirements for Specific Disease States

Disease State	Calories	Protein	Other considerations
Obesity **Critically Ill Obesity**	~~18-~~22-**25** kcal/kg ~~actual wt~~ **IBW** **BMI≥30-50:11-14kcals/kg actual wt** **BMI>50: 22-25 kcals/kg IBW**	1.2 to ~~1.5~~**2.0** gm/kg ideal wt **BMI 30-40: 2.0g/kg IBW** **BMI ≥40: up to 2.5g/kg IBW**	Consider lower protein requirements in presence of hepatic disease or renal insufficiency
Pulmonary/Respiratory	25 to 30 kcal/kg ARDS: 20 – 30 kcal/kg	1.0 to 1.5 gm/kg	Do not overfeed. If mechanically ventilated, limit CHO to 4-5 mg/kg/min. Consider small frequent feedings.
Renal	ARF: 30-45 kcal/kg CRF: 35-38 kcal/kg *may reduce requirements if wt loss desired or to avoid over-feeding in ventilated pts	Prerenal:0.6 – 0.8 gm/kg ARF: 1.0 – 1.5 gm/kg CRF: 1.0 – 1.2 gm/kg (with hemodialysis) 1.0 – 1.5 gm/kg (with peritoneal dialysis) Nephrotic syndrome: 0.8 – 1.0 gm/kg	Fluid & electrolytes as tolerated
Hepatic	Cirrhosis: 25-35 kcal/kg Hepatitis: 35 kcal/kg	Cirrhosis/hepatitis without encephalopathy: 1.0-1.2 gm/kg Cirrhosis/hepatitis with acute encephalopathy: 0.6 – 0.8 gm/kg; resume 1.0 – 1.2 gm/kg asap Cirrhosis with chronic encephalopathy: 0.6 – 0.8 gm/kg	If persistent encephalopathy, consider BCAA (hepatic formula; i.e. Nutra Hep for enteral, Hepatamine for parenteral.)
Diabetes	Needs as per normal assessment	10-20% total calories	
Cancer	25 – 35 kcal/kg, dependent upon individual patient	~~1.0 –~~ 1.5 gm/kg **Cancer cachexia: 1.5-2.5**	Consider consequences of surgery, chemo, ~~rx~~**or**~~,~~ radiation therapy.
Cardiac	25 – 30 kcal/kg	1.0 – 1.5 gm/kg	
Sepsis/critical care	25 – 30 kcal/kg Use obesity factors as applicable	1.2 – 1.5 gm/kg	Monitor glu levels; lipid levels if ventilated on propofol
Wound care	25 – 30 kcal/kg (adjusted levels as appropriate for obesity)	1.2 – 1.5 gm/kg	30 – 35 ml/kg Consider supplement with Vitamin C, zinc, Vitamin A if clinically deficient in these nutrients; evidence of clinical deficiency may be difficult to assess; thus,consider supplemental MVI with minerals.

~~27. Gottlischlich, MM, ed in chief: *The Science and Practice of Nutrition Support: A Case Based Core Curriculum.* Kendall/Hunt Publishing Company, Dubuque, IA, 2001.~~
~~28. Shikora, SA, Martindale, RG, Schwaitzberg, SD, eds: *Nutritional Considerations in the Intensive Care Unit: Science, Rationale, and Practice.* Kendall/Hunt Publ Co, Dubuque, IA, 2002.~~
~~*Manual of Clinical Dietetics*, online edition. American Dietetic Association, Chicago, IL, 2000.~~

Oceanside, California

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Women and Newborn Services
Neonatal Intensive Care Unit (NICU)

SUBJECT: **ADMISSION AND DISCHARGE CRITERIA FOR THE NICU**

ISSUE DATE: **06/07**
REVISION DATE(S): **04/09, 06/11, 8/14, 12/15**

Department Approval:	**01/18**
Perinatal Collaborative Practice Approval:	**02/18**
Medical Executive Committee Approval:	**02/18**
Professional Affairs Committee Approval:	**11/15**
Board of Directors Approval:	**12/15**

A. **PURPOSE:**
1. To define the criteria for admission to and discharge from the Neonatal Intensive Care Unit (NICU).

B. **GENERAL INFORMATION:**
1. Patients shall be admitted under the care of a California Children's Services (CCS) paneled attending neonatologist.
   a. Consult and approval from on-duty Neonatologist is required prior to admission to NICU.
   b. Patients may be admitted as a direct admission from the community, after outside provider (Pediatrician) has consulted Neonatologist and received approval.
   c. Patients presenting to the Emergency Department (ED) without Pediatrician/Neonatologist consult must be triaged and Neonatologist consulted regarding admission.
2. All admissions to the NICU are arranged with the NICU Assistant Nurse Manager and/or relief charge Registered Nurse (RN).
3. The back transport from another facility must have a completed negative Methicillin-resistant Staphylococcus Aureus (MRSA) screen prior to acceptance of admission.
4. The attending physician shall be notified of patient arrival in the unit.
5. All Patients admitted to the NICU shall have a patient history completed and documented in the patient's medical record. An initial assessment by a Physician or Allied Health Professional (AHP) shall be completed within 30 minutes of admission and documented in the Electronic Medical Record (EMR) within 24 hours of admission.
   a. This admission assessment is done and documented on all NICU admissions.
6. Ongoing assessments are completed based on the patient's acuity and documented in the patient's medical record.

C. **ADMISSION CRITERIA:**
1. Inpatient admission criteria may include, but is not limited to the following:
   a. General:
      i. Patients with gestational age less than 36 weeks.
      ii. Patients with suspected or confirmed sepsis.
      iii. Patients less than 2000 grams.
      iv. Any patient requested by a referring physician.
      v. Patients with suspected seizure-like activity.
      vi. Patients requiring a medical subspecialist.

- vii. Patients requiring advanced imaging with interpretation on an urgent basis including computer tomography, magnetic resonance imaging, and echocardiography.
- viii. Patients with suspected or confirmed genetic malformations requiring stabilization, surgical intervention and/or consultation with subspecialist.
- ix. Patients with suspected or confirmed necrotizing enterocolitis.

b. Respiratory system:
- i. Apnea requiring monitoring and observation
- ii. Respiratory instability (persistent tachypnea, grunting, cyanosis, etc.)

c. Cardiac system:
- i. Newly diagnosed or suspected arrhythmias.
- ii. Hemodynamic instability.
- iii. Suspected complex congenital heart defects.

d. Endocrine/Metabolic:
- i. Inborn errors of metabolism with acute deterioration requiring respiratory support, management of intracranial hypertension or ionotropic support.
- ii. Other severe electrolyte abnormalities such as hyperkalemia, severe hypo - or hypernatremia, hypo - or hyperglycemia requiring intensive monitoring.
- iii. Severe metabolic acidosis requiring bicarbonate infusion, intensive monitoring or complex intervention to maintain fluid balance.
- iv. Acute Intraventricular Hemorrhage (IVH).
- v. Post-hemorrhahagic hydrocephalus
- vi. Twin-to-twin transfusion
- vii. Anemia of the newborn
- viii. Hyperbilirubinemia
- ix. Thrombocytopenia

2. Outpatient Admission Criteria: Neonates may be admitted from the community as either a direct admit, or via the Emergency Department (ED).
   a. Patients up to adjusted 44 week post conceptual presenting with a diagnosis of a non-communicable nature may be admitted to the NICU at the discretion of the Neonatologist on call and depending on staff and bed availability.
   b. The patient being admitted from the community must be screened for clinical symptoms and test negative for Respiratory Syncytial Virus (RSV) and influenza.
3. Procedure for Admission via ED:
   a. ED physician consults Neonatologist.
4. Procedure for direct admits from community/home:
   a. Pediatrician or AHP consults to Neonatologist.
   b. During admission consult, give Pediatrician/AHP the NICU fax number: 760-966-2240, and request appropriate documentation as available (prenatal, birth, postnatal, outpatient information, labs)
   c. Neonatologist assesses for infectious/contagious risk factors.
   d. If no risk factors, then to admit directly to NICU.
   e. Neonatologist/Secretary to obtain best parental contact number from Pediatrician/AHP.
   f. Either Secretary or Charge Nurse is to call parent to give instructions:
      - i. Emphasize the importance of getting safely to TCMC as soon as possible for infant's admission.
      - ii. Come straight to NICU for admission, do not stop in ED. Do not check into ED.
      - iii. Obtain Translator services, if needed, to provide accurate instruction.
   g. It is preferred for the baby to come to the NICU first, and then a parent be sent down immediately to Registration.
   h. Unit Secretary or Charge RN to call registration to alert them that a parent is coming downstairs to register an infant who needs treatment ASAP.
   i. If 2 parents are present, one parent should go down to registration and one stay with the infant.

j. If baby was delivered at another hospital, have parent complete Medical Release Form and submit to the delivery facility's Medical Records Department.

D. **DISCHARGE CRITERIA:**

1. Transfer to other in-patient facility:
    a. Based on level of care required and bed availability; and/or where the infant's family lives, an infant may be transferred to a tertiary NICU for completion of care.
    b. The infant shall be referred to an attending Neonatologist.
    c. These babies may include, but are not limited to the following:
        i. Cardiac disease requiring surgical intervention and subspecialist follow up.
        ii. Patients requiring surgical intervention.
        iii. Neurologic disease needing subspecialist intervention and follow up.
2. To Home:
    a. Completion of discharge teaching.
    b. Stable cardio respiratory status. No apnea or bradycardia episodes requiring intervention within 5 to 7 days of discharge, or per physician discretion.
    c. Ability to maintain temperature without artificial heat source.
    d. Stable nutritional status and weight ≥ 1800 grams.
    e. Stable medication regimen.
    f. Completed assessment of outpatient neurodevelopmental needs.
    g. Completed Car Seat Challenge as appropriate to policy and or Physician order.
    h. Completed Hearing screening and referrals as appropriate.
    i. Completed Newborn Metabolic Screening test.
    j. Confirmed outpatient physician follow-up.

E. **REFERENCE(S):**

1. American Academy of Pediatrics. (2008). Hospital Discharge of the High-Risk Neonate: Committee on Fetus and Newborn. Pediatrics; 122 (5) 1119-1127.
2. American Academy of Pediatrics and the American Congress of Obstetrician and Gynecologists. (2017). Guidelines for Perinatal Care (8th ed.), 347-408.

Tri-City Medical Center
Oceanside, California

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Women and Newborn Services
Neonatal Intensive Care Unit (NICU)

SUBJECT: **ADMISSION AND DISCHARGE CRITERIA FOR THE NICU**

ISSUE DATE: **06/07**
REVISION DATE(S): 04/09, 06/11, 8/14, 12/15, 01/18

Department Approval:	~~**06/14**~~**01/18**
Perinatal Collaborative Practice Approval:	~~**08/15**~~**02/18**
~~**Division of Neonatology Approval:**~~	~~**08/15**~~
Medical Executive Committee Approval:	~~**10/15**~~**02/18**
Professional Affairs Committee Approval:	**11/15**
Board of Directors Approval:	**12/15**

A. **PURPOSE:**
   1. To define the criteria for admission **to** and discharge **from**~~-to~~ the Neonatal Intensive Care Unit (NICU).

B. **GENERAL INFORMATION:**
   1. Patients shall be admitted under the care of a California Children's Services (CCS) paneled attending neonatologist.
      a. **Consult and approval from on-duty Neonatologist is required prior to admission to NICU.**
      b. **Patients may be admitted as a direct admission from the community, after outside provider (Pediatrician) has consulted Neonatologist and received approval.**
      ~~1.~~**c.** **Patients presenting to the Emergency Department (ED) without Pediatrician/Neonatologist consult must be triaged and Neonatologist consulted regarding admission.**
   2. All admissions to the NICU are arranged with the NICU Assistant Nurse Manager and/or relief charge Registered Nurse (RN).
   ~~3. Patients up to adjusted 44 week post conceptual presenting with a diagnosis of a non-communicable nature may be admitted to the NICU at the discretion of the Neonatologist on call and depending on staff and bed availability.~~
   ~~4. The patient being admitted from the community must be screened for clinical symptoms of Respiratory Syncytial Virus (RSV) and influenza.~~
   ~~5.~~**3.** The back transport from another facility must have a completed negative Methicillin-resistant Staphylococcus Aureus (MRSA) screen prior to acceptance of admission.
   ~~6.~~**4.** The attending physician shall be notified of patient arriva**l**~~e~~ in the unit.
   ~~7.~~**5.** All Patients admitted to the NICU shall have a patient history completed and documented in the patient's medical record. An initial assessment by a Physician or **Allied Health Professional (** ~~Nurse Practitioner~~**AHP)** shall be completed within 30 minutes of admission and documented **in the Electronic Medical Record (EMR)** within 24 hours of admission.
      a. This admission assessment is done and documented on **all NICU** ~~patients admitted~~ **admissions.** ~~from any area of the hospital as well as transfers from other facilities.~~
   ~~8.~~**6.** Ongoing assessments are completed based on the patient's acuity and documented in the patient's medical record.

C. <u>ADMISSION CRITERIA:</u>

1. Inpatient admission criteria may include, but is not limited to the following:

a. General:

i. Patients with gestational age less than 36 weeks.

ii. Patients with suspected or confirmed sepsis.

iii. Patients less than 2000 grams.

iv. Any patient requested by a referring physician.

v. Patients with suspected seizure-like activity.

vi. Patients requiring a medical subspecialist.

vii. Patients requiring advanced imaging with interpretation on an urgent basis including computer tomography, magnetic resonance imaging, and echocardiography.

~~a.~~**viii. Patients with suspected or confirmed genetic malformations requiring stabilization, surgical intervention and/or consultation with subspecialist.**

ix. Patients with suspected or confirmed necrotizing enterocolitis.

b. Respiratory system:

~~9. Admission criteria may include but not limited to the following:~~

i. Apnea requiring monitoring and observation

ii. Respiratory instability (**persistent** tachypnea, grunting, cyanosis, etc.)

~~10.~~**c.** Cardiac system: ~~Patients with severe, life threatening or unstable cardiovascular disease. Conditions include but are not limited to:~~

~~a.~~**i.** Newly diagnosed or suspected arrhythmias.

~~b.~~**ii.** Hemodynamic instability.

~~c.~~**iii.** Suspected complex congenital heart defects.

~~11.~~**d.** Endocrine/Metabolic: ~~Patients with life threatening or unstable endocrine or metabolic disease or active life threatening bleeding. Conditions include but are not limited to:~~

~~a.~~**i.** Inborn errors of metabolism with acute deterioration requiring respiratory support, management of intracranial hypertension or ionotropic support.

~~b.~~**ii.** Other severe electrolyte abnormalities such as hyperkalemia, severe hypo - or hypernatremia, hypo - or hyperglycemia requiring intensive monitoring.

~~c.~~**iii.** Severe metabolic acidosis requiring bicarbonate infusion, intensive monitoring or complex intervention to maintain fluid balance.

~~d.~~**iv.** Acute Intraventricular Hemorrhage (IVH).

~~e.~~**v.** Post-hemorrhahagic hydrocephalus

~~f.~~**vi.** Twin-to-twin transfusion

~~g.~~**vii.** Anemia of the newborn

~~h.~~**viii.** Hyperbilirubinemia

ix. Thrombocytopenia

2. Outpatient Admission Criteria: Neonates may be admitted from the community as either a direct admit, or via the Emergency Department (ED).

a. Patients up to adjusted 44 week post conceptual presenting with a diagnosis of a non-communicable nature may be admitted to the NICU at the discretion of the Neonatologist on call and depending on staff and bed availability.

b. The patient being admitted from the community must be screened for clinical symptoms and test negative for Respiratory Syncytial Virus (RSV) and influenza.

3. Procedure for Admission via ED:

a. ED physician consults Neonatologist.

4. Procedure for direct admits from community/home:

a. Pediatrician or AHP consults to Neonatologist.

b. During admission consult, give Pediatrician/AHP the NICU fax number: 760-966-2240, and request appropriate documentation as available (prenatal, birth, postnatal, outpatient information, labs)

c. Neonatologist assesses for infectious/contagious risk factors.

d. If no risk factors, then to admit directly to NICU.

- e. **Neonatologist/Secretary to obtain best parental contact number from Pediatrician/AHP.**
- f. **Either Secretary or Charge Nurse is to call parent to give instructions:**
  - i. **Emphasize the importance of getting safely to TCMC as soon as possible for infant's admission.**
  - ii. **Come straight to NICU for admission, do not stop in ED. Do not check into ED.**
  - iii. **Obtain Translator services, if needed, to provide accurate instruction.**
- g. **It is preferred for the baby to come to the NICU first, and then a parent be sent down immediately to Registration.**
- h. **Unit Secretary or Charge RN to call registration to alert them that a parent is coming downstairs to register an infant who needs treatment ASAP.**
- i. **If 2 parents are present, one parent should go down to registration and one stay with the infant.**
- j. **If baby was delivered at another hospital, have parent complete Medical Release Form and submit to the delivery facility's Medical Records Department.**

~~12. Other:~~
- ~~a. Patients requiring a medical subspecialist.~~
- ~~b. Patients requiring advanced imaging with interpretation on an urgent basis including computer tomography, magnetic resonance imaging, and echocardiography.~~
- ~~c. Patients less than 2000 grams.~~
- ~~d. Patients with gestational age less than 35 completed weeks (35 6/7).~~
- ~~e. Patients with suspected or confirmed sepsis.~~
- ~~f. Any patient requested by a referring physician.~~
- ~~g. Patients with suspected or confirmed genetic malformations requiring stabilization, surgical intervention and/or consultation with subspecialist.~~
- ~~h. Patients with suspected or confirmed necrotizing enterocolitis.~~

~~C.~~**D.** **<u>DISCHARGE CRITERIA:</u>**

1. Transfer to other in-patient facility:
   - a. Based on level of care required and bed availability; and/or where the infant's family lives, an infant may be transferred to a tertiary NICU for completion of care.
   - b. The infant shall be referred to an attending Neonatologist.
   - c. These babies may include, but are not limited to the following:
     - i. Cardiac disease requiring surgical intervention and subspecialist follow up.
     - ii. Patients requiring surgical intervention.
     - iii. Neurologic disease needing subspecialist intervention and follow up.
2. To Home:
   - a. Completion of discharge teaching.
   - b. Stable cardio respiratory status. No apnea or bradycardia episodes requiring intervention within 5 to 7 days of discharge**, or per physician discretion.** ~~.~~
     ~~The following infants will require home cardio respiratory monitoring:~~
     - ~~i. SIDS sibling history.~~
   - c. **Ability to maintain temperature without artificial heat source.**
   - ~~c.~~**d.** Stable nutritional status **and weight ≥ 1800 grams.**
   - ~~d. Ability to maintain temperature without artificial heart source~~
   - e. Stable medication regimen.
   - **f.** Completed assessment of outpatient neurodevelopmental needs.
   - ~~f.~~**g.** **Completed Car Seat Challenge as appropriate to policy and or Physician order.**
   - **h.** **Completed** Hearing screening **and referrals as appropriate**.
   - ~~g.~~**i.** **Completed Newborn Metabolic Screening test.**
   - ~~h.~~**j.** Confirmed outpatient physician follow-up.

~~D.~~E. REFERENCE(S):

1. American Academy of Pediatrics. (2008). Hospital Discharge of the High-Risk Neonate: Committee on Fetus and Newborn. Pediatrics; 122 (5) 1119-1127.
2. American Academy of Pediatrics and the American Congress of Obstetrician and Gynecologists. (201**7**~~2~~). Guidelines for Perinatal Care (**8**~~7~~th ed.), ~~321-382~~**347-408**.

Tri-City Medical Center
Oceanside, California

WOMEN'S AND CHILDREN'S SERVICES MAN

DELETE – incorporated into Patient Care Services Policy: Special Order Durable Medical Equipment and Specialty Beds

SUBJECT: ORDERING OF DURABLE MEDICAL EQUIPMENT (DME)

ISSUE DATE: 09/06
REVISION DATE: 05/08, 04/09, 06/11, 08/12

Department Approval: 12/17
Perinatal Collaborative Practice Approval: 03/1502/18
Pharmacy and Therapeutics Approval: n/a
Medical Executive Committee Approval: 04/1502/18
Professional Affairs Committee Approval:
Board of Directors Approval:

A. **PURPOSE:**
1. To provide guidelines for case management in ordering durable medical equipment (DME).

B. **POLICY:**
1. It is the policy of Tri-City Medical Center to have a procedure in place for ordering DME for infants discharged from the NICU requiring additional home support for care.

C. **PROCEDURE:**
1. Requirements needed for the case manager to order equipment:
   a. An order must be received from the NICU **physician**MD/DO, pediatrician or **Allied Health Professional (AHP)licensed independent practitioner (LIP)**.
   b. A documented reason for prescribing the equipment shall be included in the order.
   c. Medical needs will be documented.
   d. Oxycardiogram (OCG) test results (if performed) will be documented and infant's medical record signed. **The Certificate of Medical Necessity for Apnea Monitors form is completed for Medi-Cal patients.**
   e. Facility where test was administered (if done) will be documented.
2. The case manager will arrange for the equipment to be delivered to the hospital unit prior to the infant's discharge.
3. A respiratory therapist from the DME agency will provide education on use of the monitor to the caregivers of the infant.
4. The pediatrician will follow the infant's progress.

D. **EXTERNAL LINKS:**

E. **REFERENCES:**

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

Tri-City Medical Center	Women and Newborn Services Neonatal Intensive Care Unit (NICU)
PROCEDURE:	**PATIENT ASSIGNMENT NICU**
Purpose:	To provide safe nursing care for all NICU patients based on patient needs and staff competency. To communicate and document patient assignments using consistent guidelines.
~~Supportive Data:~~	~~California Code of Regulations TITLE XXII, §70217. Joint Commission Comprehensive Accreditation Manual for Hospitals, Leadership Standards; LD 04.01.07, LD04.01.11,LD04.03.01,LD.01.03.07~~

A. **POLICY**

1. The Assistant Nurse Manager (ANM) or designee, who is a professional registered nurse, is responsible for patient care assignments at the beginning of each shift. A patient classification system is utilized. Nurse/patient ratios will be maintained to meet patient needs and Title XXII Regulations. ~~Staff floating from another unit or agency will have a TCMC NICU staff member assigned as a resource person for support.~~ The NICU Manager, ANMs or designee are responsible for monitoring appropriate patient assignments.
2. The NICU Nurse Manager has accountability for staffing and work schedules.

B. **PROCEDURE:**

1. The ANM or designee ~~utilizes~~ **determines** ~~the Cerner powerform for acuity tool to determine the number of nurses needed based on patient acuity as described in the Policy Patient classification in the NICU.~~ **the number of registered nurses for the NICU** ~~B~~based upon the information obtained **utilizing the Cerner acuity tool. This includes appropriate personnel to staff for the patient population. Reference Policy: Patient Classification in the NICU.** ~~the number of professional registered nurses are determined for the NICU including personnel with the necessary competencies for the patient population.~~
2. The ANM or designee develops the patient assignment utilizing the following criteria:
   - a. The complexity of the patient's condition and the required nursing care.
   - ~~b. The dynamics of the patient's status.~~
   - ~~c.~~**b.** The knowledge and the skill of the nursing staff member to effectively assess and care for the patient.
   - ~~d.~~**c.** The type of technology employed in providing nursing care with consideration given to the knowledge and skill required to effectively use the technology.
   - ~~e.~~**d.** The degree of supervision required by each nursing staff member based on his/her previous assessed level and current level of competence in relation to the nursing care needs of the patient.
   - ~~f.~~**e.** Relevant infection control and safety issues.
   - ~~g.~~**f.** The patient's geographical location within the NICU.
   - ~~h.~~**g.** Continuity of care by reassigning staff to patients for whom they previously provided care, **including designated primary and associate nurses.**
   - ~~i. Assigning patients to designated primary and associate nurses.~~
3. The assignment sheets include:
   - a. Date and shift
   - b. Location
   - c. Manager
   - d. ANM, or Designee
   - e. Licensed personnel
   - f. Unlicensed personnel used as support staff
   - g. Preceptees/**O**~~o~~rientees
   - h. Agency/Float personnel

Department Review	Perinatal Collaborative Practice	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors	Administration
06/14	06/14, **02/18**	n/a	n/a	10/14	09/10, 08/12, 11/14	

4. Document the Following on the assignment sheet:
   a. Each patient assigned to an RN. The following positions may be utilized to assist the RN assigned to the patient and should be indicated on the assignment sheet:
      i. An RN with a partial assignment
      ii. Assignment/Break Nurse
      iii. Charge Nurse
      iv. ANM
      ~~v. NICU Manager~~
      ~~vi. Clinical Educator~~
      ~~vii. Clinical Nurse Specialist~~
   b. Indicate the name of the TCMC NICU nurse assigned as a resource nurse**/preceptor** ~~for float or agency nurses assigned to the unit for that shift.~~**as appropriate.**
   c. Document break/~~-and~~ meal times ~~and coverage,~~ and when necessary, in-service/meeting times on the break/meal log form **per current labor laws and TCMC policy. All employees working a shift of six hours or more will receive an unpaid meal period of 30 minutes.** -Meal ~~breaks~~ **period breaks** are extended over enough hours to minimize the number of nurses out of the unit requiring coverage.
   d. Document the name of the RN providing relief.
   ~~d.~~**e.** Orientees are not utilized as direct care providers without supervision by ~~competent licensed~~ TCMC NICU **RN** staff**.**
   ~~e.~~**f.** Update the assignment sheet as patients are admitted or discharged, when a patient's acuity changes, and as personnel and/or assignments change.
   ~~f.~~**g.** The assignment sheets are archived by the TCMC NICU Nurse manager or designee. The archived sheets will be retained for the period of time as prescribed by the regulatory agencies.
5. Staffing for Periods of High Census
   a. The NICU will maintain a staffing strategy in order to accommodate staffing needs when census is high.
   b. The manager and designee (e.g. assistant nurse manager (ANM)/relief charge nurse) will make all attempts to use NICU core staff in an effort to provide consistency of care. Only nurses who are NRP certified can float to NICU. RNs that are floated to the NICU will only take care of CCS defined continuing care patients that do not require higher levels of care or competencies, (i.e., ventilator support, NCPAP, central lines or impending invasive procedures). Competencies of care will be documented for patient assignment.
   c. An RN who floats to NICU shall be assigned a resource nurse who may or may not be the ANM/relief charge nurse. On occasions when treatment modalities that the float RN does not feel competent performing arise unexpectedly, the resource nurse will perform the tasks for the float RN or the ANM/relief charge nurse will reassign the patient to ensure safe care.
   d. NICU will typically only take floats when there are appropriate acuity patients that can be assigned to them. Pre-booking through registry can be done during times that normally require a higher number of staff.
   e. Travelers are required to have the same competencies as the core staff in NICU. Attending high-risk deliveries is optional, especially for those who are only committed for a short time. Travelers may be given the opportunity to orient to high-risk deliveries, if requested.

C. **<u>REFERENCE(S):</u>**

1. California Code of Regulation, Title 22: Social Security, Volume 28, Revised, November 29, 1996. Barclays Law Publishers, South San Francisco, CA.
2. California Children's Service Manual of Procedures, Section 3.25.2.A2C

Tri-City Medical Center	Women and Newborn Services Neonatal Intensive Care Unit (NICU)

PROCEDURE:	**PATIENT CLASSIFICATION (ACUITY) IN THE NICU**
Purpose:	The purpose of the Patient Classification System and tools is to determine the nursing care needs of the individual NICU patients that reflect the assessment by the professional registered nurse The framework for the Patient Classification system is the AACN Synergy Model for Patient Care that the needs or characteristics of patients and families influence and drive the characteristics or competencies of nurses. Synergy results when the needs and characteristics of a patient, clinical unit or system are matched with a nurse's competencies.
~~Supportive Data:~~	~~California Code of Regulations TITLE XXII, Section 70053.2~~ ~~Joint Commission Comprehensive Accreditation Manual for Hospitals, Leadership Standards~~

A. **CARE PROVISION:**

1. Synergy Model for Patient Care: The **Tri-City Healthcare District (TC~~MC~~HD)** model for nursing care that links clinical practice with patient outcomes:
2. Levels of Care: Categories that define the intensity of care requirements for individual patients based on the profession registered nurse's assessment. The levels of care follow a decreasing level of intensity:
   a. Level 10 -1 RN to 1 patient
      i. Care Intensity 1:1 — High ADL Needs
      ii. Care Intensity 1:1 — Moderate ADL Needs
      iii. Care Intensity 1:1 — Minimum ADL Needs
   b. Level 9 - 1 RN to 2 patients
      i. Care Intensity :High Care Needs — High ADL Needs
   c. Level 8 -1 RN to 2 patients
      i. Care Intensity High Care Needs — Moderate ADL Needs
   d. Level 7 -1 RN to 2 patients
      i. Care Intensity High Care Needs — Minimum ADL needs
   e. Level 6 – 1 RN to 3 patients
      i. Care Intensity Moderate Care Needs — High ADL needs
   f. Level 5-1 RN to 3 patients
      i. Care Intensity Moderate Care Needs — Moderate ADL needs
   g. Level 4– 1 RN to 3 patients
      i. Care Intensity Moderate Care Needs — Minimum ADL needs
   h. Level 3– 1 RN to 3 patients
      i. Care Intensity Minimum Care Needs — High ADL needs
   i. Level 2– 1 RN to 3 patients
      i. Care Intensity Minimum Care Needs — Moderate ADL needs
   j. Level 1– 1 RN to 3 patients
      i. Care Intensity Minimum Care Needs — High ADL needs
   k. Please see Appendix A and B for additional information concerning Levels of care

B. **RESPONSIBILITIES:**

1. The NICU Manager, Assistant nurse managers (ANMs) or designees are responsible to ensure that the professional registered nurse complete the Patient Classification for their patient(s) each shift.
2. The NICU Manager and/or the ANMs will ensure that the Patient Classification system for the NICU is utilized accurately.
3. Nursing is responsible for Patient Classification utilizing the Cerner Acuity Powerform.

Department Review	Perinatal Collaborative Practice	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
01/14	03/14, **02/18**	n/a	n/a	10/14	11/14

C. **PROCEDURE:**

1. The professional registered nurse determines each patient's care intensity and activity of daily living (ADLs) indicators based on the RN knowledge of the patient status, the plan of care for the patient and the nursing assessment.
   a. The Care Intensity indicator is defined by minimal, moderate, high, 1:1 and 2:1 levels
   b. The ADL indicator is defined by minimal, moderate and high
   c. Each care intensity and ADL indicator is specific to the NICU and has a weight associated to it that assists in determining the acuity of the patient.
2. A task will be triggered each shift to the professional registered nurse for each patient assigned. It is the responsibility of the professional registered nurse to complete the acuity of their assigned patients.
3. The ANM or designee is responsible to verify that the Acuity Powerform is completed for each patient each shift.
4. The ANM or designee will complete the Staffing Calculator by 1500 and 0300 which reflects the acuity of the patient(s) as completed by the professional registered nurse(s) and the minimum number of staff required based on acuity and minimum staffing ratios
5. This information is submitted electronically to Staffing Resource Center if completed by the time previously specified.
   a. If the information is late in being completed the ANM or their designee is responsible for faxing a copy of their daily summary reports to the Staffing Resource Center as soon as possible.
6. The Manager, ANM or designee reviews the required staffing based on the Patient Classification tool and the actual staffing used.
7. Trends and patterns are analyzed by the NICU Manager. Problems related to balancing ratios will be brought to the Director and CNE attention. Information will be used to plan future staffing needs.

D. **INTER-RATER RELIABILITY PROCESS:**

1. Inter-rater reliability is defined as the degree to which two observers, operating separately and independently, assign the same care level rating to the patient
2. The purpose of this process is to ensure consistency among the registered nurses in the interpretation and use of the Patient Classification (Acuity) powerform.
3. Each shift a task will be triggered by Cerner to the ANM or designee to complete an Acuity Validation on patients in the NICU.
   a. The task is set to randomly pick 2 NICU patients
4. The information is monitored on a monthly basis and reported as appropriate
5. The NICU manager is responsible for ensuring completion of the validation tasks.

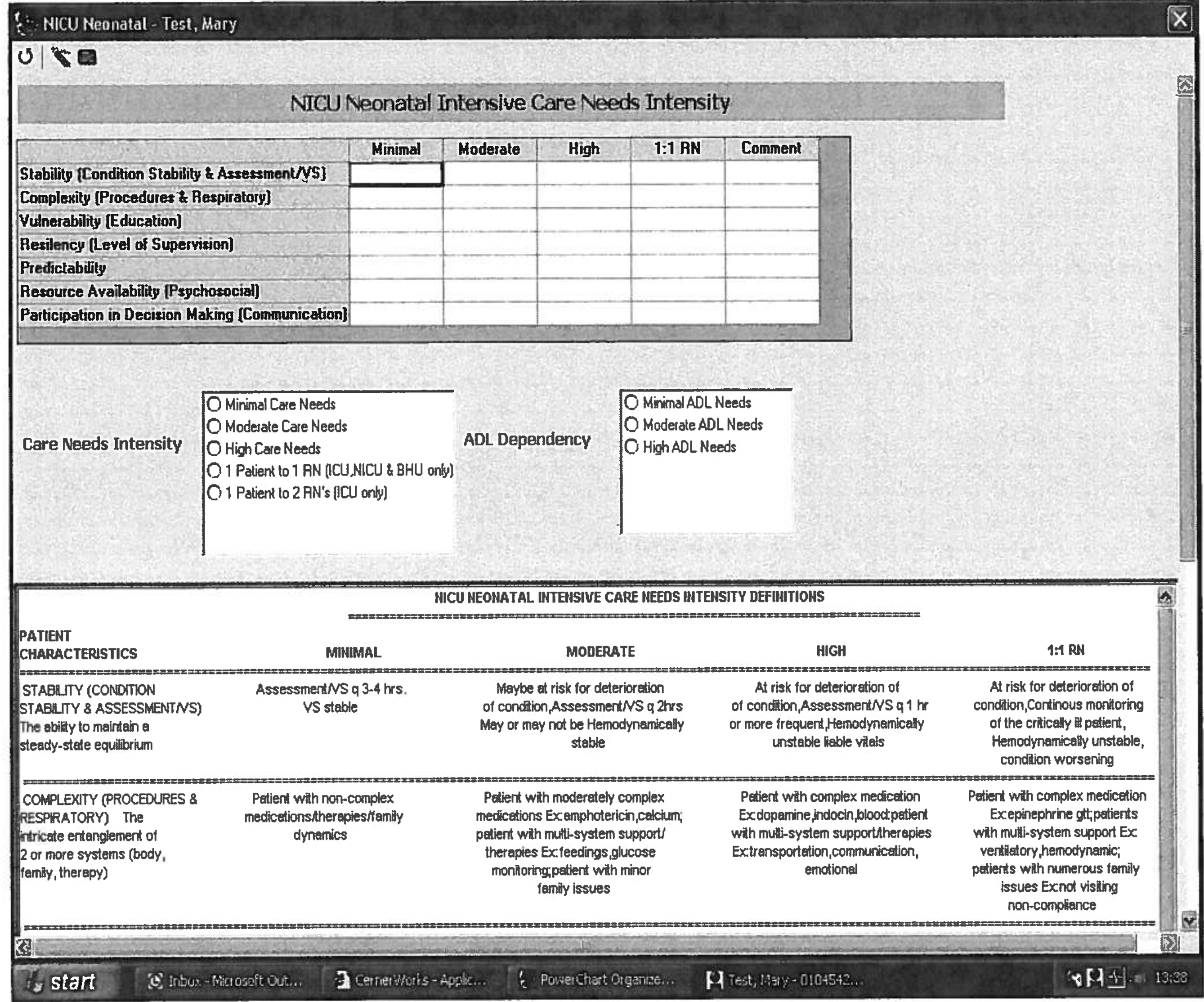
E. **ATTACHMENT(S):**

1. NICU Neonatal Intensive Care Needs Intensity
2. Care Needs

F. **REFERENCE(S):**

1. Hardin, S.R., & Kaplow, R., (2005). *Synergy for Clinical Excellence: The AACN Synergy Model for Patient Care*. Jones and Bartlett. Sudbury, Ma.

NICU Neonatal Intensive Care Needs Intensity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NICU Neonatal Intensive Care Needs Intensity

	Minimal	Moderate	High	1:1 RN	Comment
Stability (Condition Stability & Assessment/VS)					
Complexity (Procedures & Respiratory)					
Vulnerability (Education)					
Resiliency (Level of Supervision)					
Predictability					
Resource Availability (Psychosocial)					
Participation in Decision Making (Communication)					

Care Needs Intensity
- ○ Minimal Care Needs
- ○ Moderate Care Needs
- ○ High Care Needs
- ○ 1 Patient to 1 RN (ICU,NICU & BHU only)
- ○ 1 Patient to 2 RN's (ICU only)

ADL Dependency
- ○ Minimal ADL Needs
- ○ Moderate ADL Needs
- ○ High ADL Needs

NICU NEONATAL INTENSIVE CARE NEEDS INTENSITY DEFINITIONS

PATIENT CHARACTERISTICS	MINIMAL	MODERATE	HIGH	1:1 RN
STABILITY (CONDITION STABILITY & ASSESSMENT/VS) The ability to maintain a steady-state equilibrium	Assessment/VS q 3-4 hrs. VS stable	Maybe at risk for deterioration of condition,Assessment/VS q 2hrs May or may not be Hemodynamically stable	At risk for deterioration of of condition,Assessment/VS q 1 hr or more frequent,Hemodynamically unstable liable vitals	At risk for deterioration of condition,Continous monitoring of the critically ill patient, Hemodynamically unstable, condition worsening
COMPLEXITY (PROCEDURES & RESPIRATORY) The intricate entanglement of 2 or more systems (body, family, therapy)	Patient with non-complex medications/therapies/family dynamics	Patient with moderately complex medications Ex:amphotericin,calcium; patient with multi-system support/ therapies Ex:feedings,glucose monitoring;patient with minor family issues	Patient with complex medication Ex:dopamine,indocin,blood;patient with multi-system support/therapies Ex:transportation,communication, emotional	Patient with complex medication Ex:epinephrine gtt;patients with multi-system support Ex: ventilatory,hemodynamic; patients with numerous family issues Ex:not visiting non-compliance

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Care Needs

CARE NEEDS	ADL	ACUITY	CHARGE CODE
Minimum	Minimum	1	NICU 3 Level 1
Minimum	Moderate	2	NICU 3 Level 1
Minimum	High	3	NICU 3 Level 1
Moderate	Minimum	4	NICU 5 Level 1
Moderate	Moderate	5	NICU 5 Level 1
Moderate	High	6	NICU 7 Level 1
High	Minimum	7	NICU 7 Level 1
High	Moderate	8	NICU 9 Level 2
High	High	9	NICU 9 Level 2
1:1	Minimum	10	NICU 10 Level 3
1:1	Moderate	10	NICU 10 Level 3
1:1	High	10	NICU 10 Level 3

Tri-City Health Care District
Oceanside, California

DELETE: Follow Hospital Policies

OUTPATIENT INFUSION CENTER ~~- OCEANSIDE POLICY MANUAL~~

ISSUE DATE: 032/13

SUBJECT: INFECTION PREVENTION AND CONTROL ACTIVITES

REVISION DATE:

Department Approval:	06/16
~~MEDICAL/DEPARTMENT:~~	~~3/13~~
~~DIRECTOR APPROVAL:~~	~~3/13~~
Division of Oncology Approval:	03/17
Infection Control Committee Approval:	10/17
Pharmacy and Therapeutics Approval:	01/18
Medical Executive Committee Approval:	02/18
Professional Affairs Committee Approval:	
Board of Directors Approval4:	03/13

~~A. **PURPOSE:**~~

1. ~~A multidisciplinary team performs infusion related procedures. The department uses therapeutic medication and blood products. Percutaneous or vascular route of administration is the prior mode of therapy.~~
   a. ~~Aseptic Techniques~~
      i. ~~Wipe work surfaces with hospital-approved disinfectant before setting up.~~
      ii. ~~If a sterile field needed, it is prepared as close to the time of use as possible.~~
   b. ~~Sharps~~
      i. ~~Sharps safety devices are used whenever possible.~~
      ii. ~~Contaminated sharps are disposed of in a puncture resistant container as soon as possible.~~
      iii. ~~If a puncture-resistant container is not immediately accessible, there is a designated place on the field for temporary holding until the case has been completed.~~
   c. ~~Injection Safety~~
      i. ~~Are prepared for one patient only, any remaining contents are discarded. Vials of medication used are discarded immediately following the procedure.~~
      ii. ~~Use aseptic technique to avoid contamination of sterile injection equipment.~~
      iii. ~~Do not administer medications from a syringe to multiple patients even if the needle or cannula on the syringe is changed. Needles, cannulae and syringes are sterile, single-use items; they should not be reused for another patient nor to access a medication or solution that might be used for a subsequent patient.~~
      iv. ~~Use fluid infusion and administration sets, (i.e., intravenous bags, tubing and connectors) for one patient only and dispose appropriately after use. Consider a syringe or needle/cannula contaminated once it has been used to enter or connect to a patient's intravenous infusion bag or administration set.~~
      v. ~~Use single-dose vials for parenteral medications whenever possible.~~
      vi. ~~If multi-dose vials must be used, both the needles or cannula and syringe used to access the multi-dose vial must be sterile.~~
      vii. ~~Do not keep multi-dose vials in the immediate patient treatment area and store in accordance with the manufacturer's recommendations; discard if sterility is compromised or questionable.~~
      viii. ~~Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients.~~

ix. Infection control practices for special lumbar puncture procedures wear a surgical mask when placing a catheter or injecting material into the spinal canal or subdural space (i.e., during myelograms, lumbar puncture and spinal or epidural anesthesia.

x. Do not bend, recap, or break used syringe needles before discarding them into a sharps container

d. After the Procedure

i. Only items dripping with blood are discarded in red bio hazardous waste.

ii. Blood product containers should be disposed in red bio hazardous waste.

e. Cleaning

i. The procedure room is terminally cleaned between patients (see Environmental Services policy and procedure manual).

ii. Staff immediately cleans up spills of blood and/or body fluids with hospital-approved disinfectant.

f. Transmission Based Isolation Precautions

i. If a patient has a multi-drug resistant organism such as MRSA or VRE, any room surfaces they may have touched will be cleaned with a hospital-approved disinfectant prior to the next patient.

ii. Patients on airborne or droplet isolation precautions will wear a surgical mask. In accordance with OSHA regulations, employees will use N95 respirators and a portable HEPA unit for patient with known or suspected aerosol transmissible diseases. These cases should be scheduled at the end of the day when possible.

g. Perform Hand Hygiene and Wear Clean Gloves Before Handling Tubing

i. Urinary catheters: do not elevate the urine bags above the bladder in order to reduce the incidence of reflux back into the bladder.

ii. Intravenous therapy: take care not to dislodge or contaminate IV sites and lines.

h. Linen Handling

i. Handle contaminated textiles and fabrics with minimum agitation to avoid contamination of air, surfaces, and persons.

ii. Bag or otherwise contain contaminated textiles and fabrics at the point of use.

iii. Use leak-resistance containment for textiles and fabrics contaminated with blood or body substances.

B. **REFERENCES:**

1. APIC Text of Infection Control and Epidemiology. Wash. DC, 2009.**Grota, P. (Ed.). (2014) APIC Text of Infection Control and Epidemiology (4th ed). Washington DC: Association for Professionals in Infection Control and Epidemiology, Inc.**

2. Sehulster LM, chin RYW, Arduino MUJ, Carpenter J, Donlan R, Ashford D, Besser R, Fields B, McNeil MM, Whitney C, Wong S, Juranek D, Cleveland J. Guidelines for Environmental Infection Control in Health-Care Facilities. Recommendations from CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Chicago IL; American Society for Healthcare Engineering/American Hospital Association; 2004.

3.**1.** Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf.

Tri-City Medical Center	~~Pharmacy Manual~~**Patient Care Services**

PROCEDURE:	**AUTOMATED DISPENSING MACHINE**
Purpose:	To define the operation of the Automated Dispensing Machine (ADM), roles of the personnel authorized to access the ADM, resolution of discrepancies and analysis of the medication usage through the ADM.
Issue Date:	06/00

A. **PROCEDURE:**

1. System Access:
    a. Nurse Directors or their designees, and Credentialing Staff from the Medical Staff Office are authorized to submit a Pyxis System Access Request form to request access to the **Automated Dispensing Machine** (ADM). The pharmacists, Medstation System Specialist, Pharmacy Technician Supervisor, and Controlled Substance Technician have the privileges to enter a permanent user into the ADM (See Pyxis System Access Request Form).
    b. The User **identification** (ID) will be the first three **(3)** letters of the last name followed by the first three **(3)** letters of the first name (e.g. Mary Smith SMIMAR). If that user name is taken, a single numeric digit will be added starting with one (1).
    c. First time users will be prompted to change their password the first time they sign onto the system. Passwords must be five **(5) to** ~~-~~eight **(8)** characters long (may be alpha or numeric or alpha-numeric). After selecting a permanent password, the user will register a fingerprint for the "Bio ID" Pyxis function. Thereafter, the user will log onto the Pyxis Medstation with the User ID and fingerprint. All users are set up for Bio ID which is the preference, but may be switched to password ID if problem arises with Bio ID.
    d. Users who forget their passwords will need to report to the pharmacy in person with their hospital ID badge.
    e. ADM privileges, areas of the hospital, security groups, override capabilities and console privileges are defined by the ~~users~~**user's** job title.
    f. Access to ADMs will be assigned by work areas. These will be:
        i. Nurses who float outside their normal areas shall have their permanent password activated at the new ADM by the **Assistant Nurse Manager** (AN~~U~~M) **or Relief Charge Nurse**, Administrative **Supervisor**~~Coordinator~~ **(AS)**~~, charge nurse~~ or pharmacist.
        ii. Traveler nurses will be granted a permanent password with locations and a **thirteen** (13) week expiration date, unless their term date is less than **thirteen** (13) weeks.
        iii. Registry nurses will be assigned a permanent password with no ADM locations. They will be activated at the station each time they work. The temporary activation remains in effect for **fourteen** (14) hours.
    g. Human Resources will notify the Pharmacy Manager, Medstation System Specialist, and Controlled Substance Technician via email when a nurse has separated from the hospital.
    h. Medical Staff Office will notify via email to the Pharmacy Manager when a physician is separating from the hospital.
    i. The Medstation System Specialist is the primary person responsible for deleting users from the system. The Pharmacy Manager and Controlled Substance Technician serve as an alternate in the event the Medstation System Specialist is not available.
    j. In addition to the Human Resources notifications, ADM users are routinely reviewed to ensure only current ~~TCMC~~**Tri-City Healthcare District (TCHD)** employees, Anesthesiologists, Nurse Travelers, Nurse Instructors, and Registry Staff have privileges to access to the system. This is done monthly by comparing the ADM user list against a

Department Review/~~Revision~~	Clinical Policies & Procedure	Nurse Executive Committee	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Administration	Board of Directors
10/02, 11/03, 07/06, 05/15, **12/17**	**01/18**	**01/18**	07/05, 07/06, 07/09, 01/12, 05/15, **01/18**	07/05, 07/06, 07/09, 01/12, 07/15, **02/18**		08/15	07/05, 07/06, 07/09, 01/12

current list of TC~~MC~~**HD** active employees, Traveler, Anesthesiologist, and nurse instructors.

k. Nursing personnel shall notify the Pharmacy Department when a unit which contains an ADM is closing. Once notification is received, the ADM shall be de-activated. De-activation of the ADM will prevent utilization of the system. When the unit is reopening, nursing personnel shall notify the Pharmacy and the ADM shall be reactivated.

2. Medication Access:
   a. Removal of medications from the ADM:
      i. Sign onto the ADM, go to the "Patient Care" section of the main menu.
      ii. Select "Remove" button.
      iii. Select a patient. Scroll using arrows on the side of the screen or type in the first three **(3)** letters of the patient's last name.
      iv. Using the patient's **medication administration record (**MAR**)** as the reference, search for the medication by type in the first three **(3)** letters of the drug name. If the medication is ~~"~~gray~~"~~, it means the pharmacist has reviewed the order but the medication is not loaded or is out of stock in the ADM.
      v. Select the quantity to be removed. This must be accurate for billing and inventory purposes.
      vi. If more than one **(1)** med is to be removed for this patient press 'Select Next Med' and repeat the process.
      vii. Press the 'Remove Now' button.
      viii. Verify beginning med count if prompted.
      ix. All ADM stored controlled substances have the 'Blind Count' option activated that required the user to enter the correct beginning count of a medication before removal. The system does not display the expected beginning count. The user is given two **(2)** attempts to enter the correct beginning count. If an incorrect quantity is entered on the first try, a second attempt is permitted and a warning banner is displayed that informs the user that a discrepancy is about to be created. If an incorrect quantity is entered on the second attempt, a discrepancy is created as the transaction is completed, and a discrepancy slip is printed for incorrect quantity as well as for the removal.
      x. For controlled substances, there is an option of wasting part of the dose upon removal (see waste section)
      xi. Remove the med from the correct pocket.
      xii. Conclude the removal process by verifying the patient name, medication and remove quantity on this final screen against the MAR, then shut the drawer.
      xiii. Press the 'Exit' button to log off the system.
   b. Clinical Data Screens:
      i. Clinical Data Screens appear between the select quantity screen and the opening of the drawer. These are intended to alert the practitioner about some aspect of the medication (e.g. Coumadin has significant drug-nutrient interactions which require~~s~~ patient/family education). The practitioner **may be**~~is~~ required to select a response and press the 'Accept' button before the drawer will open.
   c. Patients:
      i. When the patient has not been officially admitted or transferred to the nursing unit by the hospital **admission, discharge, and transfer (**ADT**)** system, (s)he will not appear in the ADM~~.~~ (e.g. when Affinity is down). Patients added at the ADM without the billing number will not have a Pyxis Profile available. To add a patient:
         1) From the list of patients press the 'Add Patient' button.
         2) Type in the patient's last name, first name and patient ID if known. If the patient's name is not known, type in 'Doe' for the last name and 'Jane or John' for the first name. If the patient ID is unknown, leave blank.

3) The patient added at the MedStation will show for 24 hours. Once the ADT information comes across to Pyxis, that patient will show up twice in the ADM. Only the patient entry from the ADT system (usually the one with the proper account number) will have the profile of medications. The patient manually entered at the ADM will not have a medication profile.
4) Billing for patients manually entered at the ADM will be done by the pharmacy.
5) Press the 'Exit' button to log off the system.
~~6) Menu timeout for ADMs on nursing stations are set at 60 seconds.~~

d. Wastage:
i. Wastage can be done at the time of removal or after the removal transaction. **If a witness is required,** ~~T~~the person witnessing the wastage shall confirm the correct medication and amount wasted in addition to documenting the transaction in the **ADM**~~Pyxis~~ system.
ii. **See Tri-City Medical Center (TCMC) Waste Disposal Guidelines for appropriate disposal of medication that is being wasted including controlled substances.**
iii. To waste at time of removal
1) After the quantity is selected, press the 'Remove Now' button.
2) The next screen that appears will ask if ~~you plan to administer~~ a full dose **will be administered**. If yes, the drawer opens and you proceed to remove the medication. If no, the system will identify the medications that require a witness for waste, press 'Accept'.
3) Another licensed person will be required to enter their user ID and password to document as a witness.
a) Approved licensed health care professional
i) Anesthesiologist
ii) Registered Nurse
iii) Licensed Vocational Nurse
iv) Respiratory Care Practitioner
v) Radiology Technician
vi) Pharmacist
~~3)~~**vii) Pharmacy Technician**
4) Enter the amount to be given and the amount wasted is automatically calculated.
5) Press the 'Accept' button.
6) Press the 'Exit' button to log off the system.
iv. To waste after removing:
1) From the main menu select 'Waste'.
2) Select the patient by typing in the first three **(3)** letters of the patient's last name. **A list of medications removed in the past 24 hours will appear.**
~~3)~~**a)** If the patient you want is not listed, select 'Add Patient' and manually enter the patient (see adding patients at the station).
3) Select the med**ication** to be wasted from the list.
a) If the medication does not appear on the list, select 'All Meds'.
i) Use for wasting controlled substances that were not removed from same Pyxis
~~4)~~**b)** For multiple wastes, press 'Select Next Med'~~, You may~~ make multiple selections **if needed.**
~~5)~~**4)** Once all medications have been selected, press 'Waste Now'.
~~6)~~**5)** The system will identify the medications~~,~~ that require a witness for waste, press 'Accept'.

a) **When** ~~T~~the witness screen **appears**~~comes next.~~ **then** ~~H~~have **the** witness enter their User ID and Password.

~~7)~~**b) Upon completion of documentation, both staff signing for waste must properly dispose of excess medication based on the current TCMC Waste Disposal Guidelines.**

c) When wasting PCAs, drips or epidurals the waste amount will be in milliliters

d) Narcotic PCA syringes will be wasted using the same procedure as above.

e) Morphine drips will be wasted using the Narcotic Drip entry.

~~8)~~**f) To waste a fentanyl patch, estimate the amount used and document in Pyxis then fold the patch so that the adhesive side adheres to itself, then discard in the appropriate container per TCMC Waste Disposal Guidelines.**

~~9)~~**6)** Enter the amount given;~~,~~ the system will calculate the waste. If the entire dose is wasted and the patient needs to be credited, press the 'Credit Patient' button.

~~10)~~**7)** Press the 'Accept' button.

~~a) Special Note: Narcotic PCA syringes will be wasted using the same procedure as above. Morphine drips will be wasted using the Narcotic Drip entry. To waste a fentanyl patch, estimate the amount used and document in Pyxis then fold the patch so that the adhesive side adheres to itself, then discard in the appropriate container.~~

a) Press the 'Exit' button to log off the system.

e. Returns:

i. From the Main Menu, select the 'Return' button.

ii. Select the patient. Scroll using arrows on the side of the screen or type in the first three **(3)** letters of the patient's last name.

iii. Select 'Remove Meds' to view previously removed meds or select 'All Meds' to view a complete list of meds.

iv. Search for the medication using the first three **(3)** letters of the drug name and select.

v. Verify or enter the number of meds returning.

vi. Select 'Return Now' or for multiple returns select 'Select Next Med'.

vii. Press the 'Exit' button to log off the system.

viii. Medication removed from the ADM~~,~~ not administered~~,~~ and still intact**,** shall be returned to the ADM 'Return Bin' with the exception of refrigerated and some designated controlled substance medication. If the medication is a controlled substance and is too large to fit in the return bin slot, it must be wasted through Pyxis and the patient credited by touching the 'credit' button or **by** contact**ing** the pharmacy for immediate pick up. For non-controlled medications that are too large, place into the 'Return to Pharmacy' bin.

f. Override Process:

i. When overriding a medication which has not been reviewed by the pharmacist, the nurse is responsible for screening allergies, appropriate dose/route/frequency and all other relevant clinical criteria.

ii. The ADM utilizes an override feature whereby a nurse may obtain a newly ordered medication not yet entered into the system by the Pharmacy.

iii. The Pharmacy Department will manage the list of medications that may be overridden in the ADM based on their use in emergent/urgent situations. Not all medications are eligible for override.

iv. Medications shall be removed through override access only if the indication is deemed by the healthcare provider to be urgent or emergent. All healthcare

providers that use the override function are expected to use professional judgment to determine appropriateness.

1) Urgent Indications: include those in which significant patient harm could result from a delay secondary to a pharmacist's review of the order.
2) Emergent Indications: include situations in which life, limb or eyesight is threatened.
3) In each individual case, the need for the override must outweigh the risk of omitting the pharmacist's review of the order.

v. To access a medication through the override function:

1) At the ADM Profile Screen, press the override button at the bottom of the screen.
2) Type in the first three **(3)** letters of the medication.
3) Select the medication.
4) Proceed as instructed above to remove the medication.

vi. If the medication does not appear on the Pyxis override screens, the nurse does not have access to the medication and must call the pharmacist or Administrative Supervisor.

vii. An override report is generated on a daily basis and includes the patient name, drug, strength, amount taken, date/time and name of the nurse withdrawing the medication. A pharmacist reviews this report and reconciles override medications with physician orders. Any overrides without orders will be brought to the attention of ~~the Medication Safety Officer and~~a Nurse Manager for follow up. **Should the pharmacist require assistance in following up on any overrides without orders, they may contact the Medication Safety Officer.**

viii. Critical Override gives the nurse the ability to override for any medication currently located in the ADM. This function will be turned on at each station during emergencies such as network failure.

g. Controlled Drug Discrepancy:

i. Nursing is responsible for reconciling all ADM discrepancies prior to the end of a shift per the Patient Care Services Policy: Controlled Substance Management. Pharmacy staff can be utilized to run reports and assist with resolution.

ii. If the discrepancy was caused my pharmacy personnel, then Pharmacy is responsible for resolving the discrepancy.

iii. The pharmacy monitors for open discrepancies that have been unresolved for greater than 24 hours. The Controlled Substance Technician will contact the Nurse Manager or Charge Nurse to make them aware of the need to resolve the discrepancy immediately. If no action is taken, the matter will be escalated to the Medication Safety Officer.

iv. Documented Discrepancies are reviewed daily to ensure all documented discrepancies have been resolved accurately and confirm no controlled substances are unaccounted for.

v. If during the course of a discrepancy investigation controlled substances are unaccounted for, further appropriate action shall be taken. This could include an audit of individuals and reporting to appropriate agencies.

vi. Nurses shall perform a physical inventory of all controlled substances as stated in Patient Care Services Policy: Controlled Substance Management.

3. ADM Inventory and Formulary:

a. The Pyxis Console automatically prints refill lists, stock outs and new loads for each MedStation.

b. Pharmacy technicians **will** refill and load the ADMs with stock from the main pharmacy inventory.

c. Medications that need to be refilled or have stocked out, shall be verified and initialed by two (2) technicians or technician and a pharmacist prior to leaving the pharmacy.

d. New loads will be verified and initialed by a technician and pharmacist prior to leaving the pharmacy.
e. Licensed pharmacy personnel will load or refill the medication(s) in the correct pocket(s) of the appropriate ADM.
f. The Medstation System Specialist in conjunction with a pharmacist will review the usage of medications for each ADM ~~twice a year~~**on an ongoing basis** and adjust minimum/maximum levels, establish new standard stock medications if indicated, ~~and~~ **and** remove medications that have not been used recently and are not standard stock.
g. When medication stock outs occur, the pharmacy technician is encouraged to look at the present minimum and maximum levels and adjust if needed, using the following table as a guideline:
   i. Inventory Max and Min Levels (10 day usable inventory with a max/min ratio of 50%)

Max Level	**Min Level**
100	50
80	40
60	30
50	25
40	20
30	15
20	10
10	5
Patches	
6 (every day)	3
3 (every week)	1

h. Pharmacy personnel are responsible for utilizing the outdated med tracking function any time a medication is placed in the ADM.
i. An Outdated Inventory Report is run daily and pharmacy technicians shall utilize this report to remove all medications that are expiring in the near future.

4. Narcotic Vault (C-II Safe):
   a. All controlled substances (C-II through C-V) will be managed through the C-II Safe. Controlled substances which require refrigeration shall be placed in locked containers within a refrigerator. All other controlled substances shall be secured in the C-II Safe.
   b. Only Pharmacy personnel will have access to the C-II Safe.
   c. Controlled substances received from the drug wholesaler will be received into the C-II Safe by the Pharmacy Technician Supervisor or designee.
   d. All CII Safe receive reports are compared against the invoice by the Pharmacy Buyer.
   e. All controlled substances sent to a nursing floor will be placed in the ADM. Controlled substances removed from the Nursing Unit ADMs will be immediately returned into the C-II safe.
   f. All controlled substances used for compounding in the **intravenous** (IV) room will be managed through the C-II Safe.
   g. An inventory of the CII Safe shall be done monthly by the Controlled Substance Technician and a witness which may be any pharmacy personnel.
   h. Expired controlled substances that are awaiting pick up from a reverse distributor shall be placed in the expired/waste bin of the CII Safe and kept segregated from the rest of the inventory.

5. Downtime Procedures:
   a. All ADMs, the C-II Safe and the Pyxis Console will be plugged into red emergency plugs. Nursing shall contact the Pharmacy when an ADM is not functional.
   b. When facing the back of the MedStation:
      i. Key PL985 will unlock the left side and the refrigerator units.
      ii. Key PL981 will unlock the right side.

iii. ~~and~~ Key 6234 will unlock the computer lid.
iv. There is one set of back panel keys in the C-II Safe at all times which can be accessed by pharmacy personnel.
~~b.~~v. If the hospital emergency power is not functioning the pharmacy has enough back panel keys for every Pyxis MedStation. These extra keys along with the keys to unlock the doors to the C-II Safe will be kept in the Director of Pharmacy's office. The Director of Pharmacy or Pharmacy Technician Supervisor will need to be called to access these keys.

c. All medications removed from the ADM will be accounted for in the patient's chart as soon as chart is accessible.
d. Two **(2)** licensed personnel will perform controlled substance counts upon initiation of the ADM downtime procedure and at the end of each shift. The initial controlled substance count and all subsequent controlled substance activities will be recorded on a 'Daily Audit and Disposition for Controlled Drugs' Form ~~(see Attachment II)~~. Discrepancies will be resolved before any staff members are allowed to leave the unit.
e. Once the MedStation becomes functional, pharmacy personnel will update the inventory counts and capture charges. Two **(2)** nurses will inventory all controlled substances, reconcile against the 'Daily Audit and Disposition for Controlled Drugs' Form and resolve any discrepancies.
f. When interface communication is lost between the Pharmacy Computer System and ADM or the ADM console and the ADM, all new orders, changes in orders, admits, transfers and discharges will not be updated. If this condition lasts for more than **three (3)** hours, the ADM will be set to Critical Override so the licensed personnel can override any medication available in the ADM.

6. Reports:
   a. Override Reports are run daily.
   b. All C-II Safe Events - ~~Run~~**Ran** daily and kept on file for **three (3)** years. Fulfills Board of Pharmacy requirements.
   c. Charges and Credits- Run daily, billing is processed by the Medstation System Specialist for patients manually entered at the ADM. These billing adjustments are made directly into the hospital host computer system.
   d. Documented Discrepancy Report- Run daily
   e. C-II Safe vs. Pyxis MedStation Compare- Run throughout the day by staff accessing the CII Safe and reviewed by the Controlled Substance Technician.
   f. C-II Safe Activity Log- Run daily and reviewed by the Controlled Substance Technician for unusual occurrences. This report is kept on file for **three (3)** years.
   g. C-II Safe Open Discrepancy- Run daily (M**onday -through Friday**) and reconciled by the Controlled Substance Technician.
   h. Suggested Reorder Report- Run every Monday and Thursday by Pharmacy Buyer or designee.
7. Data Archival:
   a. A redundant copy of all information is automatically stored on a hard drive within the C-II Safe.

B. **FORM(S):**
   1. Pyxis System Access Request Form
   ~~1.~~**2. Daily Audit and Disposition for Controlled Drugs Form**

C. **RELATED DOCUMENT(S):**
   1. Patient Care Services (PCS) Policy Controlled Substance Management
   ~~1.~~**2. Waste Disposal Guidelines**

Pyxis System Access Request Form

PYXIS SYSTEM ACCESS REQUEST FORM
(To be completed by Unit Manager, Director, Administrative Coordinator)

USER IN FORMATION:

____________________, ____________________ __________
Last Name First Name MI

Job Code: ____________________ (RN, LVN, Anesthesiologist, RT, Nurse Instructor, OR Tech, Radiology Tech, Psych Tech, Pharmacist, Pharmacy Tech)

Work Area(s): ____________________

SYSTEMS:

If only Supply Station send form to MDC, if Med and/or Supply send form to the Pharmacy Pyxis Specialist.

☐ Supply Station

☐ Med Station

PRIVILEGES: *Med and override privileges based on user category and work area.

☐ AUM, Shift Supervisor- Station login, witness ability, report access, activate/create temp users, credit patients, add temporary patients, independent refill.

☐ Staff RN, LVN- Station login, witness ability, report access, credit patients, add temporary patients.

☐ Temp/Traveler- RN privileges with 13-week expiration.

☐ Other- RT, Anesthesiologist, Radiology tech, Psych Tech, Pharmacist, Pharmacy Tech.

☐ Registry RN- Station Login, witness ability, report access, credit patients, add temporary patients.

____________________ ____________________ __________
Approval: Signature Print Name Date

Pharmacy/Supply Use Only:

User ID: ____________________

Initial Password (Med Station only): ____________________

TCMC Waste Disposal Guidelines

Regular Waste NO NEEDLES	Biohazardous Waste NO NEEDLES	Sharps NEEDLES OK	Pharmaceuticals NEEDLES OK	Controlled Substances NO NEEDLES	RCRA Pharmaceuticals NO NEEDLES	Chemo/Hazardous Waste NEEDLES OK IN BIN, NOT BAG
▫ Empty IV bags, Piggyback bags/tubing without PHI or PHI covered ▫ Empty medication vials without PHI or PHI covered ▫ Trash ▫ Dressings ▫ Chux ▫ Diapers ▫ Sanitary napkins ▫ Gloves ▫ Empty foley bags and other drainage bags ▫ Disposable patient items ▫ Empty irrigation syringes ▫ Empty syringes (without needles) **NO PHI**	▫ Blood and all OPIM (Other Potentially Infectious Material) ▫ Blood tubing/ bags/hemovacs/ pleurevacs ▫ Intact glass or plastic bottles with bloody fluid or OPIM ▫ Suction liners with bloody fluid or OPIM ▫ Soaked/dripping bloody dressings ▫ All disposable items soaked or dripping with blood or OPIM When in doubt, use red bag.	▫ **All sharps** *Example: needles (including needles from insulin pens), lancets, broken glass vials, ampules, blades, scalpels, razors, pins, clips, staples* ▫ Trocars, introducers, guide wires, sharps from procedures etc.	▫ Syringes, needles, tubexes, carpujects with pourable medication (pourable means there is enough liquid to pour it out, not just residual amount) ▫ Partially used or wasted prescription or over-the-counter medication *Examples: vials, tablets, capsules, powders, liquids, creams/lotions, eye drops, suppositories, patches (fold in half)* ▫ Inhalers with no propellants *Examples: Advair, Foradil* **NO PHI**	**ALL Controlled Substances and propofol ONLY** ▫ Solid controlled substances -Tablets, capsules, suppositories, lozenges, and patches. Fold patch in on itself prior to disposal ▫ Liquid controlled substances -Intravenous & oral ▫ Propofol **No needles, syringes, ampules, vials, bottles, or tubing** **NO PHI**	**EPA designated R.C.R.A. Pharmaceuticals only:** *Examples:* ▫ *Insulin/Insulin Pen (needles removed)* ▫ *Inhalers -only those w/ propellant e.g Ventolin, Atrovent, Flovent, Symbicort* ▫ *Warfarin /Coumadin* ▫ *Used & Unused nicotine gum or patches, (include empty wrappers)* ▫ *Silver sulfadiazine cream* ▫ *Silver nitrate applicators (unused)* ▫ *Selenium sulfide shampoo* ▫ *Multiple trace elements* ▫ *Unused& residual alcohol/acetone/acetic acid* **No Needles** **NO PHI**	**Trace Chemo:** All supplies used to make and administer chemo medication *Example: tubing, empty bags/ bottles/ vials, syringes, needles, pads, wipes, contaminated gloves, gowns, masks etc.* **Hazardous Waste:** All supplies used to make and administer hazardous meds. **Bulk Chemo:** Return to pharmacy all unused bulk chemo in original pharmacy bag for disposal into RCRA container **NO PHI**

All bins picked up on regularly scheduled basis. Chemo/Hazardous Bin supplied by Materials (X3330). RX Destroyer and all other bins supplied by EVS (760-644-6973) If additional pick up is needed: M-F 0600-1100 page 760-926-0972. At all other times: call EVS at 760-644-6973

References: http://cwea.org/p3s/documents/DHS%20Guidance%20Pharmacy%20Waste%20from%20Hospitals.pdf; County of San Diego Department of Environmental Health Hazardous Materials Division; Stericycle Healthcare Environmental Resource Center, Epinephrine Fact Sheet http://www.dtsc.ca.gov/LawsRegsPolicies/Title22/upload/Ch11_Art4.pdf

Revised Date: 04/2017 pharmacy

Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 04/73	SUBJECT: Licensure and Professional Standards

REVISION DATE(S): 06/05, 07/06, 07/09, 01/12, 07/15

Department Approval:	~~05/15~~12/17
Pharmacy & Therapeutics Committee Approval:	~~06/05, 07/06, 07/09, 1/12, 05/15~~01/18
Medical Executive Committee Approval:	~~06/05, 07/06, 07/09, 1/12, 06/15~~02/18
Professional Affairs Committee Approval:	07/15
Board of Directors Approval:	~~06/05, 07/06, 07/09, 1/12,~~ 07/15

A. **POLICY**:

1. The Pharmacy Department will operate within all applicable state and federal laws, regulations and licensure requirements. In matters of professional judgment or practice standards, recommendations from the American Society of Health-System Pharmacists (ASHP) and The Joint Commission will be given first consideration and priority.
2. State of California: (Example)
    a. Pharmacy Department services will be provided according to the regulations of the Department of Health Services as stated in Title 22 for licensed acute care hospitals. These requirements will be integrated into policies and procedures where necessary.
        i. Pharmaceutical Services Definition (section 70261)
        ii. Pharmaceutical Services General Requirements (section 70263)
        iii. Pharmaceutical Services Staff (section 70265)
        iv. Pharmaceutical Services Equipment and Supplies (section 70267)
        v. Pharmaceutical Services Space (section 70269)
    b. All laws, regulations and licensure requirements of the California State Board of Pharmacy will be met and followed.
        i. The hospital's Pharmacy Department will have at all times a valid and current pharmacy permit issued by the board which will be posted in public view.
        ii. All Pharmacists, Pharmacist Interns and Pharmacy Technicians must maintain valid and current licensure with the board according to law and hospital policy. ~~A photocopy of license verification will be kept in the HR personnel file.~~
        iii. All Pharmacists, Intern Pharmacists, and Pharmacy Technicians shall renew licensure per Administrative Policy: Monitoring Licenses, Professional Registrations, and Certificates 430.
        iv. A current copy of State Pharmacy Law with Rules and Regulations is available on the California Board of Pharmacy website.
3. Federal:
    a. The hospital will comply with all laws, regulations and requirements of the Drug Enforcement Administration (DEA).
        i. The hospital will maintain current and valid registration with DEA. The registration certificate will be posted in public view in the Pharmacy.
        ii. All required records will be maintained by the Pharmacy Department, including order forms (DEA-222), disposal (DEA-41), loss (DEA-106) and the biannual inventory.
        iii. In accordance with DEA regulations, all schedules II, III, IV and V (CII, CIII, CIV & V) drugs will be stored separately in a locked cabinet in the main Pharmacy,

automated drug dispensing machines on the patient care units or double-lock storage cabinets in ancillary areas. Access is restricted to licensed personnel.~~,~~

b. The Pharmacy Department will comply with the Conditions of Participation for Medicare of the Centers of Medicare and Medicaid Services.

4. Practice Standards:

a. Dispensing: A Pharmacist will review each medication prior to dispensing. Exceptions to this can be found in the Pharmacy **Policy:** Technician Checking Technician Program. ~~Policy~~

b. Staffing Guidelines: The ratio of Pharmacy Technicians to Pharmacists will not exceed **two to one** (2:1), except that this ratio shall not apply to personnel performing clerical functions pursuant to California Code of Regulations and the ratio of Intern Pharmacists to Pharmacists will not exceed **two to one** (2:1) at any time.

B. <u>RELATED DOCUMENT(S):</u>

1. Administrative Policy: Monitoring Licenses, Professional Registrations, and Certificates 430
~~1.~~2. **Pharmacy Policy: Technician Checking Technician Program**

C. <u>EXTERNAL LINK(S):</u>

1. **California State Board of Pharmacy** <u>http://www.pharmacy.ca.gov/</u>
2. **Pharmacy Law Book with Rules and Regulations (2017).** ***California State Board of Pharmacy*** <u>http://www.pharmacy.ca.gov/laws_regs/lawbook.pdf</u>

D. <u>REFERENCE(S):</u>

1. **Pharmaceutical Services Definition, Title 22 California Code of Regulations Division 5 § 70261.**
2. **Pharmaceutical Services Equipment and Supplies, Title 22 California Code of Regulations Division 5 § 70267.**
3. **Pharmaceutical Services General Requirements, Title 22 California Code of Regulations Division 5 § 70263.**
~~3.~~4. **Pharmaceutical Services Space, Title 22 California Code of Regulations Division 5 § 70269.**
~~4.~~5. **Pharmaceutical Services Staff, Title 22 California Code of Regulations Division 5 § 70265.**

Oceanside, California

PHARMACY~~-MANUAL~~

ISSUE DATE: 06/80	**SUBJECT:** Medication Preparation
REVISION DATE: 06/05, 07/06, 07/09, 01/12, ~~5~~07/15	**POLICY NUMBER:** 8390-4102

Department Approval:	~~05/15~~12/17
Pharmacy & Therapeutics Committee Approval:	~~06/05, 07/06, 07/09, 1/12, 05/15~~01/18
Medical Executive Committee Approval:	~~06/05, 07/06, 07/09, 1/12, 06/15~~02/18
Professional Affairs Committee Approval:	07/15
Board of Directors Approval:	~~06/05, 07/06, 07/09, 1/12,~~ 07/15

A. **POLICY**:

1. Whenever possible, only those medications which are commercially available and/or in single-unit packages and in ready-to-administer form will be used.
2. For medications not commercially available in unit dose form, medications will be repackaged from bulk containers into single unit packages so that they may be used in a unit dose system whenever possible.
3. All medications are prepared in a safe manner.

B. **PROCEDURE**:

1. To prevent contamination of medications prepared by the Pharmacy Department~~,~~ and ~~to prevent~~ medication errors, the following guidelines will be followed in the preparation of medications:

- ~~1.~~**a.** The medication preparation and packaging operation will be isolated, to the extent possible, from other pharmacy activities.
- ~~a.~~**b.** The preparation area will be maintained in a clean and uncluttered manner, functionally separate area for product preparation to minimize the possibi**lity**~~e~~ of contamination.
- ~~b.~~**c.** Pharmacists and technicians will prepare only one (1) drug product at a time. No drug products other than the one being repackaged or prepared will be present in the immediate preparation area. No ~~other~~ labels other than for the product being repackaged should be present in the area.
- ~~c.~~**d.** Pharmacists and technicians shall use clean or sterile techniques as appropriate to the medication being prepared. For injectable products, see Pharmacy Policy: Sterile Product Preparation.
- ~~d.~~**e.** All unused labels (if separate labels are used) should be removed from the immediate preparation area.
- ~~e.~~**f.** The integrity of the product being prepared and medications ready to dispense will be examined for evidence of damage, contamination, or other deleterious effects.
- ~~f.~~**g.** The Pharmacist will be readily accessible to Pharmacy Technician staff during medication preparation.
- ~~g.~~**h.** Unit dose packages and labels will comply with law and regulation standards. See Pharmacy Policy: Labeling Standards.
- ~~h.~~**i.** Expiration dates will be checked and verified on all products prior to dispensing.
- ~~i.~~**j.** High-risk medications will be stocked and stored in a way that minimizes the likelihood of an error occurring during preparation and distribution.
- ~~j.~~**k.** All medications will be packaged and stored in a temperature-and humidity-controlled environment to minimize degradation caused by heat and moisture. ~~A relative humidity of 75% at 23 °C should not be exceeded.~~ Packaging materials should be stored in accordance with the manufacturer's instructions and any applicable regulations.

~~k.~~l. Applicable **Federal Drug Administration** (FDA) and **United State Pharmacopeia** (USP) requirements concerning the type of package required for specific drug products will be followed.

~~m. To optimize medication preparation and dispensing and to reduce the likelihood of medication preparation and dispensing errors, the Pharmacy Department utilizes a computerized order entry system and automated storage and distribution system.~~

~~n. The Pharmacy computer system includes special alerts/staff reminders identifying problematic drugs such as high-alert medications, look-alike and sound-alike drug names or medications with complicated/problematic packaging or labeling.~~

A. RELATED DOCUMENT(S):

1. **Pharmacy Policy: Sterile Product Preparation**
~~o.~~2. **Pharmacy Policy: Labeling Standards**

Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 03/06

SUBJECT: Receiving and Tracking Narcotic Pump Refills Prepared by Outside Vendors

REVISION DATE(S): 03/06, 07/09, 01/12, 09/15

Department Approval:	~~06/15~~12/17
Pharmacy & Therapeutics Committee Approval:	~~03/06, 07/09, 1/12, 07/15~~01/18
Medical Executive Committee Approval:	~~03/06, 07/09, 1/12, 08/15~~02/18
Professional Affairs Committee Approval:	09/15
Board of Directors Approval:	~~03/06, 07/09, 1/12,~~ 09/15

A. **PROCEDURE**:
1. Narcotic pump refills for Tri-City Healthcare District **(TCHD)** patients will be processed in the following manner:
   a. The outside vendor will be instructed to always deliver the medication to TCHD inpatient pharmacy.
   b. All medications will be signed in on the sheet located on the C-II safe.
   c. All medication will then be ~~signed in~~**received into** the Pyxis C-II safe in the following manner:
      i. Go to 'increase meds'
      ii. Go to 'receive meds'
      iii. Type 'narcotic pump refill outside RX'
      iv. Type quantity under 'acq. qty' field
      v. Under 'Vendor' box, hit drop down arrow and select appropriate vendor
      vi. Enter the RX # in the invoice field
      vii. In the DEA-222 field, type patient's name
      viii. Hit the '+' (plus sign)
      ix. Select Save
      x. Place the vendor invoice (or the Pyxis load receipt if invoice not available) on the pharmacy buyer's desk
         1) Write patient's full name on C-II safe printout
         2) Write drug and dose on C-II safe printout
2. Medication sent to stations will be signed out in the following manner:
   a. Go to 'Decrease Meds'
   b. Go to 'Send Meds'
   c. Select location or floor med will be delivered to
   d. Select 'narcotic pump refill outside RX'
   e. Type the quantity of med being sent
   f. Select the '+' (plus) sign
   g. Check the 'print on save' box
   h. Hit the save key
      i. Write patient's full name on C-II safe printout
      ii. Write drug and dose on C-II safe printout
      iii. Return sheet to Pharmacy Buyer's desk

Oceanside, California

PROGRESSIVE CARE UNIT (PCU)

ISSUE DATE: **NEW**

SUBJECT: ~~**Custody**~~**Safety Awareness for Justice Involved Patients**

REVISION DATE(S):

POLICY NUMBER: 002

Department Approval:	**12/17**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**02/18**
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**

1. To identify the state of California (CA) law enforcement agencies and Tri-City ~~Medical Center~~**Healthcare District**'s (TC~~MC~~**HD**) rules for the well-being of hospital employees when providing care for outpatient and inpatient justice involved **(JI)** patients.

B. **DEFINITION(S):**

1. ~~Justice Involved (JI)~~ /Custody Patients – patients held involuntarily through operation of law enforcement authorities.
2. Correctional Officer (CO) – an employee of the **CA Department of Corrections and Rehabilitation (**CDCR**)**.
3. Deputy- an employee of the San Diego **(SD)** County Sheriff Department Detention Facilities.
4. ~~3.~~**4.** **Law Enforcement Personnel – any sworn Officer recognized by the County, State or Federal Government that authority to detain a citizen.**
5. ~~4.~~**5.** Law Enforcement Restraint Devices – ~~"~~restraint devices used by law enforcement officials for custody, detention, and public safety reasons~~"~~ (**per the** Department of Health and Human Services).

C. **POLICY:**

1. ~~Justice involved~~**JI** patients have the same rights as all patients with certain safety considerations. These safety considerations are identified by **regulatory agencies, TCHD,** the CDCR**, the** ~~and~~ SD Sheriff Department **and all Law Enforcement agencies**.
2. ~~Justice involved~~**JI** patients will be escorted throughout the hospital **with** two (2) ~~correctional~~ **Law Enforcement** officers ~~or Sheriffs~~ at all times.
3. ~~3. Hospital staff must abide by the laws of the State of CA and the rules TCMC has devised for the well-being of the staff.~~
4. ~~4.~~**3.** Hospital staff must:
   a. Display a professional attitude and demeanor at all times.
   b. Follow the instructions and advice of the ~~CO and Deputies~~ **Officers** related to safety issues at all times and ask if you are not sure of a circumstance.
      i. The ~~COs and Deputies~~ **Law Enforcement Officers** are responsible to ensure the safety of the public, and the JI/~~custody~~ patient.
   c. Avoid placing yourself~~, a CO, or Deputy~~ **or an Officer** in danger by not adhering to this policy.
   d. Follow the instructions and advice of the ~~CO/Deputy~~ **Officer** related to safety at all times. Ask questions if uncertain.
5. ~~5.~~**4.** Safety Behaviors:
   a. Be aware of your surroundings at all times.
   b. Do not leave anything within hands/arms reach of a patients.

c. Be mindful of seemingly innocuous objects such as cardboard, paper, plastic, pens, **toothbrushes,** paperclips~~,~~ (these items may be used as weapons).
   i. Items such as tissue boxes (remove the tissue from the box); do not leave the box with the patient.

d. Do not walk too close or in between patient who is out of their room and ~~a CO or Deputy~~ **a Law Enforcement Officer.**

e. Cell phones and other personal electronic devices are not allowed **out** on the **Progressive Care Unit** (PCU). They are to be left at home or in a locker. Staff will be required to lock up any device that is found on their person while working on the PCU.

f. No one is allowed to photograph a JI/~~custody~~ patient or an officer at any time.

~~g. Do not engage of horseplay or similar behavior with custody patients **or Law Enforcement Officer**~~

~~h.~~**g.** Staff assigned or floating to the PCU will adhere to TC~~MC~~**HD**'s dress code and the following:
   i. No item shall be worn around the neck this includes a necklace**, ID tag holder or** ~~and~~ stethoscope.
   ii. Law Enforcement has asked that TC~~MC~~HD PCU staff do not wear solid orange or solid navy blue scrubs as these resemble clothing worn by JI individuals.
   ~~ii.~~**iii.** No provocative dress this includes but is not limited to:
      1) Low cut tops **and/**or cleavage revealing shirts, scrub tops, blouses, etc.
      2) Sheer, see through, revealing, tight, **and/**or short skirts, ~~/~~dresses~~/~~, pants **and/**or scrubs.
   ~~iii.~~**iv.** Long hair shall be tied or pulled back using ~~r~~ hair clips at all times ~~during~~ when assigned to patient care. Braids may not hang down and must be no longer than shoulder line.

D. **ENTERING AND LEAVING ~~A~~ PATIENT ROOMS:**

1. ~~Deputy~~ **Designated Officer** must enter occupied room ahead of staff. ~~Deputy/CO~~ **Officer** will remain in room at all times while staff is providing patient care.
   a. Address the ~~custody~~ **JI** patient by their last name.
   b. Never refer to a ~~custody~~ **JI** patient using endearing words such as honey, dear, or sweetie or by their first name.
2. Before entering patient room, consider the items you may have that may be considered potentially dangerous. ~~Do not take items in patient room that are not required to provide care. .~~
3. Do not take items into a JI/~~custody~~ patient's room that are not required to provide care of that particular patient.
   a. Items that you do not need immediately shall be placed outside of the patient's room on a table.
4. Never leave needles, syringes, scissors, thermometers, razors, pens, combs, wrappers from supplies, dressing supplies or paperclips in a patient's rooms. **Use caution when hanging glass intravenous (IV) vials. If accidentally dropped ensure that all pieces have been collected. Contact environmental services to clean and sweep floor.**
5. Remove and discard all items including ~~intravenous (~~IV~~)~~ tubing, IV bags, bandages, **oxygen** **(O_2) tubing,** etc. in a trash receptacle outside of patient's room.
6. Always scan the room, floor, bed, patient, and bedside table before leaving the room.
7. Do not place anything in the trash receptacle in the patient's room. Discard all trash outside of the patient's room.

E. **MEDICATION ADMINISTRATION:**

1. Medications may only be administered by licensed staff. See ~~TCMC~~ **Patient Care Services:** Medication Administration ~~Policy~~. Approved nursing students:
   a. May administer oral medications only **under the direct supervision of a TC~~MC~~HD registered nurse (RN).**
   b. May not start ~~intravenous~~ **IV** lines~~.~~.

c. May not perform invasive procedures.

2. ~~COs or Deputies~~**Officers** may not administer or handle medications of any kind.
3. Do not leave medications unattended in patient's room.
4. Ensure you observe the patient swallowing the medications before leaving the room.
   a. You may ask the patient to open their mouths to ensure the medications are swallowed and not pocketed under their tongue or buccal.
   b. If medications are not properly swallowed (i.e.~~,~~ found in the buccal or under the tongue~~,~~ or you cannot validate the patient swallowed the medication)~~;~~, notify a**n Officer** ~~CO or Deputy~~ immediately.
5. Intermittent IV medications; i.e.~~,~~ IV piggybacks (IVPB):
   a. When IVPBs are complete, remove the medication tubing from the room, and discard in the appropriate trash receptacle outside of the patient's room.

F. **MEAL TRAYS:**

1. Do not serve ~~custody~~ **JI** patients food items between regular scheduled meal times.
   a. Exceptions: crackers may be given if a medication is to be administered with food or if ordered by physician for obstetrics (OB) patients.
   ~~a.~~**b.** **Upon order by the physician, patients may receive snacks or other food item. Inform the** ~~custodial~~ **Officer that an order has been written.**
2. Breakfast, lunch, and dinner will be the only food served.
   a. Exceptions will be made with a physician's order.
3. Sodas, ice cream, milk, juices, or other snacks will not be served without a physician's order.
   a. Patients are not allowed to have snacks between meals or make request for meals.
      i. Exceptions: **OB patients,** vegetarian or vegan.
4. Meal trays may be distributed by staff to patients after they are inspected by a**n Officer** ~~CO or Deputy.~~
   a. Eating utensils must be checked and approved by ~~Cos or Deputy~~ **an Officer.**
      i. Straws, metal silverware, and alcohol-based hand wipes are not allowed in patient rooms.
   b. Meal trays are left in patients' room per the ~~CO or a Deputy's~~ **Officers** instructions.
5. Meal trays may be removed from patient rooms after the tray is inspected. ~~by a CO or Deputy~~
   a. Patients are expected to eat their meals within 30 minutes.
6. **Nothing by mouth** (NPO) patient trays may be held in the kitchen. Trays may not be left in the medication room, nursing station, or in patient rooms.
7. Special Considerations:
   a. Patients admitted for swallowing foreign objects may not have small items such as juice boxes, straws, paper wrappers, or condiments left on their trays.
8. Hunger Strikes:
   a. Hunger Strike: California Department of Corrections and Rehabilitation Policy and the Division of Correctional Health Care Services, Chapter 22 or SD County Sheriff Department, depending on incarceration status, **have policies that address hunger strikes. The TC~~MC~~HD primary care RN will follow** ~~TCMC~~ **the Progressive Care Unit Policy: Hunger Strike: Justice Involved Patients** ~~policy~~ **regarding hunger strikes.**

G. **COMMUNICATION WITH ~~JUSTICE INVOLVED~~ YJI PATIENTS:**

1. All communication concerns shall be communicated to the PCU Manager or designee immediately.
2. Do not discuss personal affairs.
   a. **P**~~p~~atients do not have a reason to know any of your personal information.
   b. Keep your relationship with patients professional.
3. Do not trade, sell, barter, lend or otherwise engage in any other personal transactions with custody patients.
4. Do not directly or indirectly give or receive from patients or member of the patient's family anything in the nature of a tip, gift, or promise of a gift **as this may be considered a violation of the law and you may be prosecuted.**~~.~~

5. Be mindful of the fact that they can hear your conversations with other staff in and outside of their room.
6. If touching a patient is not necessary, stay at arm's length when speaking to them.
7. Never argue with patient. Inform the ~~CO/Deputy~~ **Officer** of any conflict. It is the ~~CO/Deputy's~~ **Officers** responsibility to manage conflicts.
   a. If a patient becomes argumentative, leave the room.
   b. If a patient asks for extra pain medications educate patient they you can only give what is ordered by the physician.

H. **INAPP~~O~~ROPRIATE BEHAVIORS BY CUSTODY PATIE~~I~~NTS:**
1. If a patient becomes uncooperative with medical treatment or exhibits inappropriate behavior, leave the room and ensure the appropriate ~~CO or Deputy~~ **Law Enforcement Officer** is informed.
2. Do not accept compliments or inappropriate gestures from patients.
3. Report incidents to the ~~COs or Deputies~~ **appropriate Law Enforcement Officer** immediately.

I. **RESTRAINT OR SECLUSION:**
1. Only TC~~MC~~**HD** employees may implement, apply, and monitor JI/~~custody~~ patients requiring restraint for non-violent-/-non self-destructive behavior.
2. Patients requiring Non-Violent Restraint:
   a. RNs providing care for patients requiring non-violent restraint shall follow ~~TCMC~~**Patient Care Services Policy:** Restraints, Used for Non-Violent/ Non-Self-Destructive Behavior ~~policy~~.
3. Patients requiring presenting with behaviors that are violent:
   a. RNs providing care for custody patients with violent behaviors shall inform the appropriate ~~CO or Deputy~~ **Officer** immediately.
   b. If restraint is required, implement the **Patient Care Services Policy:** Restraint/- Seclusion for Violent/Self-Destructive Behavior~~, Policy~~.
4. ~~COs and Deputies~~ **Law Enforcement Officers** may restrain custody patients using Law Enforcement Restraint Devices. TC~~MC~~**HD** employees may not assist ~~COs or Deputies~~ **Law Enforcement Officers** with the application **or removal** of the following law enforcement restraint devices:
   a. Handcuffs
   b. Manacles
   c. Shackles
   d. Chain-type restraint devices
   e. Restrictive devices used by law enforcement officials

J. **INCOMING CALLS:**
1. Calls received regarding a patients shall be directed to a ~~CO or Deputy~~ **Law Enforcement Officer.**
2. When asked questions by telephone regarding a patient, the standard answer is "I have no information on this patient".
3. Inform ~~CO/ Deputy~~ **a Law Enforcement Officer** and PCU Manager of any unusual telephone calls.

K. **VISIT~~I~~ORS:**
1. JI/~~custody~~ patients will not generally have visitors unless prior arrangements and special circumstances dictate, TC~~MC~~**HD** must be notified of special circumstances.
2. Visitors must be approved through the institutional visitor's process and must comply with the PCU visitation practices which include removal of all personal items, this includes but is not limited to the following:
   a. Coats
   b. Jackets
   c. Purses

d. Backpacks

3. All staff and visitors must check in with a**n** ~~C~~**Officer**.
4. Only visitors allowed per the ~~CO or Deputy~~ **appropriate Law Enforcement agency** are allowed on the unit.
5. Visitors allowed on the unit will be identified and escorted on the unit as appropriate.

L. **DIALYSIS PATIENTS:**

1. The primary RN assigned to the patient will inform the dialysis RN of the following:
   a. Do not enter the room without ~~a CO or Deputy~~ **an Officer.**
   b. Only items or equipment that will be used to provide dialysis may be brought in the patient's room.
   c. Every item brought in the patient's room must be removed immediately after use and at the completion of the dialysis treatment.
   d. Do not leave bleach or any solutions in the patient's room unless the dialysis machine is being cleaned.

M. **DISCHARGE:**

1. Patients are not to be informed of their discharge date, time or plans.~~.~~

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

1. **Administrative Policy: 415** Dress and Appearance Philosophy
2. **Patient Care Services Policy:** ~~In-Custody~~**Justice Involved** Patients ~~Policy~~
3. **Patient Care Services Policy:** Medication Administration ~~Policy~~
4. **Patient Care Services Policy:** Plan for Nursing **Care**
5. **Patient Care Services Policy: Restraints, Used for Non-Violent/ Non-Self-Destructive Behavior** ~~**Policy**~~
6. **Patient Care Services Policy: Restraint-Seclusion for Violent/Self-Destructive Behavior**

~~5.~~**7. Progressive Care Unit Policy: Hunger Strike: Justice Involved Patient**

O. **REFERENCE(S):**

1. Department of Health and Human Services. *Federal registry part IV. Centers for Medicare and Medicaid Services (CMS) 42CFR part 482.*
2. Joint Commission (2015). *Hospital accreditation standards.* Retrieved from http://www.jointcommission.org

Oceanside, California

PROGRESSIVE CARE UNIT (PCU)

ISSUE DATE: NEW

SUBJECT: Hunger Strike: Justice Involved Patients

REVISION DATE(S):

Department Approval:	12/17
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	02/18
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**
1. To delineate the roles of Tri-City ~~Medical Center~~**Healthcare District** (TC~~MC~~**HD**) ~~and department of correction~~ when a justice involved (JI) patient participates in a hunger strike.
2. To ensure JI patients receive care to maintain their nutritional status as ordered by TC~~MC~~**HD** physician.

B. **DEFINITION(S):**
1. JI Patient – patients held involuntarily through operation of law enforcement authorities.
2. Hunger Strike – refusal of necessary food and or fluids for political, mental health or other grievance-rated reasons.
3. Baseline – date and time that initial medical assessment and documentation occur for monitoring purposes.
4. Nutrition support – nutritional therapy such as food delivered by a tube to the stomach, central venous line, or by an intravenous line when usual diet is insufficient.
   a. Requires a physician order and must be administered in a licensed health facility.~~.~~
5. Forced treatment – forced treatment that shall occur only in an emergency or with a court order for a mentally incompetent JI patient as provided in California Penal Code Section 3200.
6. Medical Emergencies as defined in the California Code of Regulation (CCR), Title 15, § 3355 (A) and California Correctional Health Care Services (CCHCS):
   a. ~~"~~Any medical, mental health, or dental condition for which evaluation and treatment are necessary to prevent death, severe or permanent disability~~",~~.
   b. ~~"~~A medical emergency exists when there is a sudden marked change in a **JI** patient-~~inmate's [e.g. JI patient]~~ condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the **JI** patient~~-inmate [e.g. JI patient]~~ or others~~"~~.

C. **POLICY:**
1. **California Department of Corrections and Rehabilitation** (CDCR) patients participating in a hunger strike shall be provided a medical and mental health assessment, monitoring, and necessary treatment, regardless of the reason for the hunger strike.
2. The identification of patient participating in a hunger strike will be performed by CDCR staff.
3. Registered ~~R~~**Nurses** (RN) assigned to a patient refusing to consume meals or stating they are participating in a hunger strike will notify the Progressive Care Unit (PCU), Clinical Manager (CM) or designee immediately and follow the CDCR Division of Correctional Health Care Services (DCHCS) guidelines outlined within this policy.
   a. The PCU, CM, **or**~~/~~designee will notify the CDCR Correctional Officer (CO) assigned to the patient.

4. Prior to administering a course of medical treatment, medical staff must first obtain the -patient's informed consent. To exercise this right, ~~a~~ must:
   a. Receive information about his/her medical condition
   b. The proposed course of treatment (including nutrition support)
   c. Prospect for recovery
5. Forced feeding (enteral or parenteral nutrition support) shall not take place except in a licensed health care facility by licensed clinical staff.
6. ~~Health care staff (~~TCMC**HD** employees~~)~~ shall grant JI patients autonomy in health care decisions related to nutrition and shall not force feed the JI patient unless one of the following criteria are met:
   a. JI patient's condition meets the definition of emergency status.
   b. JI patient is deemed unable to give informed consent as defined as outlined in CCR Title 15, Article 8, § 3353.1 and the institution obtains an appropriate court order per CCR, Title 15, Article 8, § 3351(a) to treat a mentally incompetent inmate-patient.
7. ~~TCMC employees shall use the CCHCS Hunger Strike, Fasting, & Refeeding Care guide to assist with the care and assessments of patient.~~

D. **PROCEDURE:**
1. RN Responsibilities: Initial
   a. After a JI patient is identified as participating in a hunger strike ~~by a CO implement the following:~~.
      i. Complete all nursing interventions and assessments as outlined in the Standards of Care.
      ii. Review the patient's medical history for medical diagnosis, conditions, or diseases that are an immediate risk to the patient.
         1) Examples include but are not limited to the following; diabetes, end-stage renal disease, dialysis.
      iii. Notify the physician of the intended hunger strike and the following:
         1) immediate medical risk
         2) current nutritional intake
         3) output
         4) admission weight
         5) current weight
      iv. Notify the PCU Manager, Case Manager (CM) and on duty leadership (Assistant Nurse Manager ~~(~~[ANM~~)~~] or Relief Charge RN).
         1) The CM~~/designee~~ or on duty leadership will notify the patient's facility Physician or RN on duty and provide the following information:
            ~~a) The patient's facility Phycian/RN will implement the CDCR's policies and procedures for a hunger strike~~
      ~~v. Document findings and interventions in the EHR~~
      ~~vi. Document the following on the CDCR Form 7230 Interdisciplinary Progress note and the patient's Electronic Health Record (EHR)~~
         ~~1)~~**2)** ~~Stated reason and duration of hunger strike.~~
            ~~2)~~**a)** Most recent documented weight
            ~~3)~~**b)** Current measured weight
            ~~4)~~**c)** Physician condition and appearance
            ~~5)~~**d)** Emotion and /or psychological condition
            ~~6)~~**e)** Vital signs i.e., heart rate (HR), temperature, respirations, orthostatic blood pressure
            ~~7)~~**f)** Relevant medical history including allergies to food and medications
            ~~8)~~**g)** What the patient is refusing i.e., food or liquids
            ~~9)~~**h)** Current mental health status and history of mental disorders
            ~~10)~~**i)** Suicide risk assessment ~~and known suicide attempts~~
2. ~~RN Responsibilities: 48 Hours After Identifying a JI Patient's Participation in a Hunger Strike:~~
   ~~a. The RN will complete and document in the EHR the following:~~

i. Assess the patients per the Standards of Care
ii. Assess the following daily per the CDCR:
1) Weight
2) Physical condition
3) Emotional condition
4) Vital signs including orthostatic
5) Hydration status
iii. Notify the **CMO/Chief Physician and Surgeon (CP&S)** or designee of significant changes in the patient's health status
iv. Intake and output per the Standards of Care

b. Document the following in the EHR and on the CDCR's Form 7230
i. The CDCR daily assessment requirements identified in 2.b.
ii. Patient's refusal of any health care services using the patients' words (this is not an inclusive list)
1) Assessments
2) Medications
3) Treatments
4) Procedures and test
5) Nutrition
6) Nutrition supplement

c. Ensure the **HCM** of the health care services refused by the patient

3. CDCR Staff Responsibilities will follow the guidelines established by the CCHCS

E. **INFORMED CONSENT AND STAFF INTERVENTIONS:**

1. Prior to administering a course of medical treatment, medical staff must first obtain the inmate **JI** patient's informed consent. To exercise this right, a patient shall receive information about his/her medical conditions, the proposed course of treatment (including nutrition support and his/her prospects for recovery).
2. Patient has the right to refuse all medical treatment and care at TCMC**HD** provided patient has the capacity and competency to do so. After discussion with the on duty Physician at the custodial institution, patient may be discharged **against medical advice** (AMA) back to the institution once accepted by the on duty Physician.

F. **REFERENCE(S):**

1. California Correctional Health Care Services (CCHCS). (2013, July). Cchcs hunger strike, fasting, & refeeding care guide. Retrieved from http://www.cphcs.ca.gov/careguides/MassHungerStrikeCareGuide.pdf
2. CCHCS. (2012, July). Emergency medical response system policy. 12*(4),* Medical Services. Retrieved from http://www.cphcs.ca.gov/docs
3. San Diego County Sheriff's Department Medical Services Division (2015). Hunger Strikes, MSD.H.12, CCR Title 15, Section 1206

Division of Correctional Health Care Services: Hunger Strike Reference Tool

Day	Findings	Recommendations
0	• Carbohydrates provide for most of our energy requirements- we eat → blood sugar rises → insulin released → promotes glucose uptake and storage (glycogenesis), inhibits the breakdown of fats (lipolysis), and increases cellular uptake of potassium • When cant's store anymore glucose → turns into fat	
1-3 days	• Glucose levels begin to fall which results in the release of glucagon and a reduction in insulin secretion • Glucose levels are maintained by glycogenolysis but glycogen stores rarely last more than 72 hours	Initiate TCMC Hunger Strike Policy
4-7 days	• Brain and red blood cells (RBCs) and some other tissues require glucose so it starts being made by noncarbohydrate (most importantly muscle protein alanine) sources being metabolized to glucose (gluconeogenesis) • Fatty acids broken down to energy • Resultant loss of body fat and protein Accompanying depletion of potassium, phosphate, and magnesium – serum levels maintained at expense of intracellular stores – TOTAL body levels down Fasting generally well tolerated as long as fluid intake is sufficient "Hunger pangs" and stomach cramps disappear after 2nd or 3rd day Early fasting weight loss can be 1-2 kg/day	Follow TCMC Hunger Strike Policy Monitor patient weight ○ Stop nonessential medications ○ Stop antacids (interfere with phosphate absorption) ○ Stop diuretics if possible ○ Decrease dose of essential medications if appropriate
8-14 days 8-14 days continued	Risk of refeeding syndrome begins Day 10	Follow TCMC Hunger Strike Policy Monitor patient weight Offer patients: ○ Thiamine 100mg by mouth (po) daily ○ B complex 1 po dialy ○ Multi-vitamin (e.g. Tab-a-vite) one po daily ○ Encourage 1.5 liters or more/day fluid intake If patient has clinically significant dehydration: ○ Offer oral rehydration fluids: • Pedialyte: one liter of non-flavored contains: ▪ Na: 25 mmole/liter ▪ K: 20 mmole/liter ▪ Glucose: 25 grams If patient refuses oral or is unable to tolerate offer: ○ D5NS IV (add Thiamine 100mg and MVI I amp if available)

		~~give one liter over 1-2 hours~~ ~~If patient has symptomatic hypoglycemia treat as clinically indicated using: (see Refeeding Reference)~~ ~~o Food if patient will accept~~ ~~o Carnation Instant Breakfast Lactose Free (if prolonged fast start with <500mL)~~ ~~o Glucose gel~~ ~~o D50~~ ~~Before voluntary refeeding, assess risk per Refeeding Reference~~
~~After 15-18 days~~	~~Patient suffers from dizziness and "feeling faint"~~ ~~• Severe ataxia~~ ~~• Standing up may become difficult to impossible~~ ~~• Bradycardia~~ ~~• Orthostatic hypotension~~ ~~• Lightheadedness or inversely mental sluggishness~~ ~~• Sensation of cold~~ ~~• General sensation of weakness~~ ~~• Fits of hiccoughs~~ ~~• Loss of the sensation of thirst~~ ~~Hydration needs to be particularly monitored. Too much supplement sodium chloride (NaCl) may lead to hypokalemia~~ ~~By 3rd week average weight loss 0.3kg/day~~	~~As above~~ ~~Before voluntary refeeding assess risk per Refeeding Reference~~ ~~o Hydration needs to be particularly monitored~~ ~~o Thiamine deficiency occurs within 2-3 weeks~~ ~~o Because intravenous (IV) glucose can worsen thiamine deficiency, consider IV thiamine 100mg before receiving IV glucose for patients at high or extreme risk of refeeding.~~
~~Between 35-42 days~~ ~~At > or = 18% loss of initial body weight → Medical Complications~~	~~Problems with ocular mobility due to progressive paralysis of the oculo-motor muscles (thiamine deficiency)~~ ~~• Uncontrollable nystagmus~~ ~~• Diplopia~~ ~~• Extremely unpleasant sensations of vertigo~~ ~~• Vomiting~~ ~~• Extremely difficult to swallow water~~ ~~• Converging strabismus~~ ~~This has been described as the most unpleasant phase by those who have survived prolonged fasting~~ ~~One week after the "ocular phase" – once paralysis" once paralysis of the oculo-motor muscles is total nystagmus ceases and with it all associated problems such as vertigo, vomiting~~	~~As above~~ ~~Before voluntary refeeding assess risk per Refeeding Reference~~
~~From 42 days Onward~~	~~Progressive asthenia (lack or loss of strength)~~ ~~• Increasingly confused state~~ ~~• Concentration becomes difficult or impossible~~ ~~• Somnolent state~~ ~~• Indifference to surrounding~~ ~~• incoherence~~ ~~At this stage, it is impossible to evaluate intellectual~~	~~As above~~

30% loss of initial body weight → Life-Threating	functions and to determine what the hunger strikers state of mind is. Further even more serious complications follow: • loss of hearing/blindness • diverse forms of hemorrhage: gingival, gastro-intestinal, esophageal • body "shuts down" progressively: extreme bradycardia, Cheyne-Stokes respiration, all metabolic activity diminishes	Before voluntary refeeding assess risk per Refeeding Reference
Between 45-75 days	• Death occurs from cardio-vascular collapse and/or sever ventricular dysrhythmias (prolonged QT) • More rarely lactic acidosis from sepsis secondary to immune system dysfunction → and shortness of breath (SBO) and multiple organ failure	As above Before voluntary refeeding assess risk per Refeeding Reference

Evaluation and Management of Patients Voluntarily Requesting Refeeding After Hunger Strike	
General • Principles of management are to correct biochemical abnormalities and fluid imbalances • The optimum timing for correction abnormalities in established Refeeding Syndrome (RFS) has been the source of controversy ○ The view that correction of electrolyte abnormalities must occur before commencement of feeding has been revised and recent National Institute of Health and Clinical Excellence (in the United Kingdom (UK)) guidelines indicate that feeding and correction of biochemical abnormalities can occur in tandem without deleterious effects to the patient- but no RCT data available to support either view. • Prevention is key to management: 3 factors appear fundamental: ○ Early identification of at risk individuals ○ Monitoring during refeeding ○ Appropriate feeding regimen	
• Clinical Evaluation: ○ Screening exam, review current medications ○ Risk assessment based on current BMI, weight loss and length of fasting ○ ECG if irregular pulse, abnormal HR, serum K or Phosphorus • Labs: ○ Baseline Phosphorus, magnesium, calcium, potassium, urea, creatinine before refeeding (affects risk assessment) ○ Monitor electrolytes every day as indicated based upon refeeding risk (see below) or more frequently if clinically indicated • Life-threatening changes usually in the first 3 days • Monitoring: ○ Fluid intake/output and weight – fluid overload can develop- monitor lungs ○ If gain >1/2 lb per day or 3.3 lbs per week, likely fluid retention	
Treatment: Determine based on risk assessment	
Negligible Risk: Individuals who have fasted for less than 5 days, with BMI > 15.8 kg/m2 are at little or no risk of refeeding problems, Careful assessment of hydration status and possibly tests of renal function if they have refused fluid for several days	These individuals may be allowed to eat and drink freely and no monitoring is necessary

Refeeding Syndrome (RFS) after Hunger Strike
Definition:

- Refeeding syndrome describes the biochemical changes, clinical manifestations, and complications that can occur as a consequence of feeding a malnourished catabolic individual.
- RFS is not defined by a clear set of signs and symptoms
- There are no internationally agreed definition of RFS, it is a term referring to a wide spectrum of biochemical abnormalities and clinical consequences
- Hypophosphatemia is the adopted surrogate marker for diagnosing RFS though low serum phosphate is not pathognomonic
  - There are limitations to relying on low serum phosphate as levels may be normal in patients with multiorgan failure or in the presence of impaired renal function

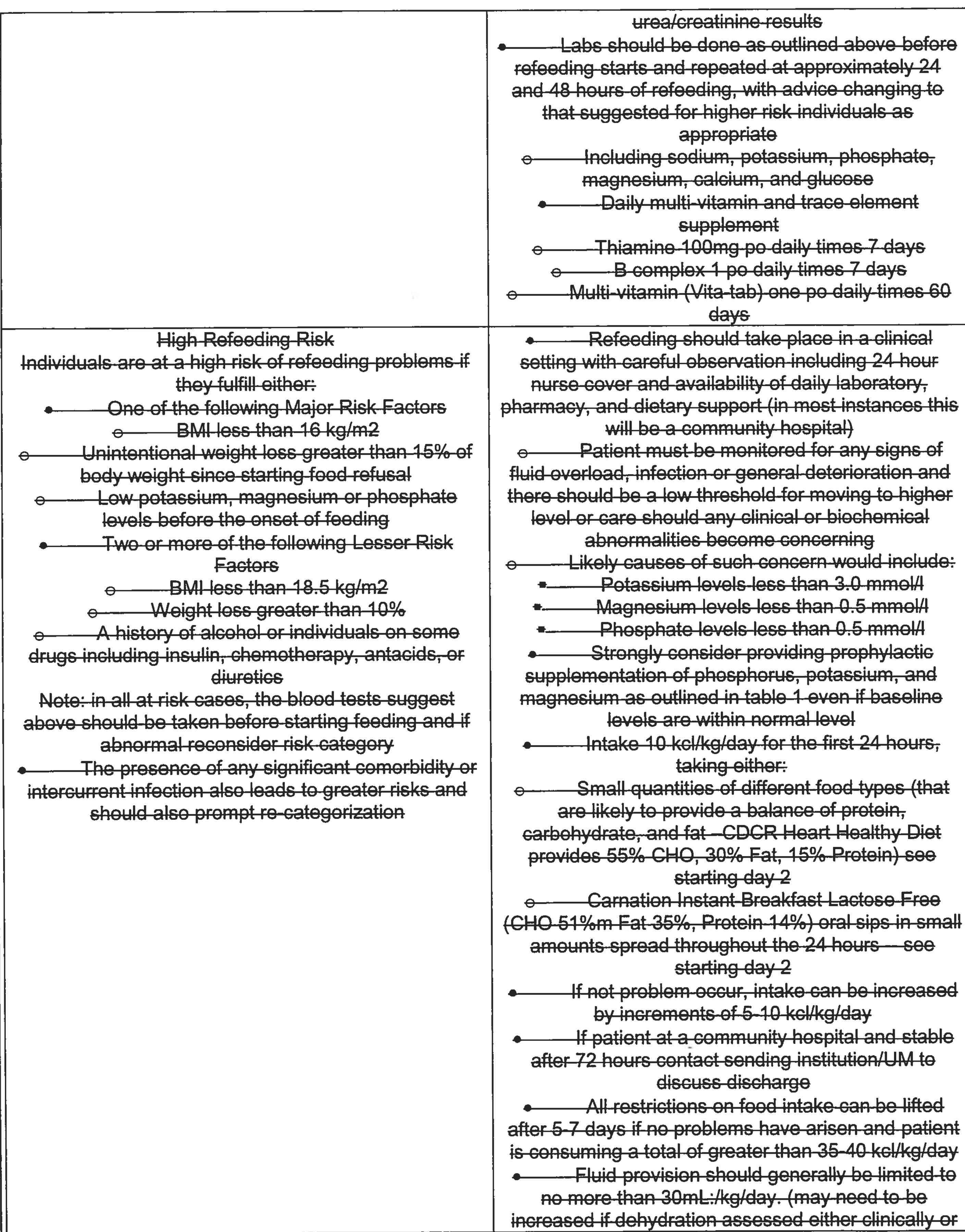
Physiology:

- Reintroduction of nutrition to a starved or fasted individual results in a rapid decline in both gluconeogenesis and anaerobic metabolisms mediated by the rapid increase in serum insulin
- Insulin stimulates the movement of extracellular potassium, phosphonate, and magnesium to the intracellular compartment → rapid fall in the extracellular concentration of these ions
- Osmotic neutrality must be maintained resulting in the retention of sodium and water
- Reactivation of carbohydrate-dependent metabolic pathways increases demand for thiamine, a cofactor required for cellular enzymatic reactions
- The deficiencies of phosphate, magnesium, potassium, and thiamine occur to varying degrees and have different effects in different patients

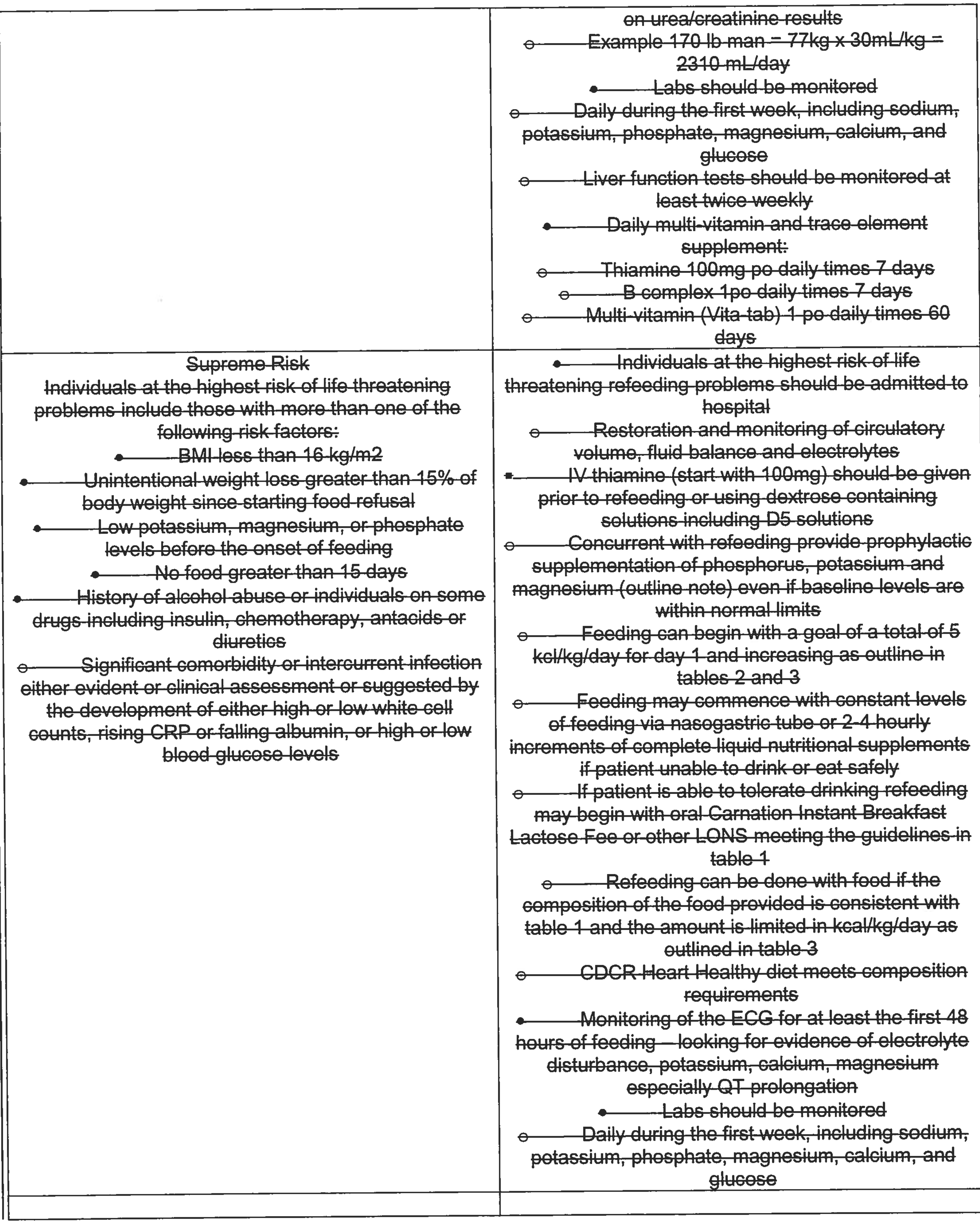
Clinical Manifestations:

- Symptoms of RFS are variable, unpredictable, may occur without warning, and may occur late
- Assessment of Risk
- Symptoms occur because changes in serum electrolytes affect the cell membrane impairing function in nerve, cardiac and skeletal muscle cells.
- Variable clinical picture in RFS reflects the type and severity of biochemical abnormality
- Mild derangements in theses electrolytes may cause no symptoms
- More often, the spectrum of presentation ranges from simple nausea, vomiting, and lethargy → respiratory insufficiency, cardiac failure, hypotension, arrhythmias, delirium, coma, and death
- Clinical deterioration may occur rapidly
- Low serum albumin concentration may be an important predictor for hypophosphatemia, although albumin is not a nutritional marker

Risk	Interventions
Modest Risk: Individuals will be at some risk of refeeding problems if they fulfill any one of the following criteria: • BMI greater than 16 but less than 18.5 or • Loss of greater than 10% of their body weight during food refusal	• Advise to eat only limited amounts of varied foods (total of greater than 20 kcals/kg/day) for the first 2 days • May eat from CDCR Heart Healthy Diet tray ◦ Example 170 lb man = 77 kg x 20 kcl/kg = 1540 kcal/day ◦ Heart Healthy CDCR tray provides 2750 kcal/day ◦ Patients to eat approximately ½ of each meal tray the first 2 days • If no problems arise over the first 48 hours of feeding, levels can be increased, building up to unrestricted ingestion by 5 days • Fluid provision should generally be limited to around 30mL/kg/day. This figure could be doubled if clear dehydration assessed either clinically or on



	urea/creatinine results • Labs should be done as outlined above before refeeding starts and repeated at approximately 24 and 48 hours of refeeding, with advice changing to that suggested for higher risk individuals as appropriate o Including sodium, potassium, phosphate, magnesium, calcium, and glucose • Daily multi-vitamin and trace element supplement o Thiamine 100mg po daily times 7 days o B complex 1 po daily times 7 days o Multi-vitamin (Vita-tab) one po daily times 60 days
High Refeeding Risk Individuals are at a high risk of refeeding problems if they fulfill either: • One of the following Major Risk Factors o BMI less than 16 kg/m2 o Unintentional weight loss greater than 15% of body weight since starting food refusal o Low potassium, magnesium or phosphate levels before the onset of feeding • Two or more of the following Lesser Risk Factors o BMI less than 18.5 kg/m2 o Weight loss greater than 10% o A history of alcohol or individuals on some drugs including insulin, chemotherapy, antacids, or diuretics Note: in all at risk cases, the blood tests suggest above should be taken before starting feeding and if abnormal reconsider risk category • The presence of any significant comorbidity or intercurrent infection also leads to greater risks and should also prompt re-categorization	• Refeeding should take place in a clinical setting with careful observation including 24 hour nurse cover and availability of daily laboratory, pharmacy, and dietary support (in most instances this will be a community hospital) o Patient must be monitored for any signs of fluid overload, infection or general deterioration and there should be a low threshold for moving to higher level or care should any clinical or biochemical abnormalities become concerning o Likely causes of such concern would include: ▪ Potassium levels less than 3.0 mmol/l ▪ Magnesium levels less than 0.5 mmol/l ▪ Phosphate levels less than 0.5 mmol/l • Strongly consider providing prophylactic supplementation of phosphorus, potassium, and magnesium as outlined in table 1 even if baseline levels are within normal level • Intake 10 kcl/kg/day for the first 24 hours, taking either: o Small quantities of different food types (that are likely to provide a balance of protein, carbohydrate, and fat –CDCR Heart Healthy Diet provides 55% CHO, 30% Fat, 15% Protein) see starting day 2 o Carnation Instant Breakfast Lactose Free (CHO 51%m Fat 35%, Protein 14%) oral sips in small amounts spread throughout the 24 hours – see starting day 2 • If not problem occur, intake can be increased by increments of 5-10 kcl/kg/day • If patient at a community hospital and stable after 72 hours contact sending institution/UM to discuss discharge • All restrictions on food intake can be lifted after 5-7 days if no problems have arisen and patient is consuming a total of greater than 35-40 kcl/kg/day • Fluid provision should generally be limited to no more than 30mL:/kg/day. (may need to be increased if dehydration assessed either clinically or



	~~on urea/creatinine results~~ ○ ~~Example 170 lb man = 77kg x 30mL/kg = 2310 mL/day~~ • ~~Labs should be monitored~~ ○ ~~Daily during the first week, including sodium, potassium, phosphate, magnesium, calcium, and glucose~~ ○ ~~Liver function tests should be monitored at least twice weekly~~ • ~~Daily multi-vitamin and trace element supplement:~~ ○ ~~Thiamine 100mg po daily times 7 days~~ ○ ~~B complex 1po daily times 7 days~~ ○ ~~Multi-vitamin (Vita-tab) 1 po daily times 60 days~~
~~Supreme Risk~~ ~~Individuals at the highest risk of life threatening problems include those with more than one of the following risk factors:~~ • ~~BMI less than 16 kg/m2~~ • ~~Unintentional weight loss greater than 15% of body weight since starting food refusal~~ • ~~Low potassium, magnesium, or phosphate levels before the onset of feeding~~ • ~~No food greater than 15 days~~ • ~~History of alcohol abuse or individuals on some drugs including insulin, chemotherapy, antacids or diuretics~~ ○ ~~Significant comorbidity or intercurrent infection either evident or clinical assessment or suggested by the development of either high or low white cell counts, rising CRP or falling albumin, or high or low blood glucose levels~~	• ~~Individuals at the highest risk of life threatening refeeding problems should be admitted to hospital~~ ○ ~~Restoration and monitoring of circulatory volume, fluid balance and electrolytes~~ • ~~IV thiamine (start with 100mg) should be given prior to refeeding or using dextrose containing solutions including D5 solutions~~ ○ ~~Concurrent with refeeding provide prophylactic supplementation of phosphorus, potassium and magnesium (outline note) even if baseline levels are within normal limits~~ ○ ~~Feeding can begin with a goal of a total of 5 kcl/kg/day for day 1 and increasing as outline in tables 2 and 3~~ ○ ~~Feeding may commence with constant levels of feeding via nasogastric tube or 2-4 hourly increments of complete liquid nutritional supplements if patient unable to drink or eat safely~~ ○ ~~If patient is able to tolerate drinking refeeding may begin with oral Carnation Instant Breakfast Lactose Fee or other LONS meeting the guidelines in table 1~~ ○ ~~Refeeding can be done with food if the composition of the food provided is consistent with table 1 and the amount is limited in kcal/kg/day as outlined in table 3~~ ○ ~~CDCR Heart Healthy diet meets composition requirements~~ • ~~Monitoring of the ECG for at least the first 48 hours of feeding – looking for evidence of electrolyte disturbance, potassium, calcium, magnesium especially QT prolongation~~ • ~~Labs should be monitored~~ ○ ~~Daily during the first week, including sodium, potassium, phosphate, magnesium, calcium, and glucose~~

Tri-City Medical Center	Progressive Care Unit
PROCEDURE:	**RELEASE OF A DECEASED ~~OF A~~ JUSTICE INVOLVED PATIENT**
Purpose:	To care for and release remains of deceased Justice Involved patients.
~~Supportive Data:~~	~~Patient Care Service (PCS) Policies: Organ Donation, Including Tissues and Eyes, and PCS Medical Examiner Notification, PCS Procedure Deceased Patient Care and Disposition, Security Department Policy # 224 and Authority for Release of Deceased Form and Consent of Anatomical Donation Form.~~

A. **PROCEDURE:**

1. The Registered Nurse (RN) will notify the Sergeant and Progressive Care Unit (PCU) Assistant Nurse Manager (ANM)/Designee to report the death.
2. All justice involved patient deaths are reportable to the **correctional facility~~'~~s and County** Medical Examiner **(ME)**.
   a. The primary RN or designee RN will:
      i. Notify the **correctional facility and ME**~~Medical Examiners' Office (858-694-2895~~.
      ii. Provide the M**E or ME representative**~~edical Examiner~~ with information as requested.
      iii. Document the M**E** ~~edical Examiner~~ or **ME** representative's name in the medical record.
      iv. Notify Lifesharing.
3. Nursing must adhere to the following procedure:
   a. ~~.~~The decedent's room is considered a crime scene.
   b. Patient is to remain attached (connected) to all equipment and devices such as the following~~:~~ (this is not an inclusive list). The equipment may be turned off.
      i. Ventilators
      ii. Infusion pumps
      iii. Cardiac monitor or Telemetry transmitter (tele box) – silence alarms~~– ask the MEedical Examiner if it is ok discharge the patient from the monitoring system~~
      iv. ~~Oxygen flow meter~~ **Sequential stocking pump**
      ~~iv.~~**v.** **Air mattresses should remain inflated to maintain decedents skin**
   c. Turn off the following and leave patient attached (connected)
      i. Oxygen flow meter
         1) Turn off the flowmeter and do not disconnect the patient from the oxygen tubing
      ii. Oxygen delivery devices e.g., nasal cannula, simple mask, non-rebreather etc.~~,~~
      iii. Turn off **intravenous** (IV) infusion(s) do not remove the IV catheter(s)
      iv. Urinary drains; e.g.~~,~~ Foley, PureWick, condom catheters or IV solutions
      v. Rectal tubes and rains
      vi. Chest drains
      vii. Dressings
      viii. Drains, etc., Jackson Pratt **(JP)**
      ix. Electrodes
      ~~ix.~~**x.** **Sequential stockings**
   d. Gather all nursing equipment such as stethoscopes before leaving room.
   e. Once you leave patients room it will be sealed and you will not be allowed to return until the ME~~edical Examiner~~ **or ME representative** arrives.
   f. Justice involved **(JI)** patients remain shackled until correctional officer **or ME**~~/Coroner~~ releases the **decedent** ~~body~~.
4. Correctional Officer/Sergeant/Deputy will provide the Death Record Packet that includes:
   a. Necessary paperwork

Department Review	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Administration
NEW 12/17	n/a	n/a	02/18		

b. Finger printing materials
c. Camera for pictures
d. "Initial Inmate Death Report":
   i. The "Initial Inmate Death Report" must be filled out by the attending physician (unless attending designates the specialist – this is not preferred) within 24 hours of death.
      1) Nursing **may not initiate or complete this form**~~does not fill out this paperwork~~.
   ii. The PCU ~~ANM/~~Manager, **ANM/** designee **will** ~~must~~ fax the completed "Initial Inmate Death Report" to the **Chief Medical Officer** ~~(this acronym must be written out)~~ at the ~~justice involved~~**JI decedent's** ~~inmate's~~ institution within 24 hours of death.
   iii. This document is not part of the TC~~M~~**C**HD medical record. If the death occurs on a unit other than the PCU, nursing must bring the completed "Initial Inmate Death Report" to the PCU **Manger or** ANM/~~Manager~~/designee. The primary care nurse is responsible for completing all charting in Cerner.
   ~~iv. If the death occurs in an area such as Radiology/Surgery, the Rapid Response Nurse or the primary nurse will complete Cerner charting.~~

5. On arrival of the **ME or ME representative** ~~Coroner~~, the primary care **RN**~~Nurse~~ will:
   a. Enter patients room with ~~Coroner~~ **ME or ME representative** to ensure that all infusions and hospital equipment is in place.
   b. Ask permission from **ME or ME representative** ~~Coroner~~ to remove infusions such as narcotics in Patient Control Analgesia~~-~~.
   c. Remove all narcotics and waste per Patient Care Service Procedure: Wasting Narcotics, Documentation in the Pyxis Machine.
   ~~c.~~**d. Narcotics are not allowed to be kept with the patient or transported outside of TCM~~C~~HD.**
6. The **ME or ME representative** ~~Coroner~~ will complete the **ME**~~Coroners~~ portion of the "Initial Inmate Death Report" once his/her investigation has been completed. ~~The Coroner may~~
   a. The ME or ME representative may:
      i. Review the ~~look at the~~ medical record
      ~~a.~~**ii.** ~~and mMay~~ Ask ~~questions of the~~ staff **assigned to the decedent questions regarding care, diagnosis, excreta, (etc.**~~,)that has had direct care of the patient.~~
      ~~b.~~**iii.** ~~c~~Clear the decedent's body for removal~~,~~.
   ~~c.~~**b. The primary** RN will ensure completion of the Authority for Release of Deceased Record.
   ~~d.~~**c.** The **ME or ME representative** ~~Coroners assistant~~ removing/transporting the **decedent's** body will fill out the bottom of the Authority for Release of Deceased Record.

~~B. FORMS:~~
~~1. "Initial Inmate Death Report"~~

~~C.~~**B. RELATED DOCUMENT(S):**
1. **Patient Care Service Procedure: Wasting Narcotics, Documentation in the Pyxis Machine**
2. Patient Care Services Policy: Medical Examiner Notification
3. Patient Care Services Policy: Organ Donation, Including Tissue and Eyes
4. Patient Care Services Policy: Patient Valuables~~,~~ Liability and Control
5. Patient Care Services Policy: Release of Deceased
6. Patient Care Services Procedure: Deceased Patient Care and Disposition
7. **Security Department Policy: Morgue Release 224**