TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE PROFESSIONAL AFFAIRS COMMITTEE
OF THE BOARD OF DIRECTORS
June 14, 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 May 2018 Meeting	3-7	2 min.	Committee
5.	New Business			
a.	Consideration and Possible Approval of Policies and Procedures	8-9		Committee
	Patient Care Services			
	1. Code Pink Resuscitation - Standardized Procedure	10-12		
	2. Computerized Axial Tomography (CT) Downtime Response Procedure	13-14		
	3. Controlled Substances Management Policy	15-18		
	4. Discharge of Patients and Discharge AMA Policy	19-24		
	5. Identification, Patient Policy	25-26		
	6. Interpretation and Translation Services	27-29		
	7. Stroke Code, In House	30-34		
	8. Wasting Narcotics, Documentation in the Pyxis Machine	35-36		
	9. WOCN-ET Standardized Procedure	37-42		
	Administrative Policies and procedure			
	1. Smoke-Free Environment	43-45		
	Unit Specific **Behavioral Health Services**			
	1. Behavioral Health Unit/ Crisis Stabilization Unit Departmental Disaster Implementation Plan	46-49		
	2. Notification of MediCal Beneficiary of Denial of Benefits	50		
	3. Patient Rights	51-53		
	Medical Staff			
	1. Appropriate Use of Commercial Support and Exhibits	54-57		
	2. CME Speaker & Honoraria Reimbursement	58		
	3. Conflict of Interest Resolution	59-60		
	4. Criteria Pain Management Privileges	61-64		
	5. Educational Planning; Needs Assessment; Objectives; and	65-67		

	Evaluation of a Continuing Medical Education (CME) Activity **Surgical Services** 1. Aseptic Technique Policy 2. Reusable Airway Equipment Cleaning Procedure 3. Steris Set-up, Use and Monitoring Procedure 4. Surgery Blood in Ice Chest Procedure 5. Testing C02 Laser Procedure 6. Universal precautions in Surgery Policy 7. Wound Classification Policy **Women and Newborn Services** 1. Skin to Skin Contact After Birth **Formulary Requests** **1.** Nitrofurantoin Suspension	 68-69 70-71 72-74 75 76 77-78 79-80 81-82 83		
6.	Motion to go into Closed Session		2 min.	Committee
7.	**CLOSED SESSION** a. Minutes Approval b. Medical Audit and/or Quality Assurance 1. Chief of Staff Report 2. Quality Assurance Committees Reports (Committee (Health & Safety Code Section 32155) c. Legal Counsel – Significant exposure to litigation (Government Code Section 54956.9(b)) d. Return to Open Session		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 July 12, 2018 .		1 min.	Chair
11.	Adjournment		1 min.	Chair

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
May 10, 2018

Members Present: Director Leigh Anne Grass, Director Laura Mitchell, Director Larry Schallock, Dr. Souza and Dr. Johnson.

Non-Voting Members Present: Steve Dietlin, CEO, Scott Livingstone, COO , Sharon Schultz, CNE/ Sr. VP, Susan Bond, General Legal Counsel and Jaclyn Hunter, Clinical Quality Manager.

Others Present: Julie Nygaard, Joy Melhado, Priya Joshi, David Lowe, Jessica Garcia, Sharon Davies, Shilla Patel, Lisa Mattia, Patricia Guerra and Karren Hertz.

Members Absent: Dr. Marcus Contardo and Dr. Gene Ma.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Grass called the meeting to order at 12:04 PM in Assembly Room 1.		Director Grass
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 Director Mitchell.	Director Grass
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Grass read the paragraph regarding comments from members of the public.		Director Grass

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Ratification of minutes from April 2018.	Director Grass called for a motion to approve the minutes from April 12, 2018.	Director Schallock approved and Dr. Souza seconded the motion to approve the minutes from April 2018.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Patient Care Services** 1. Activated Clotting Time Testing by Medtronic ACT Plus Procedure 2. Amnisure Placental Alpha- 1 Microglobulin (PAMG 1) Test for Rupture of Fetal Membranes (ROM) Procedure 3. Code Blue and Emergency Care Standardized Procedure	It was noted that David Lowe from the Laboratory Department had made sure that the testing information in this policy is accurate. Director Mitchell asked about the procedure that indicates position patient laying flat on back which she said is not advisable for pregnant women. Dr. Souza questioned the clarity of the interpretations in the results section of this testing. There was a suggestion to convert the illustration into a JPEG format for better quality of the picture. Dr. Johnson mentioned that it should say notify OR at Ext 5400 for the section that states to notify anesthesiologist. Under the section for ventricular fibrillation, it should say attempt to administer up to three consecutive defibrillation shocks.	**ACTION:** The Patient Care policies and procedures were approved. Director Mitchell moved and Dr. Souza seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Glucose Point of Care Testing Using the Nova Stat Strip Blood Glucose Meter Procedure	There was no discussion on this policy.		
5. Hemoglobin using the HemoCue HB 201 Analyzer Procedure	It was noted that Dr. Contardo had made sure that the information contained in this policy are all accurate.		
6. HMS Plus Homestasis Management System Procedure	There was no discussion on this policy.		
7. Medication Recall Policy	Director Mitchell asked for the frequency of medication recalls. There was a brief discussion on when the medication recall process starts once the recall notice is received. It starts on the day received and meds are pulled from shelf on the same day.		
8. Urine PH	There was no discussion on this policy.		
9. Whole Blood PT INR Using the Roche Coaguchek XS Plus Meter Procedure	There was no discussion on this policy.		
Unit Specific **Behavioral Health Services** 1. Treatment Planning	There was a minor typo in this policy; it should be synthesize instead of synthesis.	**ACTION:** The BHU policies were approved. Director Schallock moved and Director Mitchell seconded the motion to approve the BHU policies moving forward for Board approval.	Patricia Guerra
2. Washer Dryer Use	This policy was updated to reflect current regulatory requirements specifically applicable for the behavioral health unit.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Rehabilitation 1. Disaster Plan – Outpatient 1502 2. Fire Plan - Inpatient Rehab 1508 3. Fire Plan - Outpatient Rehab & Wound Care Center 1509 4. Fire & Internal Disaster Drill, Outpatient 1507 5. Fire Plan –Outpatient Rehab Services 1506 6. Staff Rotations 7. Supervision of Patient, OP 1106	Patricia Guerra stated that the hospital has one disaster plan for the whole hospital and outpatient locations will only have separate ones if they have any variations that specifically apply to that location. She also mentioned that there is an over-all fire plan that applies to all units in the hospital.	**ACTION:** The Rehabilitation policies were approved. Director Mitchell moved and Director Schallock seconded the motion to approve the policy moving forward for Board approval.	Patricia Guerra
Surgical Services 1. Staff Based Committee Meetings Policy	There was no discussion on this policy.	**ACTION:** The Surgery policy was approved and is moving forward for Board approval as moved by Dr. Souza and seconded by Director Schallock.	Patricia Guerra
Formulary Requests • Albuterol MDI – P & T	There was a brief discussion on this formulary as Dr. Johnson stated that they do not need a nebulizer in the OR since they only use limited doses of Albuterol in surgery and ED as well.	**ACTION:** The removal of Albuterol Inhaler was approved and is moving forward for Board approval as moved by Director Mitchell and seconded by Director Schallock.	Patricia Guerra
7. Closed Session	Director Mitchell asked for a motion to go	Director Schallock moved, Dr.	Director Grass

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	into Closed Session.	Souza seconded and it was unanimously approved to go into closed session at 12:40 PM.	
8. Return to Open Session	The Committee return to Open Session at 1:15 PM.		Director Grass
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Grass
10. Comments from Members of the Committee	No comments.		Director Grass
11. Adjournment	Meeting adjourned at 1:48PM.		Director Grass

PROFESSIONAL AFFAIRS COMMITTEE
June 14th, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Code Pink Resuscitation Standardized Procedure	3 Year Review, Practice Change	
2. Computerized Axial Tomography (CT) Downtime Response Procedure	3 Year Review, Practice Change	
3. Controlled Substances Management Policy	3 Year Review, Practice Change	
4. Discharge of Patients-Discharge AMA Policy	3 Year Review, Practice Change	
5. Identification, Patient Policy	3 Year Review, Practice Change	
6. Interpretation and Translation Services	1 Year Review	
7. Stroke Code, In-House	3 Year Review, Practice Change	
8. Wasting Narcotics, Documentation in the Pyxis Machine	DELETE	
9. WOCN-ET Standardized Procedure	2 Year Review, Practice Change	
Administrative Policies & Procedures		
1. Smoke-Free Environment	3 Year Review, Practice Change	
Unit Specific		
Behavioral Health Services		
1. Behavioral Health Unit / Crisis Stabilization Unit Departmental Disaster Implementation Plan	3 Year Review, Practice Change	
2. Notification of MediCal Beneficiary of Denial of Benefits	3 Year Review, Practice Change	
3. Patient Rights	3 Year Review, Practice Change	
Medical Staff		
1. Appropriate Use of Commercial Support and Exhibits	3 Year Review, Practice Change	
2. CME Speaker & Honoraria Reimbursement	3 Year Review, Practice Change	
3. Conflict of Interest Resolution	3 Year Review, Practice Change	
4. Criteria Pain Mgmt Privileges	3 Year Review, Practice Change	
5. Educational Planning; Needs Assessment; Objectives; and Evaluation of a Continuing Medical Education (CME) Activity	3 Year Review, Practice Change	

PROFESSIONAL AFFAIRS COMMITTEE
June 14th, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Surgical Services		
1. Aseptic Technique Policy	DELETE	
2. Reusable Airway Equipment Cleaning Procedure	DELETE	
3. Steris Set-Up, Use and Monitoring Procedure	DELETE	
4. Surgery Blood in Ice Chests Procedure	3 Year Review, Practice Change	
5. Testing CO2 Laser Procedure	DELETE	
6. Universal Precautions in Surgery Policy	3 Year Review, Practice Change	
7. Wound Classification Policy	DELETE	
Women & Newborn Services		
1. Skin to Skin Contact after Birth	NEW	
Formulary Requests		
1. Nitrofurantoin Suspension	Remove from Formulary	

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: CODE PINK RESUSCITATION

I. **POLICY:**

A. Function: Management of impending or actual cardiopulmonary arrest in the pediatric patient **greater than 30 days of age through 13 years**.

~~A.~~**1. A Code Caleb will be activated for the resuscitation and stabilization needs of the high-risk neonate/ infant up to 30 days old. Please see Patient Care Services: Code Caleb Team Mobilization Policy.**

B. Circumstances:

1. Setting: Tri-City **Healthcare District (TCHD)**~~Medical Center~~.
2. Supervision: None required. However, upon arrival of a physician the Code Pink team will follow physician orders instead of the Standardized Procedure.
3. Patient contraindications: Patients with a written "No Code Order."~~ A Code Pink will be called on any apneic and/or pulseless children greater than 30 days of age through 13 years (in the main hospital building, the Cardiac Rehabilitation building, Business Administration Management (BAM) building, and the Magnetic Resonance Imaging (MRI) building.~~

II. **PROCEDURE (CHILDREN GREATER THAN 30 DAYS OLD THROUGH 13 YEARS)** ~~14)~~**:**

A. Data Base:

1. Subjective: None
2. Objective: Significant acute change in neurologic status, status epilepticus unresponsive, absent respirations status asthmaticus and/or rhythm disturbances (monitored patient) absent pulse, acutely hypotensive or absent blood pressure.
3. Diagnosis: Impending/Actual Cardiopulmonary arrest
4. Plan:
   a. Initiate Standardized Procedure as appropriate and initiate Code Pink (dial 66 on the telephone).
   b. Assessment: Patient will be reassessed after each intervention.
   c. Record Keeping: Events are to be recorded on the Cardiopulmonary Arrest Record~~ and clinical notes~~.

B. Respiratory Distress/Arrest:

1. Establish patent airway.
2. Administer oxygen to maintain O_2 saturation greater than 95%.
3. Begin Positive Pressure Ventilation (PPV) with 100% oxygen as necessary, monitoring adequate rise and fall of chest, breath sounds, color, and work of breathing.
4. Assist with intubation as appropriate.
5. Have adequate suction readily available.
6. Obtain STAT Arterial Blood Gas (ABG) and chest X-ray as needed.

C. Heart Rate less than 60 bpm (Bradycardia**):**

1. Initiate chest compressions.
2. Begin PPV with 100% oxygen.
3. Obtain Intravenous (IV) access:
   a. Establish IV access with Normal Saline (NS) at to keep open (TKO) rate **(**may be used for resuscitation medications or fluid bolusing as needed).

Revision Dates	Clinical Policies & Procedures	Pharmacy and Therapeutics	Nursing Executive Council	Department of Pediatrics	Inter-disciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
03/00, 08/07, 02/10, 06/11, 09/14, 05/17	01/11, 09/13, 09/14, 06/17	06/11,09/13, 09/14, 07/17	03/11, 09/13, 10/14, 08/17	11/14, 02/18	06/11, 02/14, 03/15, 04/18	06/11,02/14, 03/15, 05/18	05/15	06/11, 02/14, 05/15

b. Get Intraosseous (IO) device ready for placement by physician if IV access is unobtainable (~~M~~**m**ust be placed by a physician **or supervised by a physician**).
c. Give fluid bolus for hypotension Systolic blood pressure less than (70 + [age in years times 2]) NS 20 mL/kg, Can repeat times 2 if lungs remain clear.

4. Medications for Bradycardia:
   a. Epinephrine**:**
      i. Indicated when heart rate remains less than 60 and patient is hypotensive.
      ii. Recommended route is IV/IO. Consider endotracheal (ET) route while IV access is being obtained.
      ~~iii. ET DOSING: (0.5 mg/mL/kg of 1:10,000 concentration) Administer every 3- 5 minutes during arrest until IV/IO access is achieved. (Oska to update dosing for epinephrine)~~
      iii. IV/IO DOSING: **0.01 mg/kg** (0.1 ~~mg/~~mL**/kg of 0.1 mg/mL solution)**~~/kg of 1: 10,000 concentration)~~ ~~Give~~**Maximum single dose 1 mg. Administer** every 3-5 minutes ~~during arrest.~~ **as needed.** ~~Maximum dose is 1 mg.~~
      iv. **ET DOSING: 0.1 mg/kg (0.1 mL/kg of 1 mg/mL solution). Maximum single dose 2.5 mg. Administer every 3- 5 minutes as needed until IV/IO access is established.** ~~**(Oska to update dosing for epinephrine)**~~
      v. Rate of administration is rapid.

D. Symptomatic Hypoglycemia:
   1. Obtain **a capillary**~~bedside~~ blood glucose value. If glucose level is less than 60 mg/dL then treat with ~~D25W 2 mL/kg via slow intravenous push (IVP) OR~~ D10W 5 mL/kg **via** slow IVP ~~OR D50 W 1mL/kg via slow IVP~~

E. Hypotension:
   1. IV/IO bolus for hypotension (SBP less than 70 + [age in years times 2]). Administer NS 20 mL/kg. May repeat times 2 if lungs remain clear.

F. Cardiac Rhythm Disturbances/Shock:
   1. Follow American Heart Association (AHA) 2015~~0~~ Pediatric Advance Life Support (PALS) guidelines**:**
      a. BLS for healthcare providers
      b. Pediatric Bradycardia with a pulse Algorithm
      c. Pediatric Tachycardia with Pulses and Poor Perfusion Algorithm
      d. Pediatric Pulseless Arrest Algorithm
      e. Septic Shock Algorithm
      f. Treatment of Shock Algorithm

III. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. **Registered Nurse (**RN**)** with current California license and working in the Emergency Department.
B. Education: Pediatric Advanced Life Support (PALS), or Emergency Nurse Pediatric Course (ENPC)**.**
C. Initial Evaluation: Before an RN may initiate the Code Pink Standardized Procedure, the RN must be observed in the management of a pediatric resuscitative effort and demonstrate successful skills in PALS or the ENPC course.
D. Ongoing Evaluation: Annually**.**

IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

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

V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All Emergency Department Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform Code Pink Resuscitation Standardized Procedure.

VI. RELATED DOCUMENT(S):

A. **Patient Care Services: Code Caleb Team Mobilization Policy**

VII. REFERENCES:

~~B.~~**A. American Heart Association: 2015 Pediatric Advance Life Support**

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**COMPUTERIZED AXIAL TOMOGRAPHY (CT) DOWNTIME RESPONSE**
Purpose:	To outline process during CT downtime.

A. **POLICY:**

1. **Tri-City Medical Center (TCMC) has two (2) operational CT scanners. In the event that one (1) scanner is down the patients will be prioritized for examination based on patient acuity.**
2. **Downtime response is not required for routine maintenance of one (1) scanner at a time.**
3. **For scheduled downtime of one (1) machine lasting 24 hours or greater, a mobile CT scanner will be secured prior to the downtime.**
4. **If both scanners are anticipated to be down greater than (>) two (2) hours, an attempt to locate a mobile CT scanner will be immediately initiated.**

~~A.~~B. **PROCEDURE IF BOTH CT SCANNERS DOWN:**

1. Unanticipated Downtime:
   - **a.** Radiology calls:
     - i. ~~t~~The Emergency Department (ED) Assistant Nurse Manager (ANM)/designee at extension 3509 to provide an estimate of the duration of CT Scanner downtime.
       - **1)** The ED ANM/designee notifies ED physicians of CT downtime as appropriate.
     - **ii. The Administrative Supervisor**
       - ~~b.~~**1) Notifies Hospitalists and Administration as appropriate.**
   - ~~c.~~**b.** The ED ANM/designee and ED physicians evaluate the need for diversion of head injuries, potential stroke patients, and traumas.
   - **c.** The Mobile Intensive Care Nurse (MICN) enters this information into the **Image Trend Resource Bridge**~~Quality Collector System (QCS)~~ to notify agencies of diversion status.
   - d. **Radiology leadership will notify the Radiology Medical Director or Radiologist On-Call.**
   - ~~e. The ED physician determines need for standby Balboa ambulance.~~
     - ~~i. Contact Balboa Ambulance president at 619-885-0803, if no answer, leave message and call 858-637-3548.~~
   - ~~f. The ED ANM/designee arranges for an ED Advanced Care Life Support (ACLS) Registered Nurse (RN) to accompany patient(s) needing CT scan to the Outpatient Imaging Center, Room 111 (760-940-7562).~~
   - ~~g. The Administrative Supervisor (AS) arranges accompaniment for in-house patients requiring CT scan by either an ED ACLS RN or an Intensive Care Unit (ICU) ACLS RN.~~
     - ~~i. If ED RN unavailable for ED CT transport, then ED ANM/designee notifies ED Director.~~
   - **e.** Radiology notifies:
     - ~~ii.~~**i.** ED ANM/designee when CT is functioning.
       - 1) ED ANM /designee notifies MICN **and appropriate agencies,** ~~Balboa, EMS,~~ and AS when the CT is available.
     - ~~iii.~~**ii.** Administrative Supervisor
       - 1) **Hospitalists and Administration as appropriate.**
   - ~~h. AS shall notify the Director of Patient Financial Services of all patients who have been transported to the Outpatient Imaging Center.~~
2. Scheduled Downtime:
   - a. The Medical Imaging Director shall notify the ED Manager not less than 10 days prior to scheduled Preventive Maintenance (PM) date.
   - ~~b. The ED Manager shall secure nursing support.~~

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Department of Emergency Medicine	Medical Executive Committee	Professional Affairs Committee	Board of Directors
9/05; 12/08, **03/18**	08/11, **04/18**	08/11, **04/18**	**05/18**	10/11, **05/18**	11/11	11/11

~~c. The ED Manager shall notify Balboa and Director of Managed Care of scheduled downtime.~~

~~d.~~**b.** The ED Manager shall notify ED physicians, MICN nurse, and staff of scheduled downtime.

~~e. The ED ANM/designee and ED physicians evaluate the need for diversion of head injuries, potential stroke patients, and traumas.~~

~~i. Manager/designee shall ensure a stand-by RN is scheduled for patient transports during CT downtime.~~

~~ii. Request that Balboa provide a critical care transport nurse to accompany patient if possible.~~

~~f. Arrange for Balboa Ambulance services to be on-site.~~

~~g.~~**c.** Radiology notifies ED ANM/designee when CT is functioning.

i. ED ANM/designee notifies MICN, **and appropriate agencies**~~Balboa, EMS,~~ and AS when the CT is available.

~~h.~~**d.** ~~AS shall notify the Director of Patient Financial Services of all patients who have been transported to the Outpatient Imaging Center.~~

~~3. Transport RN Responsibilities~~

~~a. The transporting RN shall continually monitor patient's condition and document on Physician's Progress Notes.~~

~~b. If condition deteriorates while patient is outside of TCMC:~~

~~i. Dial 9-1-1.~~

~~ii. Initiate basic cardiac life support.~~

~~iii. Transport patient to TCMC Emergency Department.~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE:	**08/01, 11/12**	**SUBJECT:**	**Controlled Substances Management**
REVISION DATE:	**01/03, 03/03, 07/05, 04/08, 09/09, 11/12, 03/17**	**POLICY NUMBER:**	**IV.J**

Department Approval:	**~~08/15~~02/17**
Clinical Policies & Procedures Committee Approval:	**~~05/13~~09/15~~03~~/17**
Nursing Executive Committee Approval:	**~~05/13~~9/15~~03~~/17**
Pharmacy & Therapeutic Committee Approval:	**~~09/13~~06/16~~05~~/17**
Department of Anesthesiology Committee Approval:	**~~01/16~~05/18**
Medical Executive Committee Approval:	**~~12/13~~01/16~~05~~/18**
Professional Affairs Committee Approval:	**03/14**
Board of Directors Approval:	**03/14**

A. **DEFINITION(S):**
1. Controlled Substance: as defined by the state and federal law.

B. **POLICY:**
1. Healthcare providers shall administer controlled substances in compliance with their respective Practice Acts, Tri-City **Healthcare District (TCHD)** ~~Medical Center~~ Policies and Procedures, and state and federal law.
2. All controlled substances for administration shall be maintained in the Pyxis MedStation.
3. Sequential dosing of controlled substances is not permitted at **TCHD**~~TCMC~~ except by physicians.
4. Abuses and losses of controlled substances shall be reported to the Director of Pharmacy.

C. **PROCEDURE:**
1. Replenishment:
   a. Pyxis System Controlled Substances:
      i. Pharmacy personnel shall automatically replenish the controlled drugs in each Pyxis Medstation.
      ii. All controlled substances removed from Pyxis for administration shall be documented on the patient **electronic or paper** Medication Administration Record (MAR). **Whenever possible, it is ~~best practice~~recommended that the nurse removing the controlled substance from the Pyxis is to be the nurse who administers the medication, thus ensuring the chain of custody of the medication.**
      iii. PRN response shall be documented on all narcotics.
2. Nursing Units Controlled Substance Accountability:
   a. Pyxis Nursing Units:
      i. The Pyxis home screen must be reviewed before the end of each shift to determine if there is an open discrepancy.
      ii. Any controlled substance discrepancy must be resolved by the end of each shift and resolution noted in the Pyxis.
      iii. Unresolved discrepancies are not acceptable and shall be reported to the Assistant Nurse Manager (ANM) /designee immediately.
      iv. A manual weekly inventory of all controlled substances is required.
3. Security/Storage:

a. Pyxis Nursing Units:
   i. All controlled substances are kept in the Pyxis Medstation.

4. Wasting Of Controlled Drugs:
   a. Any opened controlled substance not given or any unused partial doses shall be wasted; wastage shall be witnessed, documented, and co-signed by two licensed personnel based upon their scope of practice.
      i. The following licensed personnel may witness and co-sign wasting of controlled substances:
         1) Anesthesiologist
         2) Registered Nurse
         3) Licensed Vocational Nurse
         4) Respiratory Care Practitioner
         5) Radiology Technologist
         6) Pharmacist
         7) Pharmacy Technician
   b. Witnessing of wastage, documentation of wastage, and cosigning shall occur:
      i. Within one (1) hour after administration or removal of the drug
      ii. For procedural areas: within one (1) hour after completion of procedure
      iii. If medication is removed and not administered.
         1) Returned to Pyxis if intact
         2) Wasted if no longer intact
   c. The licensed personnel administering the medication shall document the amount wasted.
   ~~d. After removal of a used controlled substance patch (e.g. Fentanyl) dispose of by folding the adhesive side onto itself and discard into the sharps container~~**toilet.**
   ~~e.~~**d.** ~~Liquid~~ **ALL** controlled substance waste **(solid, liquid and patches)** shall be disposed of ~~in sink drains.~~**in the designated RX Destroyer container.**
      i. **Discard empty syringe into the trash unless a needle attached, then discard in sharps container.**
      ~~ii. Empty solution in sink~~
      ~~iii.~~**ii.** ~~Flush drain with running tap water~~
      ~~iv. Table/capsule controlled substance waste shall be disposed of in sharps container~~**the toilet.**

5. Controlled substances auditing procedure:
   a. The Pharmacy Department will perform regular retrospective audits on all hospital personnel who have access to controlled substances via the automatic dispensing machines.
      i. For all nursing units,
         1) Pharmacy personnel shall generate a Proactive Diversion Report monthly to identify user activity that falls out of the normal range compared to their peers.
         2) For users with a standard deviation of +3 or greater, pharmacy personnel shall notify the nursing manager and send a Pyxis Medstation Report and documentation form for review and completion.
         3) Nursing management shall conduct an investigation of reported users to verify controlled substances activity as appropriate.
         4) Nursing management shall return completed documents to pharmacy personnel within 14 days.
      ii. For Anesthesiology Department~~-~~,
         1) Pharmacy personnel shall generate a detailed ~~monthly~~ report of all audit activity**, at least monthly** and submit it to the Anesthesia Department Chair ~~and the Medical Staff Office~~ in order that evaluation and remediation may be carried out.

2) In the event that any single day the retrospective audit reveals a concerning non-compliance event, the individual Provider will be notified so prompt evaluation and remediation can be carried out. If the individual provider can't be contacted directly, the Anesthesia Department Chair ~~and the Medical Staff Office~~ will be notified so they can assist in contacting the Provider so prompt evaluation and remediation can be carried out.

6. Reporting of abuses and losses of controlled drugs:
   a. Abuses and losses of controlled substances **involving a medical staff credentialed provider will be reported to the Medical Staff Manager and** must be reported, in accordance with applicable Federal and State laws, to the Director of Pharmacy, and to the **Chief Nurse Executive or** chief executive officer, as appropriate.
   b. An investigation by the management team of the area where loss occurred and the pharmacy will be conducted. Findings along with recommendations for action will be made to appropriate staff.

D. RELATED DOCUMENTS:

~~7.~~**1. TCMC Waste Disposal Guidelines**

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; Stericyle Healthcare Environmental Resource Center, Epinephrine Fact Sheet http://www.dtsc.ca.gov/LawsRegsPolicies/Title22/upload/Ch11_Art4.pdf

Revised Date: 04/2017 pharmacy

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**08/01**	**SUBJECT:**	**Discharge of Patients and Discharge Against Medical Advice (AMA)**
REVISION DATE:	**06/03, 01/04, 06/07, 07/07, 09/09, 02/10, 06/10, 03/11**	**POLICY NUMBER:**	**VI.C**

Department Review:	**10/17**
Clinical Policies & Procedures Committee Approval:	**~~12/14~~11/17~~04~~/18**
Nursing Executive Council Approval:	**~~12/14~~04/18**
Pharmacy and Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~01/15~~05/18**
Professional Affairs Committee Approval:	**02/15**
Board of Directors Approval:	**02/15**

A. **POLICY:**

1. Patients are discharged by order of the appropriate physician~~/Allied Health Professional (AHP).~~
   a. In the event of an internal or external disaster, the established policies and procedures for patient discharge are followed as per the Emergency Preparedness Plan.
   b. Observation patients may be discharged after meeting predetermined discharge criteria on the order of a physician~~/AHP~~. (Refer to **Patient Care Services Standardized Procedure:** Discharge from Outpatient Post-Anesthesia Nursing Service ~~Standardized Procedure~~).
   c. Justice Involved Patients
      i. Justice Involved Patients are to be discharged following the Progressive Care Departmental discharge process.
      ~~b.~~ii. Justice Involved Patients have the right to sign out AMA and leave the hospital in the care of their custodial agency.
   d. Behavioral Health Services
      i. A voluntary patient may leave the hospital at any time by giving notice to any member of the hospital staff on his/her desire to leave and by completing usual discharge processes.
      ii. A Conservatee may leave in a like manner if the patient's Conservator gives notice.
      ~~c.~~iii. If a voluntary patient cannot be persuaded to continue his or her hospitalization, cannot be safely discharged, and meets criteria for involuntary hospitalization, an appropriately credentialed clinician will initiate a 72 hour hold and the patient will not be permitted to leave the unit.
2. The primary nurse is responsible for providing verbal and written discharge instructions to the patient, family, and/or caregiver.
3. All patients discharged will receive discharge education completed by nursing.
4. A Registered Nurse (RN) and/or Case Manager ~~is~~**are** responsible for explaining discharge plans to patients and their family members.
   a. Discharge instructions including medication list, signs/symptoms of potential complications, educational information, and instructions for follow-up appointment will be sent with patient and/or family upon discharge.

b. Patients will be evaluated within one **(1)** hour of discharge for any change in condition. This shall include documentation of vital signs. Any abnormality will be communicated to the primary care physician**/AHP** prior to discharge.
c. Patients and/or family members will be advised if it is necessary to stop at the business office before leaving the hospital.
d. All patients being transferred to a Skilled Nursing Facility **(SNF)** or another hospital/facility (~~including Forensic~~ **justice involved** patients) will receive a transition of care document prior to transfer.

5. All inpatients who are ambulatory are to be discharged from the front entrance via wheelchair or stretcher, if appropriate, by a hospital employee or volunteer.
a. In the event the patient has a car in the ~~TCMC~~ **Medical Center** parking lot, the patient may be escorted by an employee or volunteer.
b. If patient has no transportation to their residence after the discharge order is processed, contact Case Management/Social Services personnel or Administrative Supervisor for further assistance in obtaining transportation.
c. Staff members are not to transport patients to their place of residence.

~~d.~~**6.** If being discharged via ambulance, patient will be discharged from the Emergency Department **(ED)** entrance. Hand-off communication shall be provided to the ambulance personnel before the patient leaves the unit.

~~6.~~**7.** A discharge transaction shall be entered into Cerner within one **(1)** hour after the patient has left the unit.

~~7.~~**8.** When a patient is discharged to Acute Rehabilitation or the Inpatient Behavioral Health Unit, the acute care chart is closed and a new encounter is created.

~~8.~~**9.** Provision of Transfer Summary to Patient Upon Transfer (**Health and Safety Code** [HSC] §**Section** 1262.5)
a. HSC §**Section** 1262.5 (d) requires that a transfer summary be signed by the physician~~/AHP~~ and accompany the patient upon transfer to a ~~skilled nursing~~**SNF** or intermediate care facility or to the distinct part-skilled nursing or intermediate care service unit of the hospital.
b. A copy of the transfer summary must also be given to the patient, patient's closest available relative or patient's legal representative, if any, prior to the transfer.
i. To ensure compliance with HIPAA and California Privacy Law, ensure "the patient's legal representative" is clearly identified by a document signed by the patient approving release of information to that person.
c. The transfer summary must include essential information relative to:
i. Patient's diagnosis
ii. Hospital course
iii. Pain treatment and management
iv. Medications
v. Treatments
vi. Dietary requirement
vii. Rehabilitation potential
viii. Known allergies
ix. Treatment plan

B. **DISCHARGE AGAINST MEDICAL ADVICE (AMA):**

1. When a patient demands to leave the hospital and the patient's physician~~/AHP~~ has not ordered his/her discharge and has specifically indicated that the discharge is against medical advice, the following steps shall be completed:
a. Verify the patient is an adult with the capacity to make healthcare decisions regarding medical treatment.
b. If the patient lacks the legal authority to make healthcare decisions (minor) or if the patient lacks the capacity to make healthcare decisions, the patient has the right to have

legal representative make the decision to stay or leave against medical advice for him/her.

c. The RN will notify attending physician~~/AHP~~ immediately.

d. The attending physician~~/AHP~~ will be asked to discuss the request with the patient, either by person or by telephone as appropriate.

e. If the patient attempts to leave the hospital before discussing the matter with his/her physician~~/AHP~~, the RN shall:
   i. Inform the patient his/her physician~~/AHP~~ has been contacted
   ii. Explain the risks and consequences of leaving the hospital to the patient before he/she leaves.
   iii. Notify the Assistant Nurse Manager (ANM)**/Relief Charge**
      1) The ANM shall notify the unit director/manager as soon as possible.

f. The patient or a patient's legal representative shall complete the "Leaving Hospital Against Medical Advice (AMA)" Form.
   i. ED:
      1) The RN shall request the patient to sign the AMA form.
      ~~f.~~**2) The RN shall remove the patient from the electronic medical record as AMA.**

g. The AMA form shall state the patient has been provided information regarding possible risks that may result from the decision to leave AMA, the benefits of continued hospitalization, and any alternatives, such as transfer to another hospital or outpatient treatment.
   i. The AMA form must be witnessed by a responsible hospital employee and signed by the attending physician~~/AHP~~ he/she has explained the risks and benefits of continued hospitalization, when possible.
      1) If the attending physician~~/AHP~~ is not present to sign, the primary nurse shall document he/she called the physician~~/AHP~~.

h. If the patient refuses to sign the AMA form, the responsible hospital employee and/or RN shall:
   i. Document ~~in the (keep)~~Physician Notified"
   ii. Document on the patient's signature line, "patient refuses to sign"
   iii. The hospital employee shall sign the form in the designated space, including the exact time and date.

i. The primary nurse shall document a brief note concerning the ~~circumstances of~~**interactions with** the ~~refusal to sign~~ **patient:**
   i. Risks/benefits were reviewed.
   ii. ~~and the~~ Actions taken to ensure the patient's safety.
   ~~iv.~~**iii. Refusal to sign the AMA form, if applicable**.

~~i.~~**j.** The AMA form shall be placed in the medical record.

~~j.~~**k.** An ~~RL~~**quality review report** shall be completed.

2. Transportation Arrangements

a. The following reasonable steps shall be documented in the medical record:
   i. Attending physician~~/AHP~~ was consulted regarding patient's intent to leave and any concerns regarding transportation
      1) ~~-~~Inform the patient his/her physician~~/AHP~~ has been contacted
      2) Explain the risks and consequences of leaving the hospital to the patient before he/she leaves.
   ii. Document disposition of patient off unit, i.e. ambulatory, wheelchair, with family member.
   iii. Caution patient that driving is not advisable due to their medical condition and/or medications taken.
   iv. If the patient appears helpless or in a condition which indicates he/she should not be allowed to leave the hospital alone, every attempt shall be made to arrange transportation that is appropriate for the patient's condition.

v. If patient refuses the appropriate recommended transportation and is under the influence of any narcotic or medication that would impair their ability to operate a vehicle safely contact the hospital security and the local police.

vi. Hospital personnel shall not accompany the patient once he/she leaves the hospital premises.

3. If there are concerns regarding the patient's psychiatric stability, the physician~~/AHP~~ may consider a 72-hour hold.
   a. In the Inpatient Units:
      i. A psychiatric consult shall be requested by the admitting or attending physician~~/AHP~~ to determine if patient meets criteria for a 72-hour hold.
   b. In the Behavioral Health Unit:
      i. The Psychiatrist must be notified to determine if the patient meets the criteria for a 72-hour hold.
      ii. The RN is responsible for documenting the psychiatrist's final decision in the progress note or clinical note.
      iii. Any orders (i.e., to place the patient on an involuntary hold) shall be documented as a physician's~~/AHp's~~ order.
      iv. Explain to the patient the reason they will not be permitted to leave unit
      ~~iii.~~**v. Complete involuntary hold advisement as applicable per PCS Policy: 72 Hour Hold, Evaluation and Treatment of the Involuntary Patient Policy and Behavioral Health Services Policy: Advisement of Legal Status 72-Hour Hold**

C. **PATIENTS NO LONGER NEEDING ACUTE CARE WHO REFUSE TRANSFER OR DISCHARGE:**

1. If the patient has been discharged from the facility and the patient and/or patient's family is refusing~~,~~ or even actively blocking~~,~~ the patient's transfer or discharge, a case by case approach must be initiated.
2. Consider all available options. Try to identify the concerns and issues raised by the patient and/or family to see if resolution is possible.
3. Notify your immediate manager. If unable to resolve, the immediate manager must notify Administration and Risk Management of the situation. Social Services and/or Security shall also be involved as appropriate.
4. Inform the patient's physician~~/AHP~~ of the refusal to leave.
5. Should all efforts fail, legal remedies may be available and legal counsel shall be consulted.
6. Some permissible actions may apply during this duration, such as:
   a. The television is considered a luxury, not a necessity, and may be turned off.
   b. Food is a necessity~~,~~ and food trays must be nutritionally balanced. Depending on the patient's physical/medical condition, the diet may exclude such items as sodas, coffee, desserts, candies, and snacks, etc.
   c. Clean linen changes are not required. If the patient needs extra linen, it may be delivered, but staff is not required to make the bed.
   d. The issue of continuing nursing care shall be determined on a case by case basis, in consultation with the treating physician~~/AHP~~.
7. Follow all requirements of the applicable payer with respect to the patient's right to challenge a determination that they no longer need inpatient care. Medicare patients, for example, have the right to receive notice of their rights, including the right to appeal denials of benefits for continued services, as well as notice of any determination that they no longer require hospitalization.

D. **DISCHARGE TO SKILLED NURSING FACILITY:**

1. To ensure all appropriate steps and actions are taken to promote ~~Skilled Nursing Facility (~~SNF~~)~~ placement expeditiously, case managers, in collaboration with the interdisciplinary team, will identify patients who are appropriate for SNF.

2. The Case Manager and RN may arrange for SNF placements. Refer to Patient Care Services ~~(PCS)~~**Policy:** Discharge Planning ~~Policy, VI.E~~.
3. Prior to discharge to a ~~Skilled Nursing Facility (~~SNF~~)~~ or an intermediate care facility, primary nurse shall provide a copy of the following to the patient, family, and/or caregiver:
   a. Physician Discharge/Transfer summary
   b. Discharge (Medication Home List)
   c. Discharge instructions
4. The primary nurse shall ensure the following information is copied by the unit secretary or designee and sent with the patient to the SNF:
   a. Facesheet
   b. **History and Physical** (H&P), Consultations
   c. Physician transfer summary
   d. Physician transfer orders
   e. Physician progress notes
   f. Printed MAR (14 days)
   g. Medication reconciliation form (refer to **Patient Care Services Policy:** Medication Reconciliation ~~Policy, IV.JJ~~)
   h. Nursing transfer summary
   i. Lab results
   j. X-ray reports
   k. Therapy notes
5. The transferring/discharging nurse shall provide a hand-off communication to the SNF prior to discharge of the patient.

E. **DISCHARGE TO ~~TCMC~~ TCHD ACUTE REHABILITATION UNIT:**

1. When the primary physician~~/AHP~~ requests a stroke/neuro rehab assessment and/or a rehab consultation.
   a. The Unit Secretary enters into the computer a request for an acute rehab evaluation through Cerner.
   b. The Rehab Admission Coordinator, in collaboration with the Acute Rehab Medical Director, will complete the pre-assessment form and document the outcome in the medical record.
   c. When a patient is not accepted into the program or the patient is a potential rehab candidate and a bed will not be available for several days:
      i. A request for an order for a case manager/discharge planner consult will be made by the rehab admission coordinator in Cerner.
      ii. If the case manager/discharge planner is already involved, the rehab admission coordinator will notify the unit case manager of bed availability on the acute rehab unit.
   d. When the patient is discharged the primary nurse shall send the patient's chart and Discharge (Medication Home List).
   e. The primary nurse shall provide hand-off communication to the receiving nurse.

F. **ARRANGING TRANSPORTATION FOR THOSE WITHOUT MEANS:**

1. All patients shall be encouraged to arrange their own means of transportation whenever possible.
2. Case managers and social workers shall assist with difficult transportation needs.
3. During off hours, bus passes/taxi vouchers may be obtained from either the Administrative Supervisors or designee.
4. Refer to **Patient Care Services Policy:** Ambulance Transport for Patients ~~policy~~ for patients requiring ambulance transport.
5. The ~~Tri-City Medical~~**TCHD** Patient Transport Express is a free service providing transportation between ~~Tri-City Medical Center~~**TCHD** facilities and the patient's home (within a **seven [7]** mile

radius). This free service operates Monday-Friday 0630 - 1400. To schedule a ride, call 940-RIDE (7433) at least 24 hours in advance.

G. FORM(S):

~~6.~~**1. Leaving Hospital Against Medical Advice (AMA) Form**

~~G.~~H. RELATED DOCUMENT(S):

1. **Patient Care Services Policy:** Ambulance Transport for Patients ~~Policy, IV.R~~
~~1.~~**2. Patient Care Services Policy:** Discharge Planning ~~Policy, VI.E~~
~~2.~~**3. Patient Care Services Policy:** Medication Reconciliation ~~Policy, IV.JJ~~
~~3.~~**4. Patient Care Services Standardized Procedure: Discharge from Outpatient Post-Anesthesia Nursing Service**

I. REFERENCE(S):

1. **Cal. HSC § 1262.5 (1973).**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 8/01 **SUBJECT: Identification, Patient**

REVISION DATE: 3/03; 2/05; 6/06; 6/09; 2/12; **POLICY NUMBER:** IV.A

Department Approval:	**02/18**
Clinical Policies & Procedures Committee Approval:	**~~09/14~~04/18**
Nursing Executive Council:	**~~10/14~~04/18**
Medical Executive Committee Approval:	**~~10/14~~05/18**
Professional Affairs Committee Approval:	**11/14**
Board of Directors Approval:	**12/14**

A. **POLICY**

1. It is the policy of Tri-City Medical Center to reliably identify the individual as the person for whom the service or treatment is intended and co-match the service or treatment to that individual. Exception: Patients unable to provide identifying information, who experience conditions requiring emergency care will receive treatment prior to identification if such care and treatment is necessary to stabilize the patient's condition (example: unidentified patient arriving comatose to the emergency department, i.e. John/Jane/Baby Doe).
2. All patients must wear a correct and legible patient identification (ID) band at all times.
3. The patient's primary nurse is responsible for the accuracy of the patient's ID band.
4. Two patient identifiers are used when administering medication, blood or blood components, when collecting blood samples and other specimens for clinical testing and when providing treatments or procedures and diagnostic testing (excluding consultation and teaching) to ensure the correct patient is involved.
   a. The first identifier is the patient name (If the name is too long an exact match up to 13 characters is required).
   b. The second identifier is:
      i. Patient date of birth - ~~(~~Outpatient Areas~~)~~
      ii. Patient Medical Record Number - ~~(~~Inpatients~~)~~
      iii. Patient Account~~/ vs~~ **Financial** Number **(FIN)** - ~~(~~Emergency Department~~)~~

~~6.~~**5.** All containers used for blood and other specimens will be labeled in the presence of the patient.

~~5.~~**6.** Additionally, staff shall verbally assess the patient to assure proper identification, asking the patient's name **if appropriate for~~consistent with~~** age, condition and ability to understand and matching the verbal confirmation to the written information on the identification band.

7. If a patient is to have blood products administered, a Transfusion Service ID band must be applied by either laboratory staff or nursing personnel and can only be removed by laboratory staff.

a. Contact Lab to remove and replace the armband

~~6.~~**b. Surgical Services RNs may remove the transfusion service ID band if necessary for site access. The band must be immediately reapplied to the available site.**

~~7.~~**8.** Any staff person removing an ID band for any reason is responsible for replacing the ID band and ensuring accuracy and legibility.

~~8.~~**9.** If the patient is not alert, a family member or representative may verify accuracy of the information.

~~9.~~**10.** Name alert signs for similar patient names shall be posted on the chart and at the nurse's station.

~~10.~~**11.** All newborns must be banded before being separated from their mother (see Patient Care Services **Procedure:** Identification of Newborns ~~Procedure~~).

12. No procedure shall be conducted when patient identification cannot be verified because the imprinted band is illegible or missing. Defective or missing ID bands shall be replaced immediately with new, accurate, legible ID bands.

B. RELATED DOCUMENTS:

~~11.~~**1. Patient Care Services Procedure: Identification of Newborns**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 11/11

SUBJECT: Interpretation and Translation Services

REVISION DATE: 10/13; 01/14; 01/15, 03/16

POLICY NUMBER: II.J

Department Approval:	**~~09/16~~04/18**
Clinical Policies & Procedures Committee Approval:	**~~10/16~~04/18**
Nurse Executive Council Approval:	**~~10/16~~04/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/16~~05/18**
Professional Affairs Committee Approval:	**01/17**
Board of Directors Approval:	**01/17**

A. **PURPOSE:**

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

B. **DEFINITIONS:**

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

e. General Information Interpreter: Personnel with validated competency to interpret limited topics relating to providing directions, obtaining specific demographic information, and/or assisting patients with registration, basic daily activities, and comfort.
f. Telephone Interpreters: Contracted provider, designated telephone interpreter focused on quality health care communication to be used when a qualified interpreter (facility identified) is not available.
g. Video Remote Interpreters: Contracted providers, designated video remote interpreter focused on quality health care communication to be used when a qualified interpreter (facility identified) is not available or in lieu of a telephone interpreter.

6. Critical Medical Communications: Generally includes but not limited to:
   a. Consent and/or acknowledgement of information discussion
   b. Advance directive discussion
   c. "Do Not Resuscitate" (DNR) and discussion
   d. Explaining any diagnosis and plan for medical treatment
   e. Explaining any medical procedures, tests or surgeries
   f. Initial medication education
   g. Patient complaints
   h. Final discharge instructions
7. Critical Service Information: Generally includes but not limited to:
   a. Agreement for Services
   b. Notices pertaining to the denial, reduction, modification or termination of services and benefits, and their right to file a grievance or appeal
   c. Applications to participate in a program or activity or to receive hospital benefits or services.

C. **POLICY**

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

D. **PROCEDURE**

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

i. A service information interpreter shall be utilized as needed

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

E. **DOCUMENTATION**

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

F. **FORM/RELATED DOCUMENTS:**

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

G. **REFERENCES**

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

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

A. **POLICY:**

1. The primary **Registered Nurse** (RN) shall call the Rapid Response Team (RRT) if a patient is experiencing new or worsening "stroke-like" symptoms and will obtain a blood glucose level via point of care blood glucose meter prior to RRT arrival.
   ~~a. The Telemetry RN will also perform National Institute of Health Stroke Scale (NIHSS) 1,5, and 6 prior to arrival of RRT.~~
2. The RRT will do a patient assessment with the National Institute of Health Stroke Scale (NIHSS) detailed stroke scale assessment on the patient when they arrive on the unit.
3. The RRT will initiate the in-house stroke code by dialing 66 from the patient's room and inform the Public Branch Exchange (PBX) operator that there is an in-house stroke code on the unit and will give the patient's room number.
~~3.~~**4. The RRT or designee will order the In House Stroke Code power plan**
~~4.~~**5.** PBX Operator:
   a. The operator shall call a stroke code overhead and will page the Stroke Team which consists of the following staff members:
      i. Computerized technologist
      ii. Lab phlebotomist
      iii. Stroke coordinator
      iv. Radiology technologist
~~5.~~**6.** The primary nurse or designee will contact the on call hospitalist at (760) 966-2499 and inform the hospitalist of the in-house stroke code.
7. The hospitalist will come assess the patient and if the hospitalist agrees with the stroke code, the ~~primary nurse or designee~~**hospitalist** will contact the neurologist on call at (760)940-~~3000~~ **3002** ~~and provide the RRT return phone # (760) 802-3727~~
   a. The Stroke Code will continue unless cancelled by the hospitalist on call.
   ~~6.~~**b. If the hospitalist does not ~~respond~~arrive to assess the patient in a timely manner, the RRT will page the neurologist ~~after the STAT CT Stroke Code without contrast.~~and continue on with the stroke code.**
   ~~a. If the hospitalist doesn't agree, the stroke code will be cancelled~~
      ~~7.~~**i.** RRT to give the on call Neurologist the patient's NIHSS score and patient assessment details so the neurologist can verify the stroke code is appropriate and any further orders.
8. The RRT and/or Stroke Coordinator serve as the team leader:
   a. Evaluates timeline (time from symptom onset to intravenous thrombolytic administration should be less than 4.5 hours). Determines eligibility for thrombolytics in collaboration with Neurologist
   b. Performs patient NIHSS and patient assessment
   c. Orders necessary tests/labs –
      i. In House stroke code order set which includes:
         1) STAT **Computerized Tomography** (CT) Stroke Code without Contrast, **CT Stroke Code Angio COW (Circle of WILLIS), and CT Angio Carotid**
         ~~1)~~**a) ~~(n~~No need to wait for creatinine level or GFR prior to scans~~)~~**

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Division of Neurology	Medical Executive Committee	Professional Affairs Committee	Board of Directors
New, 8/15	05/14, 9/15, **05/17**	05/14, **09/15, 05/17**	11/14, **04/18**	11/14, **05/18**	01/15	01/15

2) **Prothrombin Time** (PT), **Partial Thromboplastin Time** (PTT), **International Normalized Ratio** (INR), **Chemical Panel** (Chem 12) and **Complete Blood Count** (CBC)

d. Discusses possible treatment options that may be ordered by physician with patient/family
e. Accompanies monitored patient to CT scanner as indicated by acuity
f. Administers thrombolytic agent if ordered
g. Monitors for signs/symptoms of bleeding, neurologic deterioration, changes in vital signs

9. The Neurologist shall collaborate with RRT and the attending physician when available during the stroke code.
10. Primary nursing:
    a. Administers supplemental oxygen as ordered
    b. Assesses vital signs
    c. Monitors cardiac rhythm(in monitored areas) and pulse oximetry
    d. Ensures **intravenous** (IV) access (prefer 18-20 g in antecubital or forearm)
    e. Considers/secures second IV as indicated for thrombolytic administration
    ~~e.~~**f. Administer thrombolytics as ordered**
11. Lab Phlebotomist:
    a. Draws stat blood tests as ordered, draws PT/INR, PTT, Chem 12 and CBC
    b. Immediately delivers to lab and hands off to technologist
12. Laboratory technologist:
    a. Performs testing
        i. If specimen hemolyzes, immediately initiate redraw. Notify RRT 760-802-3727 or physician of delay.
    b. Call results directly to the RRT (760)802-3727, and document the communication in Cerner.
        i. Time from order to communication of results should be less than 45 minutes
13. Pharmacist:
    a. RRT or designee will notify pharmacy of possible tPA candidate
    b. Pharmacy will verify inclusion/exclusion criteria and weight while awaiting tPA orders from Neurologist
    c. When tPA ordered pharmacy will prepare and send tPA to RRT RN
14. Assigned radiology transporter:
    a. Transports patient to CT scanner
15. Radiology technologist:
    a. Verifies with RN that Stroke Code notification was received.
    b. Prepares the CT scanner for emergent head CT as per imaging protocol
    c. Performs the CT.
        i. Time from order to completion of test should be less than 25 minutes for patients eligible for thrombolysis.
    d. CT alerts Radiologist to stroke code
16. Radiologist:
    a. Reads CT immediately and contacts the on-call neurologist with results: (Time from completion of test to communication with Neurologist should be less than 20 minutes for patients eligible for thrombolysis.)
17. The (ANM) Assistant Nurse Manager/designee shall assist RRT to assure patient is placed on the appropriate nursing unit.
    a. Patients receiving tPA shall be assigned to a bed in the Intensive Care Unit (ICU)
    b. All other patients, are assigned based on acuity or physicians order, to 4P or Telemetry
    c. Whenever possible patients must be in the monitored/camera beds on 4P
18. Post-Stroke Code Care; per CPOE Stroke Care Set (unless superseded by physician orders):
    a. Continuous cardio respiratory monitoring
    b. Blood pressure recording
    c. Monitor temperature

d. Monitor neurological status: NIH Stroke Scale and neuro checks
e. Monitor peripheral circulation and end-organ perfusion (skin temperature, capillary refill, peripheral pulses, and urinary output).
f. Monitor for signs of bleeding or other complications if tPA administered.
g. Maintain two (2) intravenous lines (if tPA administered).
h. Monitor blood studies.
i. Measure intake and output

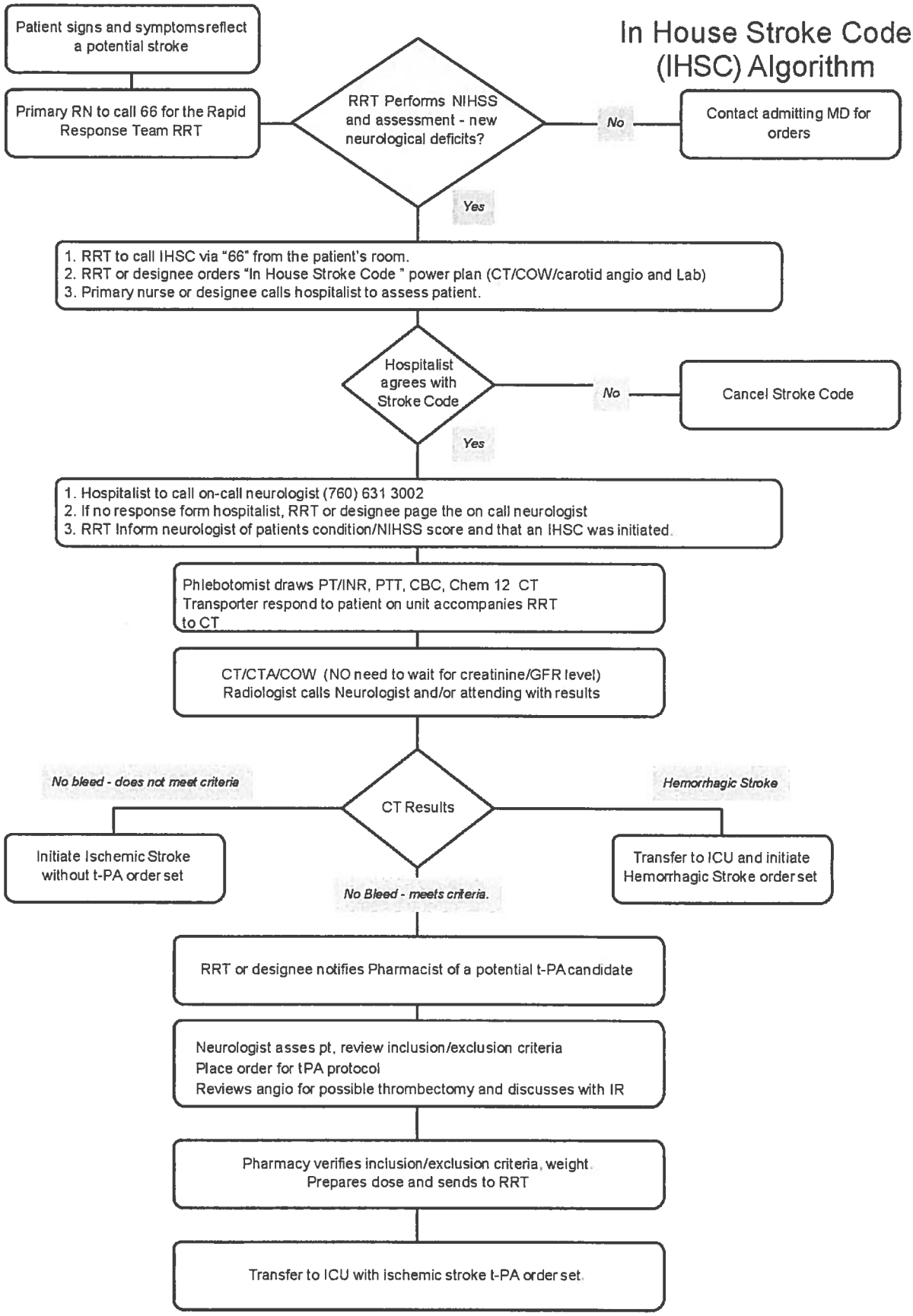
19. Documentation:
    a. RRT shall document events in the patient's medical record. (NOTE: Obtaining CT scan and labs have highest priority and should not be delayed unless absolutely necessary for patient safety.)

C. **FORMS (LOCATED IN PATIENT CARE SERVICES MANUAL; FORM/RELATED DOCUMENTS FOLDER):**

1. Stroke Code; In-House Algorithm

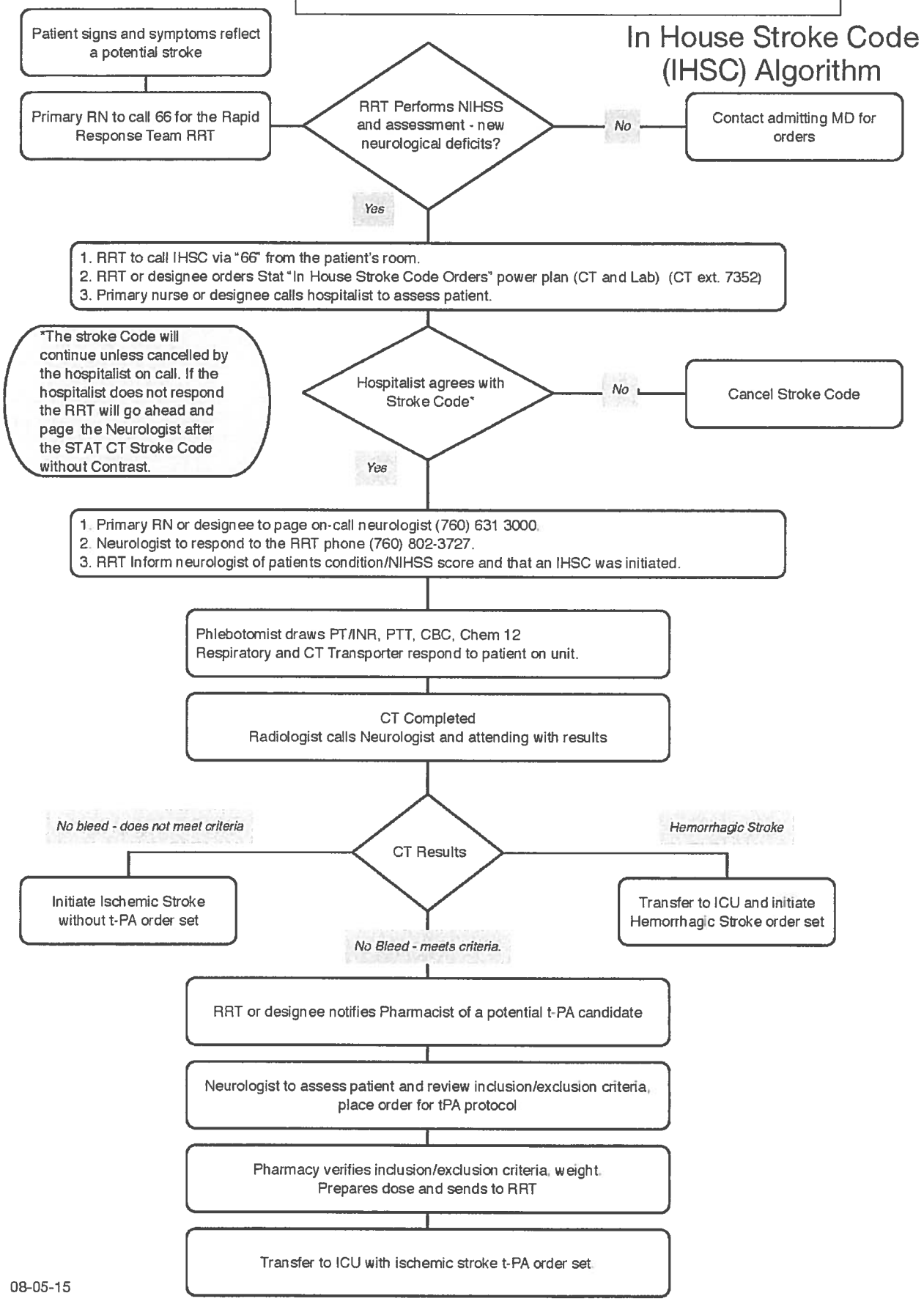
D. **REFERENCES:**

1. **Guidelines for Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals from the American Heart Association /American Stroke Association. ~~2013~~2018:49e46-e99;44:870-947**~~Guidelines for the Early Management of Adults with Ischemic Stroke. Stroke, Journal of the American Heart Association, 2007: 1655-1708~~
~~1.~~2. **Scientific Rationale for the Inclusion and Exclusion Criteria for Intravenous Alteplase in Acute Ischemic Stroke. Stroke 2016;47:581-641**
~~2. The National Institute of Neurological Disorders and Stroke rt-PA Stroke Study Group. N Engl J Med. 1995; 333:1581-7.~~


In House Stroke Code (IHSC) Algorithm
Patient signs and symptomsreflect a potential stroke
Primary RN to call 66 for the Rapid Response Team RRT
RRT Performs NIHSS and assessment - new neurological deficits?
No
Contact admitting MD for orders
Yes
1. RRT to call IHSC via "66" from the patient's room.
2. RRT or designee orders "In House Stroke Code " power plan (CT/COW/carotid angio and Lab)
3. Primary nurse or designee calls hospitalist to assess patient.
Hospitalist agrees with Stroke Code
No
Cancel Stroke Code
Yes
1. Hospitalist to call on-call neurologist (760) 631 3002
2. If no response form hospitalist, RRT or designee page the on call neurologist
3. RRT Inform neurologist of patients condition/NIHSS score and that an IHSC was initiated.
Phlebotomist draws PT/INR, PTT, CBC, Chem 12 CT
Transporter respond to patient on unit accompanies RRT to CT
CT/CTA/COW (NO need to wait for creatinine/GFR level)
Radiologist calls Neurologist and/or attending with results
No bleed - does not meet criteria
CT Results
Hemorrhagic Stroke
Initiate Ischemic Stroke without t-PA order set
Transfer to ICU and initiate Hemorrhagic Stroke order set
No Bleed - meets criteria.
RRT or designee notifies Pharmacist of a potential t-PA candidate
Neurologist asses pt, review inclusion/exclusion criteria
Place order for tPA protocol
Reviews angio for possible thrombectomy and discusses with IR
Pharmacy verifies inclusion/exclusion criteria, weight.
Prepares dose and sends to RRT
Transfer to ICU with ischemic stroke t-PA order set.

DELETE

In House Stroke Code (IHSC) Algorithm



08-05-15

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**WASTING NARCOTICS, DOCUMENTATION IN THE PYXIS MACHINE**
Purpose:	To outline the process and corresponding documentation for wasting controlled substances in the Pyxis.

DELETE – incorporated into Pharmacy/Patient Care Services Policy: Automated Dispensing Machine (Pyxis)

~~A. **DEFINITIONS:**~~

~~1. Pyxis: Automated Dispensing Machine used to dispense and~~

~~2. Approved licensed health care professional~~

~~a. Anesthesiologist~~
~~b. Registered Nurse~~
~~c. Licensed Vocational Nurse~~
~~d. Respiratory Care Practitioner~~
~~e. Radiology Technician~~
~~f. Pharmacist~~
~~g. Pharmacy Technician~~

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

~~1. Wasting Single Dose Narcotics and Patient Controlled Analgesia (PCAs):~~

~~a. Select "Waste" key~~
~~b. Select patient's name and a list of medications removed in the past 24 hours will appear.~~
~~c. Select medication to be wasted~~
~~d. Type in amount of medication given (amount to waste will be automatically filled in)~~
~~i. When wasting PCAs, drips or epidurals the waste amount will be in milliliters~~
~~e. Waste requires another nurse or other approved licensed health care professional to witness~~
~~f. Select "Accept" key~~
~~g. Upon completion of documentation, both people signing for waste must properly dispose of excess medication based on the current waste disposal guidelines.~~

~~2. The above process can also be completed in Pyxis at time of medication removal. The Pyxis will prompt the nurse to enter information in steps d and e at time of removal. Steps a-c will not need to be completed.~~

~~3. Wasting controlled substances that were not removed from same Pyxis~~

~~a. Select "Waste" key~~
~~b. Select patient's name. Since the medication was not originally removed from this Pyxis, the medication will not be listed on the patient's profile.~~
~~c. Select "all meds" key and a list of all meds will appear on the screen~~
~~d. Select medication to be wasted~~
~~e. Type in amount of medication given (amount to waste will be automatically filled in)~~
~~f. Waste requires another nurse (or other approved licensed health care professional) to witness.~~
~~g. Select "Accept" key~~
~~h. Upon completion of documentation, both people signing for waste must properly dispose of excess medication based on the current waste disposal guidelines.~~

~~4. See Waste Disposal Guidelines for wasting controlled substances.~~

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

~~1. Waste Disposal Guidelines~~

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
05/03, 06/09, 07/12, 09/15, 02/17, **12/17**	07/12, 10/15, 03/17, **01/18**	08/12, 10/15, 03/17, **01/18**	12/15, 05/17, **01/18**	08/12, 02/16, 06/17, **02/18**	09/12, 07/17	09/12, 07/17

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; Stericyle Healthcare Environmental Resource Center, Epinephrine Fact Sheet http://www.dtsc.ca.gov/LawsRegsPolicies/Title22/upload/Ch11_Art4.pdf

Revised Date: 04/2017 pharmacy

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: WOUND, OSTOMY, CONTINENCE NURSE ~~/ ENTEROSTOMAL THERAPIST~~ (WOCN/~~ET~~) ~~STANDARDIZED PROCEDURE~~

I. **POLICY:**

A. Function: Wound, Ostomy, Continence Nurse~~/Enterostomal Therapist~~ (WOCN/~~ET~~) **consult or** referral for **wound team** evaluation and treatment of patients with **partial or full thickness** wounds, ostomies, **incontinence associate** impaired skin integrity**, fungal rashes,** ~~and~~ incontinence**, pressure injury prevention and treatment**.

B. Circumstances:

1. Setting: Tri-City Medical Center acute care setting
   a. Assessment management of **high risk patient for pressure injuries,** acute and chronic wounds, ostomy and peristomal problems, impaired skin integrity, and incontinence.
   b. Collaborating with physicians, and other health care disciplines including, but not limited to physical therapy, dietary consultation.
2. Supervision: None required
   a. The WOCN shall communicate with the physician for the following situations and any others deemed appropriate.
      i. Emergent conditions requiring prompt medical interventions.
      ii. Acute decompensation of patient situation
      iii. Problem that is not resolving as anticipated
      iv. Any adverse episode

II. **PROCEDURE:**

A. This Standardized procedure covers the assessment, management, and treatment of patients with acute and chronic wounds including, but not limited to pressure **injuries**~~ulcers~~, venous ulcers, arterial ulcers, diabetic foot ulcers, post-operative wounds, traumatic wounds, skin tears, superficial burns, ostomies, fistulas, and percutaneous tubes. Associated skin conditions may include, but are not limited to stasis dermatitis, **moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).**~~contact dermatitis, and cutaneous fungal infections.~~

B. Acute and Chronic Wounds:

1. Assessment data may include, but is not limited to:
   a. Historical information
   b. Review of previous treatment of current condition and response to treatment
   c. Review of current medications
   d. Review of associated risk factors
   e. Wound measurement: Length x width x depth
   f. Wound bed appearance: granulating, necrotic, presence of slough
   g. Wound drainage including amount, color, and consistency
   h. Periwound skin surface (intact, denuded, macerated)
   i. Presence of edema
   j. Circulatory status
   k. Wound type of stage / deep tissue exposed
2. Plan:
   a. Therapeutic regimen:

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Pharmacy and Therapeutics	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
04/07, 06/11	03/11, **05/17**	03/11, **05/17**	06/11, **05/17**	06/11, **07/17**	06/11, **03/18**		06/11

i. Dependent upon the conclusion of the assessment process

b. Patient education regarding:
   - **i.** Disease process
   - ~~i.~~**ii. Prevention and treatment of pressure injuries**
   - ~~ii.~~**iii.** Risk factors / change in behavior and routine
   - ~~iii.~~**iv.** Procedures
   - ~~iv.~~**v.** Diagnostic testing
   - ~~v.~~**vi.** Medications

c. Treatment appropriate to the condition and status of wound, including but not limited to:
   - **i. Wound Culture as clinical indicated aerobic / anaerobic and gram stain**
   - **ii.** Application of dressings to maintain moist wound bed
   - ~~i.~~**iii. Negative pressure wound therapy**
   - ~~ii.~~**iv.** Conservative sharp debridement and autolytic debridement
   - ~~iii.~~**v.** Compression therapy
   - **vi.** Use of equipment
   - ~~iv.~~**vii. Specialty mattress and bed selection as clinical indicated**

3. Consultation:
   a. Consultation and referral to the appropriate specialist or health care professional is initiated when the condition necessitates.
4. Follow-up:
   a. Follow-up shall be initiated by the WOCN at his/her discretion as indicated to evaluate the patient's condition at appropriate time intervals.
   b. Evaluate for possible referral to the TCMC Center for Wound Healing and Hyperbaric Medicine.

C. Pressure **Injuries:** ~~Ulcers:~~
1. A pressure **injury** ~~ulcer~~ is any lesion caused by unrelieved pressure resulting in damage of underlying tissue.
2. Pressure **injury** ~~ulcers~~ are usually located over bony prominences **or under a medical device excluding mucosal membranes** and are graded or staged to classify the degree of tissue damage observed.
3. Treatment:
   - **a. Apply a prevention foam composite dressing to high risk areas or under a medical device to prevent injury. Assess under the dressing q shift and with a change in condition.**
   - ~~a.~~**b.** Turn and reposition patient at least every 2 hours **or more frequently as needed to prevent injury.**
   - ~~b.~~**c.** Assure the appropriate selection of support surface.
   - ~~c.~~**d.** Educate staff**, patient and or family** on pressure **injury** ~~ulcer~~ prevention and treatment per hospital policies.
   - ~~d.~~**e.** Dry Wounds:
     - i. **T**~~t~~opical wound care to include, but not limited to the use of hydrogels, ointments, creams, cover dressings.
   - ~~e.~~**f.** Wet Wounds:
     - **i.** **T**~~t~~opical wound care to include, but not limited to use of absorptive fillers, granules, paste, powder, alginates, **ointments** and absorptive cover dressings.
   - ~~a.~~**g. Prevention of Pressure Injuries is a comprehensive and collaboratiative approach involving the staff and the patient. This includes but is not limited to: product evaluation, patient recommendations for care, staff education and in-services, specialty bed selection, and as indicated Consultation with Wound Physician, Plastic Surgeon Service, Dietician, Physical Therapy.**
4. Adjunctive therapies:

a. Vacuum Assisted Closure (VAC) **or Veroflo**
b. Wound debridement:
   i. Autolytic
   ii. Enzymatic
c. Topical therapy for odor management and reduction of bacterial burden.

D. Ischemic (Arterial) Ulcers:
1. Arterial ulcers are caused by lack of blood flow and tissue perfusion. Pressure, trauma and other factors may precipitate their development.
2. Treatment:
   a. Circulatory status will determine treatment and management of arterial ulcers
   b. Assessment of circulatory status to include but not limited to:
      i. Palpation of pulses
      ii. Assessment of skin color, skin temperature, and capillary refill time
      ~~b.~~**1) Atrophy of the skin; skin cool to touch; absent hair**
      ~~ii.~~**iii.** Presence of hair and toenail changes
      ~~iii.~~**iv.** Dependent rubor
      ~~iv.~~**v.** Sensation, pain
      ~~v.~~**vi.** **Arterial duplex study to evaluate physiologic wave forms for wound healing** ~~nkle-Brachial Index~~
   c. Topical dressings may include hydrogels, absorptive wound fillers, **matrix dressing,** nonocclusive absorptive dressings, and hydrophilic dressings.
   d. Enzymatic debridement or conservative sharp tissue debridement after vascular status is established and as been ordered by the physician.
   e. Consultation with Vascular Service, Dietician, Physical Therapy, Podiatrist, Orthotist, as indicated.
   ~~e.~~**f. Arterial wound should not be classified as pressure injury.**
3. Educate patient and staff on pressure reduction and trauma prevention to lower extremities.

E. Venous Ulcers:
1. Venous ulcers may be defined as ulceration secondary to chronic venous insufficiency. Veins can be normal, but patient may have poor venous return, due to calf muscle pump incompetence, i.e., paraplegics or rheumatoid arthritis.
2. Treatment:
   a. Assessment of circulatory status to include but not limited to:
      i. Presence of edema
      ii. Stasis dermatitis
      iii. Lipodermatosclerosis
      iv. Hyperpigmentation
   b. Topical wound care to absorb excess drainage and maintain moist wound bed.
   c. Compression therapy, if arterial circulation is satisfactory
      i. Stockings or tubular elastic bandage, compression socks, stockings or tubular elastic bandage
      ii. 2 or 4 layered wraps
      iii. Pneumatic compression device
      iv. Foot pumps

F. Alteration in Skin Integrity: **moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).**
1. Alteration in skin integrity may be the result of the following factors:
   a. Excessive exposure of the skin to moisture due to but not limited to:
      i. **P**~~p~~erspiration~~,~~
      ii. **W**~~w~~ound ~~——~~drainage~~,~~
      iii. **U**~~u~~rine and **F**~~f~~ecal **I**~~i~~ncontinence~~.~~
   b. Mechanical trauma due to pressure, friction and shear

c. Adhesive tape removal
d. Fungal/yeast infections
e. Allergic
f. **C**~~c~~ontact dermatitis

2. Treatment of partial or full thickness skin loss:
   a. Partial or full thickness skin loss may present as maceration, redness, denudation, itching, dermal stripping, flaking, rash, macular or popular pustules, fluid-filled blisters, and skin tears due to trauma.
   b. Cleanse with normal saline or commercially prepared dermal cleanser.
   c. Treatment appropriate to the condition and status of the wound, such as application of wound gel, oil emulsion gauze, hydrocolloids, and/or transparent dressing.
3. Treatment of fungal/yeast infections:
   a. Fungal infections are classified as dermatophyte or yeast infections that grow in moist, warm, dark surfaces such as in skin folds or between toe webs.
   b. Cleanse with normal saline or use commercially prepared skin cleansers.
   c. Thoroughly dry skin and skin folds.
   d. Apply anti-fungal ointment, powder, or cream, per manufacturer's recommendations.
4. Treatment of hypergranulation:
   a. Hypergranulation is when granulation tissue exceeds the height of the epidermal layers.
   b. Cleanse wound with normal saline or commercially prepared dermal cleanser and pat dry.
   c. Moisten tip of silver nitrate stick with water.
   d. Apply to affected area. Neutralize with normal saline.
   e. Reassess treatment effectiveness with next dressing or ostomy pouch change.
5. **Treatment of Incontinence related Skin Damage:**
   a. Cleanse the perineal area with ph balanced peri wipes.
   b. apply protect ointment or paste to affected area as needed to repel urine and stool.
   c. consider implementation female urinary diversion device or male urinary diversion device.
   d. consider a fecal containment device for liquid stool incontinence.
   e. Reevaluate placement and patency to ensure a medical device does not cause injury.

G. Diabetic Foot Ulcers or Neuropathic Wounds:

1. Diabetic Foot Ulcer (DFU) is a combination of local and systemic risk factors that result in ulceration in the foot. Wound healing and limb salvage outcomes are based on identifying the causative and contributing factors. Five key areas: patient, skin, circulation, limb, and wound. These factors influence wound treatment modality and limb salvage.
   a. Peripheral Sensory Neuropathy:
      i. Semmes-Weinstein monofilament exam. This tests for neuropathy resulting in loss of protective sensation.
   b. Peripheral Arterial Disease:
      i. Evaluate vascular status by history of symptoms of intermittent claudication, ischemic rest pain, and peripheral vascular surgery; clinical signs of ischemia, such as skin temperature, dependant rubor, pallor, hair loss, and shiny skin and a clinical assessment of lower extremity pulses, ABI, or arterial duplex waveform study to determine perfusion status.
   c. Mechanical trauma due to pressure, friction and shear:~~,~~
      i. Evaluation of skin and nail changes

ii. Musculoskeletal examination

d. Infection:~~,~~

i. Soft tissue and bone infection

1) X-ray or MRI

e. Prevention:

i. Evaluate risk factors and risk stratification to prioritize the patient's treatment according to the patient's needs. Preventive Education to reduce Diabetic Foot Ulcers.

ii. Protective Footwear and Pressure Redistribution

1) Primary role of therapeutic footwear is to protect the foot from repetitive injuries and eliminate the shoe as a source of pathology.

2. Treatment of Diabetic Foot Wound:

a. Antibiotic therapy and revascularization of ischemia will be initiated by Physician Team.

b. Sharp Debridement of the ulcer removes the devitalized tissue, reduces the bacterial load, eliminates proteases from the wound bed, and provides bleeding to the wound bed. Enzymatic debridement or autolytic debridement may be an option if sharp debridement is not possible or PAD.

c. Cleanse with normal saline or commercially prepared dermal cleanser, promote moist wound healing.

d. Treatment appropriate to the condition and status of the wound, such as application of wound vac or veroflo, ointments, enzymatic debridement ointments, composite dressings, silver dressings and/or foam dressing.

e. Off – Loading of wound to allow for wound healing.

f. Consultation with Wound Physician, Vascular Service, Dietician, Physical Therapy, Podiatrist, Orthotist, as indicated.

g. Diabetic Foot Wounds should not be classified as pressure injury.

~~e.~~h. Educate patient and staff on pressure reduction and trauma prevention to Diabetic Foot Wounds.

~~G.~~**H.** Ostomies, Fistulas, and Percutaneous Tubes

1. Treatment:

a. Assessment will include, but not limited to:

i. Description and evaluation of ostomy, fistula, peristomal skin, or percutaneous tube status

ii. Review of previous treatment of current condition and response to treatment

iii. Access stoma, fistula, or percutaneous tube drainage

iv. Presence of hernia or other stomal complications

b. Treatment appropriate to the condition:

i. Ostomy care and associated skin irritation

ii. Evaluation of stoma and peristomal skin condition to determine appliance choices

iii. Peristomal skin irritation, contact dermatitis interventions, such as:

1) Cleansing and application of protective skin barrier paste, powder, or barrier rings

2) Treatment of peristomal hypergranulation with silver nitrate cautery

iv. Management and removal of stents, drains, or stomal bridges as ordered by the physician

v. Evaluate fistula and perifistular skin condition to determine appropriate method to contain drainage

vi. Treatment of perifistular skin irritation, contact dermatitis, and skin erosion due to drainage

vii. Cleansing and application of wound containment device or topical wound product
viii. Barrier ointments or dressings to treat and protect the surrounding skin

c. Percutaneous tube skin treatment:
i. Cleansing, use of barrier powder, creams or ointments
ii. Dressing changes appropriate to drainage volume, or
iii. Use of containment devices.

III. DOCUMENTATION:

A. The WOCN shall document services provided and patient response to treatment in the medical record.

IV. REQUIREMENTS FOR RNS INITIATING STANDARDIZED PROCEDURE:

A. Current California RN license.
B. Education:
1. Be a graduate of an approved Wound, Ostomy, Continence Education Program ~~with current certification,~~ or
~~2. Be a graduate of a professionally recognized school of Enterostomal Therapy.~~
2. Participate in 30 hours of continuing education every 2 years.
~~2.~~**C. Annual Competency Assessment including Sharp Conservative Debridement Validation**

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

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

VI. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform Wound, Ostomy, and Continence Nurse Standardized Procedure.

Tri-City Health Care District
Oceanside, California

Administrative Policy ~~Manual~~
District Operations

ISSUE DATE: 11/08 **SUBJECT:** SMOKE-FREE ENVIRONMENT

REVISION DATE: 5/12 **POLICY NUMBER:** 8610-205

Department Approval:	**03/18**
Administrative Policies & Procedures Committee Approval:	**~~01/15~~04/18**
Medical Executive Committee	**~~02/15~~05/18**
Professional Affairs Committee Approval:	**03/15**
Board of Directors Approval:	**03/15**

A. **PURPOSE:**

~~1. The purpose of this policy is to describe the Tri-City Healthcare District (TCHD) smoke-free environment.~~

~~2. Smoking of tobacco is a known danger to health and a cause of material discomfort and a health hazard to those who are present in areas where tobacco is being smoked. The United States Surgeon General has concluded that smoking tobacco can lead to numerous diseases for the smoker as well as others, as there is no risk-free level of exposure to second-hand smoke, the smoke created by another individual smoking tobacco.~~

~~3.~~ ~~The policy recognizes the health, safety and comfort benefits of smoke-free air, and the District's responsibility to establish and maintain an optimally healthy, safe environment for its patients, employees and visitors. Effective November 20, 2008 TCHD will become a smoke free campus.~~

~~4.~~**1. To provide adequate guidelines regarding Tri-City Healthcare District's commitment to providing a safe and healthful work environment for all employees, contracted staff, medical staff, vendors, patients, visitors and other customers**

~~5.~~**2. Smoke inhaled from direct smoking, as well as, indirectly from other's who are smoking nearby is a major cause of preventable disease and death.The hospital serves as a model for our community in the area of promoting good health of our staff and influencing public attitudes about smoking. It is therefore, TCHD's policy to provide a smoke free environment.**

~~B. SCOPE:~~

~~1. This policy is in effect during and after work hours and applies to all individuals working, visiting, or receiving medical care within all of the District's inpatient and outpatient facilities. It includes all property and buildings owned or leased by TCHD including parking areas.~~

~~C.~~**B. DEFINITIONS:**

~~1. District premises: All property and buildings owned or leased by TCHD including parking lots.~~

~~2.~~**1.** Tobacco products: Any product containing tobacco intended to be lit, burned, or heated to produce smoke as well as any device used to smoke the tobacco, including but not limited to a pipe, cigar, or cigarette, (including electronic cigarettes).

~~3.~~**2.** Electronic cigarette: Any electronic device designed or intended to produce smoke or vapors for inhalation.

C. **POLICY:**

1. **It is the policy of TCHD to provide a safe, healthful and comfortable work environment for all employees, contracted staff, vendors, patients visitors and physicians by prohibiting smoking or all tobacco based products at all facilities owned or operated by TCHD.**
2. **Employees, contracted staff, patients, vendors, visitors and physicians are prohibited from smoking or utilizing tobacco based products on or in any TCHD facility, adjacent**

grounds, including parking lots and TCHD leased or owned vehicles. Employees, contracted staff, patients, vendors, visitors and physicians are prohibited from smoking or utilizing tobacco based products in their own or others vehicles when they are parked on TCHD property.

D. **PROCEDURES:**

~~Prohibition of Tobacco Use~~

~~a. Smoking of any kind is prohibited on all TCHD owned and/or leased locations/premises; entrances and exits and in all TCHD owned and/or leased vehicles. In addition, use of all tobacco products, which produce smoke or vapor, is prohibited.~~

~~2.~~**1.** Communication of Policy

a. Signs bearing the message "Smoke-Free Campus" are posted at strategic locations around the property (as applicable), and each building owned or leased in full will display a decal that states "Smoke Free Facility." No ashtrays or smoking shelters are provided on the campus property.

b. Patients and their families/friends will be informed of this policy upon arrival or as soon thereafter, as is medically appropriate.

c. ~~Patients will be informed of the smoking policy on admission.~~

d. All employees are authorized to communicate this policy with courtesy and diplomacy to other employees, medical staff, patients, and visitors.

~~3.~~**2.** Tobacco Cessation Programs

a. TCHD is committed to providing support to all TCHD employees who wish to stop using smoking products. TCHD is committed to ensuring that TCHD employees have access to smoking cessation assistance.

b. Supervisors are encouraged to refer employees and other personnel to Employee Health for information on available services.

~~4.~~**3.** Responsibilities

a. Adherence to this policy is the responsibility of all individuals working, visiting, or receiving medical care within TCHD as cited above. Compliance with this policy is mandatory and will be strictly enforced. Policy violations by employees will be subjected to the standard TCHD disciplinary actions.

b. Employees who choose to use smoking products must do so on their own time

c. Respectful monitoring of this policy will be shared by all TCHD staff and Security.

~~5.~~**4.** Enforcement - Employees

a. This policy will be enforced through administrative action by supervisors and managers.

b. ~~Any person who observes violations of the policy is encouraged to report these violations to their supervisor and/or security.~~ Once the employee's supervisor has been notified of a violation by an employee under their direction, the supervisor is responsible for discussing the violation with the employee and taking appropriate disciplinary action. ~~The same disciplinary approach should be applied that is used in addressing violations of other TCHD policies.~~

c. Standard disciplinary procedures will be followed for compliance with staff. Violations of this policy will result in progressive disciplinary actions, up to and including termination.

~~b.~~**d. All personnel are responsible for adherence to and enforcement of the smoke free policy**

~~6.~~**5.** Enforcement – Patients and Visitors

a. Patients, visitors, and any other guests who fail to comply with this policy will be reminded that TCHD is a smoke-free facility and will be advised of resources available to assist with compliance while they are on TCHD property.

b. Patients will not be permitted to smoke during hospitalization. Refer to Patient Care Policy, *Patient Smoking* for management of patients refusing to comply with this policy.

E. **RELATED DOCUMENTS:**

1. Administrative Policy 424: Coaching and Counseling for Work Performance Improvement

2. Administrative Policy 234: Security Department Incident Notification
3. **Behavioral Health Services Policy: Smoke Free Environment**

F. **REFERENCES:**

1. Centers for Disease Control and Prevention. *Healthy Workforce Initiative:* Implementing a Tobacco-Free Campus Initiative – United States 2004. Available at: www.cdc.gov/nccdphp/dnpa/hwi/toolkits/tobacco/index.htm
2. The Joint Commission (2011). *Keeping your hospital Property Smoke-Free: Successful strategies for effective policy enforcement and maintenance*. Retrieved from: **http://www.jointcommission.org/assets/1/18/Smoke_Free_Brochure2.pdf**
3. The Joint Commission (2015). Caution: E-Cigarettes pose potential hazards: Follow standards and update smoking policies to maintain compliance. *The Joint Commission Perspectives*

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Behavioral Health Unit (BHU) / Crisis Stabilization Unit (CSU) Departmental Disaster Implementation Plan**

ISSUE DATE: **11/88**
REVISION DATE(S): 09/93, 03/97, 5/00

Department Approval:	**08/16**
Division of Psychiatry Approval:	**n/a**
Environmental Health and Safety Committee Approval:	**05/18**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**

1. To assure proper management **and safety for staff, patients and visitors in the Behavioral Health Unit (BHU)/Crisis Stabilization Unit (CSU)** ~~of the department~~ during a disaster **or emergency situation**.

B. **SCOPE:**

~~B.~~**1. This document outlines the disaster emergency response actions to be taken in the event or series of events which is, or may become, detrimental to the well-being of the patients, staff, workers or visitors within the Inpatient** ~~**Behavioral Health Unit (BHU)**~~ **and Outpatient** ~~**Crisis Stabilization Unit (CSU)**~~**.**

C. **PERSONNEL:**

1. **Manager, Assistant Nurse Manager (ANM),** ~~Director; Charge RN;~~ **Registered Nurses (**~~R.N.'s~~**);** ~~,~~ **Advanced Care Technicianss (ACTs)/** ~~L.V.N.'s; L.P.T.'s;~~ **Nursing Assistants (**~~N.A.'s~~**)**; Unit Secretaries; Mental Health Workers (~~MHU~~**MHW); Psychiatric Liaisons; Marriage Family Therapist (MFT); Licensed Social Workers; Therapeutic Recreational Specialist (TR); Family Support, Peer Support, and Mental Health Interns.**

D. **EQUIPMENT:**

1. ~~Telephone call-~~**call-**~~back list-~~**Staff Disaster Call-Back Roster**
2. ~~Supplies list-~~**Supply Inventory**
3. Department Specific Information List**s (patient census, medication lists, staff rosters)**

E. **PROCEDURE:**

1. Disaster Plan Implementation:
   a. The **Private Branch Exchange** (PBX) operator will announce "Code Orange" three times over the intercom.
   b. Communication Chain of Command:
      i. The ~~Director~~ **Manager or designee** will ~~contact~~ **instruct** the ~~Charge RN~~**ANM** ~~and~~ **to** initiate the ~~telephone~~ **Staff Disaster Call-Back Roster** ~~**Call-back tree**~~**in an event where additional staff members may be needed.**
      ~~i.~~**ii.** The ~~acting charge nurse~~**ANM or nurse in charge** at the time of the disaster will continue to be in charge of the unit.
      ~~ii.~~**iii.** All personnel off the unit on duty will return immediately.
      ~~iii.~~**iv.** All personnel called into the hospital will be required to wear their I.D. badges in order to be admitted. **Arriving staff**~~They~~ will report directly to the **BHU** Unit~~.~~ **or** Labor Pool location **as directed by Manager or designee.. If their employee**

badge is not available the staff member will be directed to Employee Health ~~for~~ to obtain a temporary badge.~~: French Room 3.~~

c. Child Care Provisions:
   i. ~~Employees~~ **Personnel** called back to the hospital **will be advised if the child care program has been activated for them to bring their children if necessary.**~~may bring their children to the child care center on site. (if it~~**the** ~~**child care program** is activated)~~
   ii. In the event of a major disaster, child care provisions ~~will~~**may** be made at **an alternative care site away from the facility**~~the First Baptist Church~~.

d. Department Disaster:
   i. If the disaster has occurred on the BHU, all **additional** personnel will report to the **Labor Pool location as designated by the Command Center** ~~**designated** Labor Pool **site**~~.

e. Summary of Locations:
   i. Incident Command Center **(ICC)**: French Rooms 1 and 2 **(or alternative location).**
   ii. Labor Pool: French Room 3 **(or alternative location) as designated by Command Center.**

f. Duties of the ~~Charge Nurse~~**ANM**:
   i. Determine number of staff on the unit.
   ii. Determine patient census and number of empty beds on the unit.
   iii. Assess those patients who could be discharged and who could be moved to other areas of the unit if beds are needed.
   iv. **All** ~~This~~ information will be communicated to the ~~Command Center~~**ICC**.

g. Assessment:
   i. The ~~charge nurse~~**ANM** will determine the number of personnel who will remain on the unit and how many can be released to the Labor Pool.

h. Services to be Provided:
   i. Routine care may be discontinued at the discretion of the Incident Commander **(IC)**, ~~Director~~**Manager** or ~~charge nurse~~**ANM** until all disaster casualties have been admitted to the unit or the emergency no longer exists.
   ii. Patients will ~~be asked to meet in~~ **be directed to** the day room on the BHU and be reassured by the nursing staff.
   iii. The BHU can accept acute med**ical**-surg**ical** patients if necessary.
   iv. The nursing staff will be available to provide support to all patients and family members affected.
   v. Status reports will be completed by either the ~~Director~~ **Manager** ~~or the~~ ~~charge nurse~~**ANM, or Designee** and communicated as directed to the Command Center in French Rooms 1 and 2.

2. Discharge Plan**:**
   a. The ~~Director/charge nurse~~**Manager/ANM or Designee** will determine which patients can be safely discharged in collaboration with the Medical Director of the Behavioral Health Unit.
   b. This information will be communicated to Patient Placement who will contact the Medical Staff Director. The Medical Staff ~~Director~~ retains the final responsibility in designating which patients can be discharged. ~~Patient Placement will be stationed in the Business Office.~~
   c. As requested by the Command Center, a bed availability status/report will be made by the ~~Director~~ **Manager** ~~or the~~/**ANM**~~charge nurse~~ **or Designee**~~.~~
   d. The **Manager**~~Director/charge nurse~~**ANM** will communicate with the Discharge Unit Leader.
   e. When a patient is cleared for discharge, **an**~~the floor runner~~**RN/MHW** will escort the patient off the BHU through the ~~southwest~~ **front door** exit**, patio or recreational therapy room**. ~~The Business Office and Patient Placement will be notified by **phone or by** a designated runner as soon as the patient has been discharged.~~

F. **INFORMATION SPECIFIC TO THE ~~BEHABIORAL~~ BHU/CSU~~HEALTH UNIT~~ IN THE EVENT OF A DISASTER:**

1. Personnel:
   - **a. Manager/ANMs**
   - **b.** R~~.~~N~~.~~'s
   - ~~a. (8)~~
   - **c. Psychiatric Liaisons (PLs), Marriage Family Therapists (MFTs), Liscensed Clinical Social Workers (LCSW)**
   - ~~b.~~**d. ACTs/N.A.s** ~~L.V.N.'s and L.P.T.'s (6)~~
   - ~~c.~~**e.** Unit Secretaries **(US)** ~~(1)~~
   - ~~d. Manager~~Director ~~(1)~~
   - ~~e.~~**f.** Per diem personnel**, Therapeutic Recreational Specialist (TR), Family Support,~~ **Peer Support, Mental Health Interns** ~~(7)~~
2. Bed Capacity:
   - **a.** BHU has ~~20~~ **18 general locked** ~~open unit~~ beds **and one observation~~seclusion~~ room.**
   - ~~a.~~**b.** ~~and~~**CSU has** ~~9 locked unit beds~~**12-16 crisis stabilization** ~~unit~~**stations/recliner chairs and 2 seclusion rooms**.
3. Oxygen/Suction: **(Contact Engineering if cover plates need to be removed for access)**
   - a. Piped in ~~O2~~ **Oxygen (02)** is present in Rooms 171, 172, 173, and in the treatment room.
   - b. Suction is present in Rooms 168, 169, 170, 171, 172, 173, and the treatment room.
   - c. Portable oxygen and suction is also on crash cart.
   - d. Staff ~~will~~ **shall** know the location of the O2 Shut ~~off~~ **Off** Valve for the unit **but shall not shut off without notification or approval from unit Manager, ANM, ~~or~~ Designee, or the Engineering department**.
4. Emergency Equipment:
   - a. Four fire extinguishers (3 on **general locked**~~open~~ unit; 1 in ~~O.T.~~**CSU**).
   - b. Crash cart with ~~defibrillator~~**AED** and emergency medications.
   - c. **Hard Rubber / Plastic** ~~Leather~~ restraints and postural supports.
5. Population:
   - a. Some of the patients which comprise the BHU are ambulatory and self-care.
   - b. Agitated or non-ambulatory patients may be transported via wheelchair **or gurney**.
6. Environment:
   - a. Staff lounge, ~~O.T~~**Recreation Therapy (RT) room**~~.~~, the dining room, or the day room may be used for a conference or triage room.
   - ~~b. Treatment room with one exam table available on unit.~~
   - **b.** Washer/dryer present on unit.
7. **Shelter in Place (SIP):**
   - **a. During certain types of events (examples: active shooter/fire/hostage situation in another building or when evacuating may be more harmful to the patients, visitors or staff), it may be advisable to shelter-in-place (SIP). At the discretion of the CEO or IC, local law enforcement, or fire department, a decision may be made to keep the patients and staff members sheltered in place within the BHU/CSU.**
     - **i. If necessary, the Engineering department can be called to shut down the HVAC ventilation system.**
     - **ii. Access into and exiting the unit can be controlled with the badge readers and locking mechanisms on the doors. Staff should not allow individuals into the BHU/CSU unless they are able to clearly identify the person(s) attempting to enter.**
     - **iii. BHU/CSU staff members may move patients into areas deemed safe locations within the BHU/CSU units (examples: Away from windows, seclusion rooms, offices with locked doors).**
     - **iv. Transfers to alternative safe locations within the medical center may be utilized to provide patient care services. Examples of locations that may be used for temporary alternative care sites might include: The ED Fast Track due to the location's access controlled environment, the Special Procedures Recovery Area (SPRA) due to ability to house patients in a**

location with close observation abilities and limited entrance/exit routes).

8. Evacuation:
   a. Evacuation procedures shall be implemented in the event of a fire or other emergency within the BHU or nearby location that could threaten the well-being or safety of the staff, ~~and/or~~ patients or visitors.
   b. An evacuation of the BHU unit may be partial or full or it may be part of a full evacuation of the entire medical center.
   c. The authorization to evacuate depends on the situation. A voluntary evacuation is at the discretion of the Chief Executive Officer (CEO) or in the event the CEO is not available, then his/her designee(s) in the following order: Chief Operating Officer (COO), Chief Nurse Executive (CNE), or the Safety Officer. A mandatory evacuation is an evacuation that is ordered by an authorized governmental authority having jurisdiction. Government authorities with jurisdiction include, but are not limited to, fire, law enforcement, OSHPD and local emergency services.
   d. On-Site evacuation: If possible, all BHU/CSU patients, visitors and staff shall evacuate the building and exit into the large secured patio area located outside the general locked unit.
      i. Alternate option would be to evacuate the individuals located in the CSU ~~patients~~ out of the building and into the CSU secured patio area and the individuals in the general BHU ~~patients~~ into the large secured patio area outside of the general locked unit.
      ~~c.~~ii. In the event that the patio areas become unsafe/life threatening, the patio gate doors may be unlocked by the BHU staff. Every effort will be made to keep the patients safe and accounted for during the evacuation.
   ~~d.~~e. Off-Site evacuation: In the event that behavioral health patients require being transferred to alternative care site or facility, the Incident Command Center (ICC) would contact the San Diego County Emergency Medical Services for assistance and direction of where and when the evacuation transfers would occur. The Liaison Officer will be responsible for inter-facility communication between the medical center and the designated alternative care site.
      ~~e.~~i. Transportation would depend on the level of medical needs and may be provided by TCHD patient transport vans, BLS ambulance, or Specialty Care ambulances. The Manager/ANM and BHU/CSU Medical Director in conjunction with the ICC would determine the appropriate level of transportation needed to safely transfer the patients.

~~f.~~9. Recovery/Repopulation post evacuation:
   ~~g.~~a. Repopulation of the BHU or CSU areas post evacuation is at the discretion of the CEO or IC in conjunction with the BHU medical staff, department manager and may require the approval of the California Department of Public Health (CDPH), other public safety and utility agencies, as appropriate.
   ~~h.~~b. Prior to repopulation surveillance of temperatures, refrigeration, air/water quality, pharmaceuticals, facility security, and perishables need to be assessed and replaced/restocked or corrected as appropriate.

~~i.~~G. RELATED DOCUMENT(S):
   ~~j.~~1. ~~Tri-City Medical Center's~~ Emergency Operations Procedure Manual: Emergency Operations Plan ~~(EOP)~~

~~G.~~H. REFERENCE(S):
1. Hospital repopulation after evacuation guidelines and checklist (2011). *California Hospital Association*
   ~~a.~~2. Hospital Evacuation Plan (Checklist 2011). *California Hospital Association*
   ~~b.~~3. Hospital Shelter in Place (Checklist 2011). *California Hospital Association*
   ~~2.~~4. Planning for psychiatric patient movement during emergencies and disasters (2012). *U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response*

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: Notification of Medi-Cal Beneficiary of Denial of Benefits
POLICY NUMBER: 103

ISSUE DATE: 03/08
REVISION DATE(S): 08/09, 03/13, 06/16

Department Approval:	~~06/16~~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 ensure that all Medi-Cal beneficiaries are notified in a manner consistent with CCR, Title 9, Chapter 11, Section 1850.210 when the Point of Authorization ~~(United Behavioral Health: UBH)~~**Optum** denies continued inpatient hospitalization services to the beneficiary by the Mental Health Provider (MHP), i.e. Tri-City ~~Medical Center~~**Health Care District (TCHD)** Behavioral Health Services **(BHS)**.

B. **POLICY:**

1. When it becomes known, through the continued stay utilization review process, that payment for continued stay on the Inpatient Behavioral **Health** Unit **(BHU)**, known herein as the ~~Mental Health Provider (~~MHP~~)~~ has been denied, the Utilization Review Manager will notify the Medi-Cal beneficiary of the action and of his/her right to appeal the payment decision and will discuss the beneficiary's rights to appeal.

C. **PROCEDURE:**

1. A fax will be sent from ~~UBH~~**Optum** to the MHP indicating that further treatment days will be denied.
2. The Utilization Review Manager will discuss the faxed information with the patient. The Notice of Action includes:
   a. The reason the mental necessity criteria was not met.
   b. The beneficiary's options for obtaining care outside of the MHP, if applicable.
   c. The beneficiary's right to request a second opinion on the determination.
   d. The beneficiary's right to file a complaint or grievance with the MHP.
   e. The beneficiary's right to a fair hearing including the method by which a hearing may be obtained and information that describes that the beneficiary may be either ~~self represented~~**self-represented** or be represented by an authorized third party such as legal counsel, relative, friend or another person, as well as the time limits for requesting a fair hearing.

D. **REFERENCE(S):**

~~f.~~**1. CCR, Title 9, Chapter 11, Section 1850.210**

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: Patient Rights
POLICY NUMBER: 514

ISSUE DATE: 3/08
REVISION DATE(S): 8/09, 3/13, 6/16

Department Approval Date(s):	**05/18**
Division of Psychiatry 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. **PURPOSE:**
1. To define the rights of patients.
2. To identify justification to deny patient rights.
3. To define restoration of patient rights.

B. **POLICY:**
1. Behavioral health patients have the right to:
   a. To wear their own clothes, to keep and use personal possessions including toilet articles, and to keep and spend a reasonable sum of their own money for expenses and small purchases.
   b. To have access to individual storage space for private use.
   c. To see visitors each day.
   d. To have reasonable access to telephones, both to make and receive confidential calls or to have calls made for them.
   e. To have ready access to letter-writing materials, including stamps, and to mail and receive unopened correspondence.
   To refuse convulsive treatment, including, but not limited to, electroconvulsive treatment, any treatment for a mental condition that depends on the induction of a convulsion by any means, and insulin coma treatment.
   g. To refuse psychosurgery, defined as those operations referred to as lobotomy, psychiatric surgery, behavioral surgery, and all other forms of brain surgery if the surgery is performed for the purpose of any of the following:
      i. Modification or control of thoughts, feelings, actions, or behavior.
      ii. Modification of normal brain function or normal brain tissue in order to control thoughts, feelings, actions, or behavior.
      iii. Treatment of abnormal brain function or abnormal brain tissue in order to modify thoughts, feelings, actions, or behavior when the abnormality is not an established cause for those thoughts, feelings, actions, or behaviors.
      iv. Psychosurgery includes prefrontal sonic treatment if there is any possibility of destruction of brain tissue or brain cells.
   h. To see and receive the services of a patient advocate who has no direct or indirect clinical or administrative responsibility for the patient.
   i. Other rights, as specified by regulation.

~~h.~~**j. The rights specified in this section may not be waived by the person's parent, guardian, or conservator.**

2. Denial of Rights: Patients' rights may be denied only when there is good cause to do so. Good cause exists when:
   a. Exercise of the specific right would be injurious to the patient.
   b. There is evidence that the specific right, if exercised would seriously infringe upon the rights of others.
   c. The unit or hospital district would suffer serious damage if the specific right were not denied.
   d. There is no less restrictive way of protecting the interests specified above.

   e. The reason used to justify the denial of a right to a patient must be related to the specific right denied. A right must not be withheld or denied as a punitive measure nor shall a right be considered a privilege to be earned. When a right has been denied, staff must use the least restrictive means of managing the problem that led to the denial.

C. **PROCEDURE:**

1. Notification of rights:
   a. Each patient will be given a Patient Rights Handbook at the time of admission to the unit.
      i. The handbook will be in a language that is accessible to the patient
      ii. The patient will be asked to sign a statement indicating that he or she received the rights information; the signed statement will be kept in the patient's medical record.
      iii. Patients will be informed to the processes available to them if they believe a right has been compromised.
   b. Rights information posters will be displayed in a prominent place on the unit in the approved threshold languages.
   c. Additional copies of Patient Rights Handbooks will be made available to patients upon request.
   d. Patients will be informed of their rights related to the 14-day certification process in the event that such a certification occurs (See Policy: Notice of Certification and Advisement of Rights).
   e. Patients will also receive advisements related to their treatment when indicated by their legal status and changes therein.
   f. Patients will be given a Tri-City Medical Center Patient handbook at the time of their admission.

2. **Denial of Rights**
   a. Each denial of a patient's rights must be noted in the medical record.
   b. Documentation must take place immediately whenever a right is denied, and each denial of a right must be documented regardless of the gravity of the reason for the denial or the frequency with which a specific right is denied either in the unit or to a particular individual.
   c. If a patient in seclusion or restraints is denied any right, the denial must also be documented.
   d. The documentation must include:
      i. The specific right denied.
      ii. The date and time the right was denied.
      iii. The reason (good cause) for denial of the right.
      iv. The date of review if the denial of the right extended beyond 30 days.
      v. The signature of the professional person in charge of the unit or a designee.
   e. The patient must be told the contents of the note.
   f. Quarterly reports of the number of persons whose rights were denied, and the specific right or rights denied, must be submitted to the local mental health director, who must report to the state Department of Mental Health.

3. Restoration of Rights
   a. A right may not be denied a patient when good cause for its denial no longer exists. **The rights that is denied is evaluated on a daily basis by the physician or designee, and assigned nurse to ensure that good cause for its denial no longer exists.**
   b. The date a specific right is restored must be documented in the patient's medical record.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE: 3/06	**SUBJECT: Appropriate Use of Commercial Support and Exhibits**
REVISION DATE: 5/08; 10/12	**POLICY NUMBER: 8710-603**
Department Approval:	**03/17**
CME Committee Approval:	**04/08; 10/12; 10/15; 01/18**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**05/08; 11/12; 11/15; 05/18**
Professional Affairs Committee Approval:	
Board of Directors Approval:	**05/08; 11/12; 12/15**

A. **PURPOSE:**

1. To describe appropriate behavior in planning, designing, implementing, and evaluating **continuing medical education (**CME**)** activities for which commercial support is received.

B. **DEFINITIONS:**

1. Commercial Support: Financial and other support provided by commercial organizations to enhance the quality of CME activities.

C. **POLICY:**

1. Tri-City ~~Medical Center~~**Healthcare District** adheres to the **Accreditation Council for Continuing Medical Education (***ACCME) ~~2004~~ Standards for Commercial Support: Standards to Ensure the Independence of CME Activities*. In operational issues, the CME Program is guided by what is in the best interest of the public, and decisions are made with the principles of independence from commercial interests, transparency and keeping CME separate from product promotion.
2. **STANDARD 1: Independence**
   a. ~~Tri-City Medical Center~~ **TCHD** CME Committee ensures that CME activity content is free of control of a "commercial interest" including the identification of CME needs; determination of objectives; selection and presentation of content; selection of all persons and organizations that will be in the position to control the content of the CME; selection of educational methods; and evaluation of the activity.
   b. ~~Tri-City Medical Center~~**TCHD** does not jointly sponsor CME activities with a commercial interest.
3. **STANDARD 2: Resolution of Personal Conflicts of Interest**
   a. Relevant financial relationships with commercial interests of everyone who is in the position to control the activity content must be disclosed. Relationships in any amount and occurring within the past 12 months that create a conflict of interest are to be disclosed.
   b. Individuals who refuse to disclose relevant financial relationships will be disqualified from being a planning committee member and cannot have responsibility for the development, management, presentation or evaluation of the CME activity.
   c. ~~Tri-City Medical Center~~**TCHD** CME Committee will identify and resolve all conflicts of interest prior to the CME activity taking place, using the **Medical Staff** policy 8710-605, "*Conflict of Interest Resolution Policy.*"
4. **STANDARD 3: Appropriate Use of Commercial Support**
   a. All commercial support for ~~Tri-City Medical Center~~**TCHD** CME activities shall be obtained as unrestricted grants and dispensed by the CME Committee/designee in

accordance with the Accredited Council for Continuing Medical Education (ACCME) Commercial Support Standards.

b. ~~Tri-City Medical Center~~**TCHD** CME Committee makes all decisions regarding the disposition and disbursement of commercial support and all funding must be received by Tri-City Medical Center to support the expenses associated with Tri-City Medical Center sponsored activities.

c. ~~Tri-City Medical Center~~**TCHD** is not required to accept advice or services from the commercial interest regarding teachers or content as conditions of contributing funds or services. Content development must remain beyond the control of the commercial supporter. Content validation by the provider should be established.

d. ~~Tri-City Medical Center~~**TCHD** must be aware of all commercial support associated with the CME activity and must approve all such support. Tri-City Medical Center and its agents (joint sponsors) must decide what commercial support will be accepted and how it will be utilized, not the commercial interest.

i. **Written Agreement documenting terms of support**

1) ~~Tri-city Medical Center~~**TCHD** and the commercial supporter will have a written agreement indicating the terms, conditions, and purposes of the commercial support for all directly and jointly sponsored activities. ~~(See Appendix).~~

2) The Letter of Agreement specifies the commercial interest at the source of the commercial support.

3) The Letter of Agreement must be signed by ~~Tri-City Medical Center~~**TCHD** (accredited provider) and commercial supporter.

ii. **Expenditures for an individual providing CME**

1) ~~Tri-City Medical Center~~**TCHD** adheres to its policy 8710-604, "CME Speaker & Honoraria Reimbursement" which governs honoraria and reimbursement of out-of-pocket expenses for planners, teachers, and authors of CME activities. Honorarium amount is set by the CME Committee.

2) ~~Tri-City Medical Center~~**TCHD** CME Committee/designee is responsible for payment of honoraria and expense reimbursement in compliance with policy governing such.

3) No additional payment may be given to the planning committee members, teachers or authors, joint sponsor, or any others involved with the supported activity.

4) When teachers or authors also participate as a learner, their expenses can be paid for their teacher or author role only.

iii. **Expenditures for learners**

1) Social events or meals at CME activities will not take precedence over the educational events and will be planned by the CME Coordinator or designee.

2) Commercial support funds are used to underwrite the expenses for developing and presenting the activity, including expenses of teachers and staff working on the activity.

iv. **Accountability**

1) Tri-City Medical Center maintains all income and expense documentation related to its directly and jointly sponsored activities. This will detail the receipt and expenditure of the commercial support.

5. **STANDARD 4: Appropriate Management of Associated Commercial Promotion**

a. Commercial exhibits or advertisements cannot interfere with the presentation nor be a condition of the provision of commercial support.

b. Product promotion material or product specific advertisement of any type is prohibited during CME activities. Staffed exhibits and/or presentations or enduring printed or electronic ads must be kept separate from CME. Adherence to the ~~*2004*~~ *Standards for Commercial Support Standard 4.2* is required.

c. Educational materials such as slides, abstracts and handouts cannot contain any advertising, trade name or product message.
d. The program book which contains non-CME elements that are not directly related to the transfer of education may include product promotion material or product specific advertisement.
e. Commercial interests cannot provide a CME activity to learners either by distribution of self-study activities or arranging for electronic access to CME activities. The commercial supporter may distribute promotional materials developed by the provider.
f. CME Exhibits are not considered "Commercial Support;" however, the ACCME Standards of Commercial Support apply with regard to the location of the exhibits.
   i. Exhibitors may not display exhibits in the same room as the CME activity or in the direct path of the activity.
   ii. Exhibitors may not promote products or services directly prior to, during, or immediately following the CME activity in the same lecture hall.
   iii. Exhibitors/vendors are required to complete a "CME Exhibit Request Form." Prior approval from the CME Committee/designee is required for vendors to exhibit during a ~~Tri-City Medical Center~~**TCHD** sponsored CME activity.
   iv. Reasonable exhibit fees shall be assessed to exhibitors in an amount to be determined by the CME Committee, but shall not be less than $500, and are due and payable to "~~TCMC~~ **TCHD** Medical Staff Treasury" prior to the activity.

6. **STANDARD 5: Content and Format Without Commercial Bias**
   a. ~~Tri-City Medical Center~~**TCHD** CME activities and related materials promote improvements or quality in healthcare and not a specific proprietary business interest of a commercial interest.
   b. Presentations must give a balanced view of therapeutic options and use generic names when possible; or use multiple trade names, not the trade name from a single company. CME must be free of commercial bias and not promote products or services, but promote improvements in healthcare.
7. **STANDARD 6: Disclosures Relevant to Potential Commercial Bias**
   a. Relevant financial relationships of those with control over CME content
      i. Individuals must disclose to the learners all relevant financial relationships, including the name of the individual, the name of the commercial interest, and the nature of the relationship. Disclosure is preferred to be written and available to all learners. Verbal disclosure may be used to supplement written disclosure when the event is televised.
      ii. Disclosure must also be made when the individual has indicated no relevant financial relationships.
   b. Commercial support for the CME activity
      i. The source of commercial support must be disclosed to learners, and the "in-kind" support must include specific information about the actual support, e.g. equipment loan.
      ii. Trade names or product group message must never be included in such disclosure.
   c. Timing of disclosure
      i. Disclosure of relationships and support by a commercial interest must be provided to the learners prior to the beginning of the educational activity.

D. ~~**REFERENCE**~~**RELATED DOCUMENTS:**
1. **Medical Staff** Policy 8710-604: CME Speaker & Honoraria Reimbursement
2. **Medical Staff** Policy 8710-605: Conflict of Interest Resolution
3. **Written Agreement for Commercial Support**
~~2.~~4. **CME Exhibit Request Form**

~~1.~~**E. REFERENCES:**

~~2.~~**1.** Accreditation Council for Continuing Medical Education (ACCME) Standards for Commercial Support

~~3.~~**2.** *Institute for Medical Quality (IMQ)/California Medical Association (CMA) ~~2011~~ **2017** CME Accreditation Standards Manual/ Essential areas and their Elements/ ~~2006~~ Accreditation Criteria*

a. Element 3.3: The provider must present CME activities in compliance with the ACCME's policies for disclosure and commercial support

~~**A. APPENDIX:**~~

~~1. Written Agreement for Commercial Support~~

~~2. CME Exhibit Request Form~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION ~~POLICY MANUAL~~(CME)

ISSUE DATE: 10/05	**SUBJECT:** CME Speaker & Honoraria Reimbursement
REVISION DATE: 5/08, 4/09	**POLICY NUMBER:** 8710-604
Department Approval:	03/17
CME Committee Approval:	4/09; 10/12; 10/15; 01/18
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	5/09; 11/12; 11/15; 05/18
Professional Affairs Committee Approval:	
Board of Directors Approval:	5/09; 11/12; 12/15

A. **PURPOSE:**

~~A.~~1. To outline the process utilized by the **Continuing Medical Education** CME Committee to determine honoraria and reimbursement expenses paid to individual faculty, authors, planners, and activity support staff and volunteers.

B. **POLICY:**

1. Tri-City ~~Medical Center's~~**Healthcare District's (TCHD)** ~~Continuing Medical Education~~**CME** Committee is responsible for approving funds for speaker honoraria.
2. The CME Committee Chairperson/designee is responsible for approving honoraria and reimbursement expenses greater than $500.
3. Honorarium shall not be paid to the director of the CME activity, CME Committee members, teachers, authors, joint sponsor, members of the medical staff involved with the supported activity, or others involved with the supported activity, unless funded by commercial support. No other payment as aforementioned shall be provided.
4. Members of the medical staff, who provide educational presentations, may request reimbursement for their expenses, i.e., development of PowerPoint/slide presentation as outlined in the following procedure.

C. **PROCEDURE:**

1. The CME Coordinator may contact commercial support in an effort to secure an unrestricted educational grant.
   a. All commercial support funds shall be made payable to "TCMC Medical Staff Treasury".
2. The CME Coordinator shall inform the speaker of the approved, offered honorarium.
   a. The CME Coordinator shall obtain a completed W-9 form from the speaker.
   b. Upon completion of the CME activity, the CME Coordinator shall mail the honorarium check, "Thank You Letter", and a copy of the activity "Evaluation Summary" to the speaker.

D. **REFERENCE:**

~~D.~~1. ACCME Standards of Commercial Support – Standard 3.7

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION ~~POLICY MANUAL~~(CME)

ISSUE DATE: 5/08	**SUBJECT: Conflict of Interest Resolution**
REVISION/REVIEW DATE: 5/08; 10/12; 7/14	**POLICY NUMBER: 8710-605**
Department Approval:	**03/17**
CME Committee Approval:	**04/08; 10/12; 08/14; 01/18**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**05/08; 11/12; 08/14; 05/18**
Professional Affairs Committee Approval:	
Board of Directors Approval:	**05/08; 11/12; 08/14**

A. **PURPOSE:**

~~A.~~1. To outline a process that will ensure all stated potential conflict of interest of anyone in control of content for *AMA PRA Category 1 Credit(s)™* is resolved.

B. **DEFINITIONS:**

1. Conflict of Interest: A relationship with a commercial interest that benefits the individual in any financial amount and that has occurred within the past twelve (12) months; and has the opportunity to affect **continuing medical education (**CME**)** activity content with respect to the commercial interest's products or services.
2. Resolution of Conflict of Interest: To alter the financial relationship with the commercial interest; and/or alter the individual's control over the CME activity content with respect to the commercial interest's products or services.

C. **POLICY:**

1. All conflict of interest for individuals who are in the position to control content for Category I CME activities shall be disclosed and resolved.
2. If conflict of interest status cannot be identified or resolved, the individual(s) shall not have any content control for Category I activities.

D. **PROCEDURE:**

1. Document all conflict of interest that is not resolved in CME Committee minutes.
   a. If a conflict of interest is identified for a CME activity-planning member (to include significant other), he/she shall recuse themselves from contributing to the discussion of content planning.
   b. If a conflict of interest is identified for a speaker/author with the ability to control content, the CME Committee or designee shall do one of the following:
      i. Replace the speaker/author.
      ii. Review the speaker/author's presentation materials prior to the CME activity to ensure they are free of commercial bias.
      iii. Notify the speaker/author that he/she is not to discuss any therapeutic options.
      iv. Choose the materials from which the therapeutic recommendations will be made.
   c. If it is determined that the chosen speaker/author with a conflict of interest is the best candidate to deliver the presentation, the speaker/author shall read, complete, and sign the following documents:
      i. Faculty Disclosure & Resolution Declaration Form ~~(Appendix)~~
      ii. Content Validation Form ~~(Appendix)~~
2. Ask participants if commercial bias was observed in the speaker/author's presentation.

3. If commercial bias is determined, appropriate action shall be taken by the CME Committee/designee to rectify future CME activities and reduce the potential for commercial bias in these activities.

E. **~~APPENDIX~~FORMS**:
1. Faculty Disclosure & Resolution Declaration Form; Content Validation Form

F. **REFERENCE**
1. ACCME Standards of Commercial Support

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 02/03	**SUBJECT:** Criteria for Pain Management Privileges
REVISION DATE(S): 12/07	**POLICY NUMBER:** 8710 – 541
Department Approval:	02/17
Department of Anesthesiology Approval:	05/18
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~11/07~~05/18
Professional Affairs Committee Approval:	
Board of Directors Approval:	12/07

A. **PAIN MANAGEMENT DEFINITION:**

1. Pain management is the medical specialty concerned with the evaluation and treatment of patients suffering from acute or chronic pain.

B. **REQUIRED QUALIFICATIONS FOR PAIN MANAGEMENT PRIVILEGES:**

1. Initial Applicant: (applicants must meet all of the following)
   a. **Medical Doctor** (M.D.) or D.O.
   b. Successful completion of an **Accreditation Council for Graduate Medical Education** (ACGME) (or equivalent) accredited training program in Anesthesiology, Diagnostic Radiology, Neurology, Neurosurgery or Physical Medicine and Rehabilitation.
   c. Successful completion of a minimum of **twelve** (12) months of formal training (or fellowship) that includes the diagnosis and management of patients with acute and chronic pain, interventional technology or completion of the equivalent of **twenty-four** (24) months of continuous, full time pain management practice.
   d. Certification in Anesthesiology, Radiology, Neurology, Neurosurgery or Physical Medicine and Rehabilitation or Pain Management by the American Board of Medical Specialties (ABMS), or actively involved in the examination process.
   e. Provide documentation of a minimum of **twenty** (20) pain management patients in the previous **two** (2) years.

C. **ELIGIBILITY:**

1. Eligibility for the granting of Pain Management Privileges shall be based on documented education, training and experience, demonstrated current professional competence and judgment, physical and mental health status and the ability to cooperate with others and to deliver care at a generally recognized level of professional quality.

D. **CONSULTATION:**

1. All practitioners are expected to exercise good judgment and request consultation when:
   ~~1.~~**a.** Diagnosis and/or management remain in doubt for an undue period of time, especially in the presence of a life threatening illness;
   ~~2.~~**b.** Complications or conditions arise which are outside their level of competence or scope of practice.
   ~~3.~~**c.** Specialized treatments or procedures are contemplated with which they are not familiar.

E. **PAIN MANAGEMENT CORE PROCEDURES:**

1. Epidural Procedures: Translaminar and transforaminal Epidural injections (cervical, thoracic, Lumbar); Epidural blood patch
2. Joint Injections: Facets, **Sacroiliac (**SI**)** joint
3. Sympathetic Blocks
4. Chemo Denervation: Stellate Ganglion Block, Peripheral Nerve Block, Botox Injections, Intra-muscular Phenol Injections
~~4.~~**5. Discograms**
~~5.~~**6.** Initial Application: See required qualifications for Pain Management privileges. Current certification required for fluoroscopically-guided procedures**.**
~~6.~~**7.** Reappointment Criteria: Documentation of twenty (20) cases within the previous two (2) years and ongoing **continuing medical education (**CME**)** in pain management are required to maintain clinical competency.
~~7.~~**8.** Proctoring: Five **(5)** cases (of core pain management privileges) should be proctored, which should include at least three spinal (thoracic or lumbar) cases; with the exception of cervical cases, which would require an additional three cases be proctored.

F. **PAIN MANAGEMENT SPECIAL PROCEDURES:**

~~Discograms:~~

~~4. Initial Application: See required qualifications for Pain Management privileges. Must provide documentation of training in "Discograms" in Residency of fellowship, or provide documentation of a hands-on training course in discography. Must also provide documentation of the performance of a minimum of ten (10) Discograms during the previous **twenty-four** (24) months.~~

~~5. Reappointment Criteria: Five (5) cases within the previous two (2) years with acceptable outcomes.~~

~~6. Proctoring: Concurrent proctoring on a minimum of three (3) cases with satisfactory proctoring report is required for initial appointment. Proctoring shall be performed by a member of the medical staff at TCMC (Tri-City **Healthcare District**Medical Center) **(TCHD)** with the same privileges being proctored.~~

1. Radiofrequency Thermocoagulation Lesion Ablation (RFTC):
~~1.~~**a.** Initial Application: See required qualifications for Pain management privileges. Must provide documentation of training in "RFTC" in Residency of fellowship, or provide documentation of a hands-on training course in RFTC.
~~2.~~**b.** Reappointment Criteria: Satisfaction of the reappointment criteria for the Core Procedures will automatically satisfy reappointment criteria for this procedure.
~~3.~~**c.** Proctoring: Concurrent proctoring on a minimum of three (3) cases with satisfactory proctoring report is required for initial appointment. Proctoring shall be performed by a member of the medical staff at ~~TCMC~~ **TCHD**~~(Tri-City Medical Center)~~ with the same privileges being proctored.

2. Intradiscal Electrothermal Annuloplasty**:**
~~1.~~**a.** Initial Application: See required qualifications for Pain management privileges. Must provide documentation of training in Intradiscal Electrothermal Annuloplasty in residency or fellowship, or provide documentation of a hands-on training course in Intradiscal Electrothermal Annuloplasty.
~~2.~~**b.** Reappointment Criteria: Satisfaction of the reappointment criteria for the Core Procedures will automatically satisfy reappointment criteria for this procedure.
~~3.~~**c.** Proctoring: Concurrent proctoring on a minimum of three (3) cases with satisfactory proctoring report is required for initial appointment. Proctoring shall be performed by a member of the medical staff at ~~TCMC~~ **TCHD**~~(Tri-City Medical Center)~~ with the same privileges being proctored.

3. Implantables (Intrathecal or Epidural Infusion Pumps with Tunneled Catheter, Spinal Cord Stimulator)**:**

~~1.~~**a.** Initial Application: See required qualifications for Pain management privileges. Must provide documentation of training in Intrathecal or Epidural Infusion Pump with Tunneled Catheter and Spinal Cord Stimulator in residency or fellowship, or provide documentation of a hands-on training course in Intrathecal or Epidural Infusion Pump with Tunneled Catheter and Spinal Cord Stimulator.

~~2.~~**b.** Reappointment Criteria*:* Three (3) cases within the previous two (2) years with acceptable outcomes.

~~3.~~**c.** Proctoring: Concurrent proctoring on a minimum of three (3) cases with satisfactory proctoring report is required for initial appointment. Proctoring shall be performed by a member of the medical staff at ~~TCMC~~ **TCHD**~~(Tri-City Medical Center)~~ with the same privileges being proctored.

4. Cranial Nerve Blocks – All Types

~~1.~~**a.** Initial Granting: Five **(5)** cases within two years of Residency

~~2.~~**b.** Reappointment: One **(1)** per year (two **(2)** per reappointment cycle)

~~3.~~**c.** Proctoring: Two **(2)** cranial nerve blocks – all types

~~**RELATED DOCUMENT(S):**~~

~~4. **Peer Review Table**~~

~~**Approvals:**~~

~~**Medical Division Approval:**~~

~~**Medical Executive Committee Approval: 11/07**~~

~~**Board of Directors Approval: 12/07**~~

~~**Peer review TableAttachment A**~~

~~**Peer Review**~~

~~**INDICATOR**~~	~~**THRESHOLD**~~	~~**THRESHOLD**~~
~~Infections~~	~~Any infection related to any pain management / or devise insertion for pain / procedure~~	~~**# Infections related to pain management**~~ ~~# Pain management procedures / devices~~ ~~Review all occurrences~~
~~Bleeding~~	~~Any bleeding related to any pain management / or devise insertion for pain / procedure~~	~~**# Bleeding related to pain management**~~ ~~# Pain management procedures / devices~~ ~~Review all occurrences~~
~~Unexpected Hospitalization~~	~~Any Hospitalization related to any pain / or devise insertion for pain / procedure~~	~~**# Hospitalization related to pain management**~~ ~~# Pain management procedures / devices~~ ~~Review all occurrences~~
~~Sepsis~~	~~Any patient admitted with a diagnosis of sepsis related to any pain management / or devise insertion for pain~~	~~**# Patient admitted with DX of Sepsis related to pain management**~~ ~~# Pain management procedures / devices~~ ~~Review all occurrences~~
~~Any other related complications~~	~~Any complications associated with any pain management procedure~~	~~All occurrences~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION ~~POLICY MANUAL~~(CME)

ISSUE DATE: 10/05	**SUBJECT:** Educational Planning; Needs Assessment; Objectives; and Evaluation of a Continuing Medical Education (CME) Activity
REVISION DATE: 5/08, 4/09; 7/12	**POLICY NUMBER:** 8710-600
Department Approval:	03/17
CME Committee Approval:	4/09; 7/12; 10/15; 01/18
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	5/09; 8/12; 11/15; 05/18
Professional Affairs Committee Approval:	
Board of Directors Approval:	5/09; 8/12; 12/15

A. **PURPOSE:**
1. To outline criteria utilized for educational planning and evaluation of a **continuing medical education** (CME) activity.

B. **DEFINITIONS:**
1. Prioritization Grid – a tool utilized to organize the educational needs of the medical staff and assigning a CME scheduling priority according to the impact topics have on performance, HWOP, JCAHO functions, cultural/linguistic implications, and National Patient Safety Goals.
2. FOCUS-PDCA Tool – an organization-wide process used for performance improvement.
3. Professional Practice Gap – The difference between health care processes or outcomes observed in practice and those potentially achievable on the basis of current professional knowledge.

C. **EDUCATIONAL PLANNING – NEEDS ASSESSMENT**
1. Annually our physician's learning needs are surveyed to: a) identify educational needs or professional practice gaps, and b) evaluate the performance of the continuing medical education component at Tri-City ~~Medical Center~~**Healthcare District**. This data is then summarized and provided to the CME Committee to use in planning educational activities and in determining the potential value of the activity.
2. Identified needs from multiple sources are used to initiate and support the planning process. Need documentation is the first step in planning a CME activity.
3. Each source of need requires a supporting document to use in setting methodology, design, objectives, and evaluation of the CME activity.

D. **EDUCATIONAL PLANNING - OBJECTIVES**
1. Based upon the identified needs, the objectives are developed for each CME activity.
2. The purpose or objectives of the activity describes learning outcomes in terms of physician performance or patient health and are consistently communicated to the learner.
3. The target audience is identified and stated in all learning materials.
4. Background requirements of the prospective participants are listed when indicated.
5. Learning outcomes in terms of knowledge, skills, and/or attitudes are indicated and communicated to the learner.

E. **EVALUATION & IMPROVEMENT**

1. All educational activities are evaluated for effectiveness in meeting identified educational needs, as measured by satisfaction, knowledge, or skills.
2. When applicable, educational activities are evaluated for effectiveness in meeting identified educational needs, as measured by practice application and/or health status improvement.
3. The overall CME program is evaluated regularly by the CME committee with review of its mission and activities of the previous year.
4. Improvements are made in the CME program by incorporating suggestions of the CME committee into the operating CME policies and procedures.
5. Outcomes in physician behavior which influence the health of the population are measured when applicable by repeated surveys or statistical review of morbidity data.

F. PROCEDURE

1. ACTIVITY REQUEST - Upon request, the CME Coordinator will provide the activity planner with an "Activity Request" form for *AMA PRA Category I Credit*™.
2. CME COMMITTEE REVIEW/APPROVAL PROCESS:
   a. The CME Coordinator will submit the completed Activity Request form to the CME Committee for review/approval.
   b. A quorum of the CME Committee members has the authority to approve a CME Activity Request outside of committee via electronic mail response. The CME Coordinator will make a copy of the electronic mail responses and file with the Activity Request form.
   c. *AMA PRA Category I Credit*™ requests shall be granted at the discretion of the CME Committee.
   d. The CME Committee may utilize prioritization grids and/or the FOCUS-PDCA tool in planning CME activities to organize and prioritize topics maximizing the impact CME activities have on physician performance and patient outcomes.
3. DOCUMENTS – The CME Coordinator ~~will~~ **may** utilize the CME checklist ~~(appendix)~~ for each activity, and will provide the following documents to the activity planner following approval by the CME Committee:
   a. Confirmation ~~letter~~ **notification** with A-V form;
   b. Faculty disclosure form for disclosure of financial relationships with resolution declaration should a conflict of interest exists;
   c. Cultural diversity form;
   d. Content validation form;
   e. Commercial guidelines (ACCME Commercial Support Standards);
   f. W-9 form (if applicable)
4. REQUIRED DOCUMENTS – The CME Coordinator shall ensure documentation is on file for each approved CME activity per the CME Checklist. The activity planner will provide the following completed and signed documents to the CME Coordinator. Note: *AMA PRA Category I Credit*™ will not be assigned to a course if the following are not provided in a timely manner before the course date.
   a. Faculty's curriculum vitae (mandatory);
   b. Faculty disclosure form (mandatory);
   c. Content validation form (mandatory);
   d. Original handout material, and/or electronic (PowerPoint) presentation (if applicable);
   e. W-9 (if applicable);
   f. Audio-visual (AV) requirements (if applicable);
5. PROCESSING TIME - Processing time for CME requests is typically 60-90 days.
6. ADVERTISEMENT - All *AMA PRA Category I Credit*™ approved activities shall be advertised to the Medical Staff. The CME Coordinator will assure that the advertisements include:
   a. Title of the activity and topics to be presented
   b. Statement of desired outcomes
   c. The CME accreditation and credit designation statement
   d. Acknowledgement of educational grants or other financial contributions (if known at the time of the publication)

7. RELEVANT FINANCIAL RELATIONSHIPS (Conflicts of Interest) – Disclosure of relevant financial relationships will be provided at every CME activity. *See Commercial Support and Disclosure of Interest policy.*
8. EVALUATIONS/SIGN-IN SHEETS – An activity evaluation form and a sign-in sheet shall be provided at every CME activity where *AMA PRA Category I Credit*™ is awarded.
9. FACULTY - The CME Coordinator shall summarize the evaluations and provide a copy of the evaluation summary, a letter of appreciation and honorarium (if applicable) to the speaker within ~~two~~ **four** weeks of activity closure.
10. LEARNERS – The CME Coordinator ~~shall~~ **may** send a follow-up e-mail to the learners six (6) weeks following the activity.
11. CME COMMITTEE – The CME Coordinator shall provide the CME Committee with a summary of evaluations.
12. CME CREDIT - The CME Coordinator shall provide ~~TCMC~~ **TCHD** Medical Staff members a copy of their CME records ~~on an annual basis, and within 72 hours of a~~**upon** request.
13. RECORD MAINTENANCE - CME records shall be maintained for a minimum of six (6) years.

G. REFERENCE:

1. *Institute for Medical Quality (IMQ)/California Medical Association ~~2011~~ **2017** CME Accreditation Standards Manual Essential areas and their Elements 2006 Accreditation Criteria*
2. Element 2.1: The provider must use a planning process that links identified educational needs with a desired result in its provision of all CME activities.
3. Element 2.2: The provider must use needs assessment data to plan CME activities.
4. Element 2.3: The provider must communicate the purpose or objectives of the activity so the learner is informed before participating in the activity.
5. Element 2.4: The provider must evaluate the effectiveness of its CME activities in meeting identified educational needs.
6. Element 2.5: The provider must evaluate the effectiveness of its overall CME program and make improvements to the program.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

DELETE
PCS Sterile Technique policy covers this content

SUBJECT: ASEPTIC TECHNIQUE

ISSUE DATE: 06/09
REVISION DATE(S): 11/12

Department Approval Date(s):	03/18
Department of Anesthesiology Approval Date(s):	n/a
Operating Room Committee Approval Date(s):	03/18
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	05/18
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

A. PURPOSE:

To provide guidelines for establishing and maintaining a sterile field.

B. POLICY:

1. All members of the surgical team shall demonstrate competence in understanding the basic principles and practices of aseptic technique.
2. Scrubbed persons shall wear sterile gowns and gloves.
   a. Materials for gowns shall be selected according to recommended practices for protective barrier materials.
   b. Surgical hand scrubs/surgical hand asepsis shall be performed before donning sterile gown and gloves.
   c. The scrubbed person shall don sterile gown and sterile gloves from a sterile field away from the main instrument table.
   d. Sterile gowns shall be considered:
      i. Sterile from two inches above the elbow to the cuff
      ii. Unsterile at the neckline, shoulders, underarm, back and sleeve cuff
   e. The scrubbed person shall inspect gloves for integrity after donning them.
      i. The preferred method for changing contaminated gloves is for one member of the sterile team to glove the other.
      ii. The alternative method for changing contaminated gloves is by the open-glove method.
3. Sterile drapes shall be used to establish a sterile field.
   a. Surgical drapes shall be selected according to AORN recommended practices for protective barrier materials.
   b. Sterile drapes shall be placed on the patient and on all furniture and equipment to be included in the sterile field.
   c. Sterile drapes shall be handled as little as possible.
   d. During draping, the draping material shall be compact, held higher than the OR bed and draped from the operative site to the periphery.
   e. During draping, sterile gloves shall be protected by cuffing the draping material back over the hand.

f. Once the sterile drape is placed in position, it shall not be moved.

4. Items used within the sterile field shall be sterile.
   a. Packaging materials shall meet AORN recommended practices for selection and use of packaging systems.
   b. Methods of sterilization, storage and handling of sterile items shall meet AORN recommended practices for disinfection, storage and handling.
   c. All items presented to the sterile field shall be checked for proper packaging, processing, moisture, seal integrity, package integrity, and appearance of sterilization indicator.
5. All items introduced onto the sterile field shall be opened, dispensed and transferred by methods that maintain sterility and integrity.
   a. When opening wrapped supplies, unscrubbed persons shall open the wrapper flap farthest away from them first, then the side flaps, and the nearest flap last.
   b. Wrapper edges shall be secured when supplies are presented to the sterile field.
   c. Sterile items shall be presented to the scrubbed person or placed securely on the sterile field.
   d. Sharp or heavy objects shall be presented to the scrubbed person or opened on a separate surface, to avoid making a hole in the sterile barrier.
   e. When dispensing solutions to the sterile field, the entire bottle contents shall be poured into the receptacle and/or the remainder discarded.
      i. Solution receptacles shall be placed near the edge of the table, or held by the scrubbed person.
      ii. Solutions shall be poured slowly to avoid splashing.
6. A sterile field shall be constantly monitored and maintained.
   a. Sterile fields shall be prepared as close as possible to the time of use.
   b. Sterile fields shall not be covered.
   c. Unguarded sterile fields shall be considered contaminated.
   d. Every team member shall observe for events that may contaminate the sterile field and initiate corrective action.
   e. Conversation shall be minimal in the operating room.
   f. Non-perforating devices shall be used to secure equipment to the sterile field.
   g. Non-sterile equipment brought into or over the sterile field shall be draped with sterile material.
7. All persons moving within or around a sterile field shall do so in a manner to maintain the integrity of the sterile field.
   a. Scrubbed persons shall remain close to the sterile field and shall not leave the room.
   b. Scrubbed persons shall keep arms and hands at or above the level of the sterile field.
   c. Scrubbed persons shall avoid changing levels and shall be seated only when the entire surgical procedure will be performed at this level.
   d. Scrubbed persons shall change positions by moving face-to-face or back-to-back, maintaining a safe distance between each other.
   e. Scrubbed persons shall always face the sterile field.
   f. Unscrubbed persons shall face sterile areas, maintaining an awareness of distance so as to avoid contacts with sterile areas.

DELETE

Content covered in PCS Policies High Level Disinfection & Immediate Use Sterilization. Process has been moved to SPD.

Tri-City Medical Center	Distribution: Su
PROCEDURE:	**REUSABLE AIRWAY EQUIPMENT CLEANING**
Purpose:	To outline nursing and Anesthesia Tech respo airway equipment: • Laryngoscope handles • Magill forceps and reusable Laryngeal M • Fiberoptic scopes • Glidescopes & Glidescope stylet • Anesthesia machines
Supportive Data:	When anesthesia equipment is used it is necessary to have a standard procedure for decontamination and disinfection that is followed routinely by all personnel performing cleaning.
Equipment:	• Laryngoscope handles • Magill forceps • LMA's • Fiberoptic scopes • Glidescopes • Glidescope stylet • Anesthesia machines • Instrument cleaning solution (Enzymatic cleaner) • Soaking container/bucket • Sanicloth • Gloves • Eye protection

A. LARYNGOSCOPE HANDLES, MAGILL FORCEPS, LMA's

1. Don gloves.
2. Remove laryngoscope handles, Magill forceps, and LMA's from anesthesia cart after use.
3. Cover item(s) and transport to dirty utility room, following Body Substance Isolation Protocol.
4. Soak Magill forceps and LMA's in enzymatic cleaner solution in dirty utility sink.
5. Rinse item(s) and sterilize in autoclave (Immediate Use Sterilization) on 3-minute gravity cycle. Follow Patient Care Services Procedure "Immediate Use Sterilization, Intraoperative".
   a. Magill forceps may be processed in the Steris or autoclave.
6. Allow Laryngoscope handles and LMA's to cool completely, then place in a clean wrapper.
7. Return all equipment to the proper location.

B. FIBEROPTIC SCOPES

1. Transport used scope to the dirty utility room in a closed container.
2. Don gloves and eye protection.
3. Clean scope according to PCS Procedure "High Level Disinfection" and process the scope according to Steris manufacturer's directions.
4. Document, including patient ID sticker, in the Steris log book.
5. After successful completion of the Steris cycle, label the scope with date

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processed and staff initials.

6. Hang clean scope in scope box on difficult airway cart.

C. GLIDESCOPES & GLIDESCOPE STYLET

1. Place attached cap over electronic connection of used (dirty) Glidescope.
2. Transport used Glidescope and Glidescope stylet (if used) to the dirty utility room in a closed container.
3. Clean items according to PCS Procedure "High Level Disinfection" and process the items according to Steris manufacturer's directions.
4. Document, including patient ID sticker, in the Steris log book.
5. Allow items to dry and place individual item(s) in separate peel packs.
6. Return item(s) to drawer on difficult airway cart.

D. ANESTHESIA MACHINE EQUIPMENT

1. Don gloves.
2. Clean machine after each case with Sanicloth.
   a. Wipe down all horizontal surfaces and drawer handles.
3. Clean all cables; return to hanging position on IV pole, ready to use.
4. Change all one-time use items (i.e. breathing circuit, suction assembly)
5. Change sodasorb when color changes to lavender, or monthly (whichever is first).
   a. Sodasorb containers are labeled with date opened.
6. Check that machine is assembled correctly and completely prior to bringing next patient into the room. Anesthesia checks machine before use.

E. DOCUMENTATION

1. For all anesthesia items reprocessed via High Level Disinfection, document the following in the logbook:
   a. Patient name (in writing or place patient sticker in log book)
   b. Description of bronchoscope that was used (i.e. Large, Small, OB)
   c.a. Serial number of Glidescope

Tri-City Medical Center	Distr
PROCEDURE:	**STERIS SET-UP, USE AND MONITORING**
Purpose:	To ensure a standard and effective ste… n through an automated, microcomput…
Supportive Data:	The Steris process will sterilize immersible medical instruments and rinse the instruments with sterile water. The effectiveness of the Steris process is dependent upon the proper cleaning and mechanical preparation of instruments prior to processing, and contact of all external and internal surfaces of the medical instruments with the liquid sterilant. The instruments are sterile rinsed and ready for immediate use upon successful completion of the processing cycle. The use of instruments sterilized should be in a manner consistent with "Immediate Use" processing and delivery.
Equipment:	• Steris System 1E Machine • Steris S40 sterilant concentrate • Appropriate Steris base tray with clean instruments to be sterilized • Chemical monitoring strip and orange holder • Appropriate Quick Connector for Endoscopes

DELETE

Info added to PCS Immediate Use Sterilization, Intraoperative and covered in Steris manufacturer's IFU's

A. SET-UP, USE AND MONITORING

1. Assemble clean instruments in Steris tray.
   a. Consult instrument manufacturer recommendations to determine if the instrument is compatible with the Steris process.
   b. Instruments must be clean to ensure proper sterilization.
   c. Failure to properly position instruments so that all surfaces will be exposed to the liquid sterilant and overloading the container may result in an ineffective sterilization process and/or damage the instruments.
2. Fasten chemical indicator in orange holder and place in tray with instrument(s).
   a. Chemical indicator will indicate, by turning to a pink color, that the instruments have been exposed to the sterilizing process.
3. Place lid on container.
4. Place container in Steris machine.
   a. Align fluid port located on bottom of tray over the fluid port in the bottom of the Steris machine. The container should be resting on the red fluid port gasket.
5. Remove Steris S40 container from box.
   a. Always open Steris S40 box using pull-tab. Always inspect Steris S40 box and cup for leaking or damaged contents. Leaking of the internal cup is signaled by a strong pungent odor similar to that of vinegar and/or a yellowing of the inside box.
6. Place Steris S40 sterilant container in sterilant chamber.
   a. Sterilant chamber is located in the lower right hand corner of the Steris machine. DO NOT attempt to manually open the sealed container. Avoid contact with skin as the active ingredient is 35% peroxyacetic acid and is corrosive. DO NOT use Steris S40 after the expiration date indicated on the label. DO NOT use leaking or damaged containers.
7. Push down sterilant container in chamber until flush with tray.
   a. Pushing down the cup will open bottom of sterilant container.

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8. Insert aspirating probe into top of sterilant container.
   a. Position tip of the probe over crisscross cuts located in the center of the lid. Flexible connecting tube should be in the 5 o'clock position. Ensure tubing is not kinked.
9. Close lid of Steris machine.
   a. If resistance is met, stop and inspect position of tray and/or aspirator assembly. Do not force lid close.
10. Interpret & document results on Steris Sterilization Log Sheet located next to Steris machine.
   a. Press start button on Steris control panel.
   b. Printer will start in approximately 30 seconds. The printout will advance to show Steris logo, date, time, load ID and remarks.
   c. Sterilization cycle is approximately 12.5-15 minutes. Cycle time is dependent on temperature and pressure of incoming water and filter cleanliness. As the cycle advances, the yellow stage lights will sequentially be turned on indicating the process of the cycle.
11. When sterilization cycle is complete:
   a. Press CANCEL only once; an audible tone of 6 one-second beeps will be heard.
   b. Pressing CANCEL more than once will cause the machine to move to another function and the lid will not open.
12. Wait for seal to deflate then lift handle and open lid.
   a. Printer will start and the printout will advance to show sterilization parameters.
13. Check printout for sterilization parameters.
   a. Check temperature between (46-54°C)
   b. Check exposure time (6 minutes)
   c. Check concentration (>175)
   d. Inlet temp (42-48°C)
   e. Fill time <5 min (change filter "A" if fill time is >5 minutes).
14. Check printout for "Warning: Sterilization not complete".
   a. Steris machine will cancel cycle if there is a problem with the sterilization cycles.
15. Remove aspirator probe from sterilant.
   a. Remove probe carefully as it is plastic and may break. If it breaks, call BioMed for replacement.
16. Remove empty sterilant container and discard.
   a. Always verify that sterilant cup is empty. If cup not empty refer to Steris manual for instructions on disposal of Steris S40. Call Customer Service. FLUSH with copious amounts of water.
17. Remove sterilized tray.
   a. Instruments in covered tray are sterile. If applicable, ensure connector is still connected to scope.
18. After being removed from Steris unit, sterilized items must be used immediately.
   a. Devices not used immediately must be reprocessed prior to patient use.
19. Document on tape: date, time, case number, name of item sterilized, and initials of operator.
20. Ensure the tray remains covered; it may be carried by the handles with unsterile gloves and transported through the hallway to the point of use.
   a. The covered tray houses a sterile interior and does not communicate with outside air.

21. Verify chemical monitor by the scrub nurse/tech.
    a. Scrubbed personnel verifies the instruments have been exposed to the sterilization process.
22. Remove sterile instruments from tray to sterile field.
    a. Scrubbed personnel using sterile technique removes the instruments to the field.
23. Run a diagnostic test every 24 hours without sterilant or instruments & document.
    a. Diagnostic test will ensure the machine filter is operating properly and ready for use.
24. Document patient name, cycle #, OR #, names of items run in Steris, code # and initials in Steris log. Tape the processed indicator to the log book in the designated space.

B. ENDOSCOPES

1. Clean and leak test the endoscope following instructions provided by the manufacturer of the endoscope and according to PCS Procedure "High Level Disinfection".
2. Following the instructions provided by Steris, attach the irrigating tubes to the scope.
    a. Refer to Steris Instruction Manual for each scope.
3. Perform Steps 1 through 22 of the above Steris procedure.
4. If processor is cancelled, document the reason it is cancelled.
5. Dispose of any remaining sterilant per Steris Instruction Manual.

Tri-City Medical Center	Surgical Services
PROCEDURE:	**SURGERY BLOOD IN ICE CHESTS**
Purpose:	To outline the steps for transport and storage of blood in ice chests in Surgery.
Supportive Data:	To have blood readily available in the surgical suite when administration in anticipated in a surgical procedure.
Equipment:	Ice chest with ice blocks (from Blood Bank).
Issue Date:	08/95

A. **POLICY**

1. Surgery staff members may check out blood from the Blood Bank and transport to Surgery after demonstrating competency.
2. Each unit of blood has a Safe-T-Vue temperature monitor affixed.
   a. The Safe-T-Vue temperature monitor is checked by the blood transporter and the Blood Bank staff when checking out the blood.
   b. The Safe-T-Vue temperature monitor must be white; if it is red the blood must be returned to the Blood Bank and may not be used.
3. Ice chests:
   a. Units of blood are placed in an ice chest for transportation to Surgery and storage in the surgical suite during the procedure.
   b. An ice chest may be used when two (2) or more units of blood are ordered to the surgical room.
   c. No more than **five (5)** units of blood may be placed in an ice chest. Obtain multiple ice chests for more than **five (5)** units of blood.
   d. Ice blocks to keep the blood cold must be changed every **nine (9)**~~6~~ hours. After ~~6~~ **nine (9)** hours the ice chest must be returned to the Blood Bank for new ice blocks.
      i. The Blood Bank monitors time for the ice blocks and notifies the surgical suite when ice blocks need to be changed.
   e. Units of blood must be stored in the ice chest with the Safe-T-Vue temperature monitor down.

B. **PROCEDURE:**

1. Transporting blood to surgery:
   a. Blood may only be checked out for one patient at a time.
   b. After blood is checked out from the Blood Bank, the transporter must proceed directly to the receiving surgical suite. The transporter may not stop during transport.
   ~~Upon arrival to the surgical suite, the transporter and circulating nurse must check two patient identifiers on each unit of blood before leaving the ice chest in the room.~~
   c. **Prior to transfusing, each unit of blood must be checked by two (2) licensed healthcare providers (a registered nurse [RN] and a second RN, perfusionist, or anesthesiologist) in accordance with Patient Care Services Procedure: Blood Products Administration.**
   d. If additional blood is required during a procedure, it will be sent in a new ice chest.
   ~~d.~~**e. Ice chests are low level disinfected (i.e., wiped with hospital approved disinfectant) in the lab after each use.**

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03/18	n/a	03/18	n/a	**05/18**		11/96; 06/00; 03/03; 01/06; 10/09; 09/12

Tri-City Medical Center	Distribution: Surgic
PROCEDURE:	**TESTING CO2 LASER**
Purpose:	To outline nursing responsibilities in setting up and before use in surgical procedures.
Supportive Data:	Ensuring safe, effective use of the CO2 laser used in surgical procedures to perform directed, precise cutting during a surgical procedure.
Equipment:	• Basin of tap water • "DANGER: Laser in Use" signs • Laser goggles • Wet tongue blade • Wet blue towel • Laser key (in OR Pyxis) • CO2 Laser • Microscope & micromanipulator (per case requirements)

DELETE

We no longer have a CO_2 laser.

A. TESTING CO2 LASER

1. Place "DANGER: Laser in Use" signs on each doorway to the room.
   a. Precautions must be taken to protect those entering the room while the laser is in operation.
2. Ensure that laser goggles are available for all persons in the laser room while it is operated. Have a pair of goggles outside of room for anyone entering.
   a. Eye protection must be worn when the CO2 laser is in operation.
3. Prepare a basin of tap water and bring to the room where the laser is tested.
   a. Water must be available in case of laser-generated fire.
4. Place a wet tongue blade on a wet towel on the prep stand.
   a. Laser must be tested on **wet** materials ONLY, to prevent fire.
5. Attach the laser hand-piece (with lens inside) onto laser arm. If laser is being used with the micromanipulator you must test with it in place.
   a. Test laser in mode in which it is being used. Exception- sterile laparoscope.
6. Insert key and turn on laser.
   a. Laser will perform a self-check.
7. Enter the mode on which to test the laser. Laser is ready to be tested.
   a. Test the laser on continuous mode. Be sure the red laser beam is directly in the center of the tongue blade.
8. Enter the amount of wattage used for testing. The recommended power for testing is 10 watts on continuous power.
9. Place tip of laser hand piece directly on wet tongue blade.
10. Place laser in "ready mode".
11. Depress foot pedal of laser emission.
    a. Testing time should be approximately one second. You should see smoke rising from the tongue blade.
12. Check for accuracy.
    a. The laser burn mark should match where the red laser beam was directed.
13. If burn mark does not appear on tongue blade, place unit in stand-by mode and repeat steps 6 through 12.
    a. If unable to test laser, Call BioMed at x7711 to request they test the laser.

B. REFERENCE

1. American National Standards Institute ANSI (2007).

Department Review	Department of Anesthesiology	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
03/18	n/a	03/18	n/a	05/18		

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

SUBJECT: ~~UNIVERSAL~~ **STANDARD PRECAUTIONS IN SURGERY**

ISSUE DATE: 06/09
REVISION DATE(S): 11/12; 07/15; ~~03/18~~

Department Approval Date(s):	03/18
Department of Anesthesiology Approval Date(s):	n/a
Operating Room Committee Approval Date(s):	03/18
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	05/18
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

A. **PURPOSE:**

1. To identify those practices used by surgical ~~care~~ personnel in addition to the hospital ~~Universal~~ **Standard** Precautions policy, to protect both patients and ~~themselves~~ **personnel** from exposure to bloodborne pathogens.

B. **POLICY:**

1. ~~Universal~~ **Standard** precautions shall be used for all invasive procedures.
2. Blood and body fluids from all patients shall be considered infectious.
3. Protective barriers shall be made available to all personnel to reduce the risk of exposure.
4. **Personal** ~~P~~protective equipment **(PPE)** shall depend upon the degree of exposure anticipated and may include:
   a. Goggles
   b. Glasses with side barriers
   c. Face shields
   d. Masks
   e. Gowns (including impervious)
   f. Shoe covers
   g. Gloves
5. Eye protection shall be worn by all scrubbed personnel.
6. Scrubbed personnel are strongly encouraged to double glove for added personal protection.
7. Perioperative personnel shall take precautions to prevent injuries caused by scalpels and other sharp instruments.
   a. The "hands-free, Neutral Zone" technique shall be used when possible, to transfer sharps between personnel.
   b. Used needles shall not be sheared, bent, broken, or recapped by hand. If recapping is necessary, an instrument, or the one-~~-~~handed **scoop** technique shall be ~~employed~~**used**.
   c. Knife blades shall be loaded and removed using an instrument.
   d. Disposable sharps shall be placed in a puncture resistant, labeled, or color-coded leak proof container.
   e. Reusable sharps shall be placed in a puncture resistant container, isolated from other surgical instruments.
   f. Use gloves and an instrument to pick up sharp items that have fallen on the floor.
8. Perioperative personnel shall handle specimens as potentially infectious material.
   a. All specimens shall be placed in a container which prevents leakage during collection, handling, processing, storage, transport or shipping.

b. Specimen containers received directly from the operative field shall be placed in a leak-proof plastic bag.

9. Perioperative personnel shall control work practices to minimize the risk of exposure to bloodborne pathogens. This includes prohibition of eating, drinking, applying cosmetics, and handling of contact lenses in restricted and semi-restricted areas.
10. Perioperative personnel who have exudative lesions or weeping dermatitis shall refrain from providing direct patient care or handling of medical devices used in performing invasive procedures.
11. Perioperative personnel who participate in invasive procedures are encouraged to receive Hepatitis B immunization.
12. Perioperative personnel shall adhere to Employee and Occupational Health Service (EOHS) policies regarding work restrictions for personnel with infectious diseases.
13. Patients requiring Isolation Precautions shall be placed in a private cubicle in Pre-Op and Post-Op, **when possible.**~~and are not to be placed in general Pre-Op Hold or PACU area.~~
    a. Transport gurneys will be cleaned as soon as the patient is transferred to the operating table, prior to leaving the surgical suite.
    b. The post-~~-~~operative receiving unit shall be notified of patient diagnosis as soon as possible.
    c. ~~A p~~**P**atient**s on Airborne Precautions, including those** with suspected or active pulmonary tuberculosis ~~should~~**shall** be recovered in a private cubicle with a portable ~~Hepa~~ **high efficiency particulate air (HEPA)** filter.
14. Unopened supplies may be returned to stock after the surgical procedures if there has not been contamination or compromise in the packaging.

C. **REFERENCES:**

1. **Conner, R. (2017). Guidelines for Perioperative Practice, 2017 Edition. Denver, CO: Association of PeriOperative Registered Nurses.**

~~TRI-CITY MEDICAL CENTER~~
~~Oceanside, California~~

~~SURGICAL SERVICES POLICY MANU~~

DELETE
PCS Wound Classification During Surgical Intervention covers this content

SUBJECT: WOUND CLASSIFICATION

ISSUE DATE: 04/94
REVISION DATE(S): 02/05; 08/11; 11/12

Department Approval Date(s):	**03/18**
Department of Anesthesiology Approval Date(s):	**n/a**
Operating Room Committee Approval Date(s):	**03/18**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**05/18**
Professional Affairs Committee Date(s):	
Board of Directors Approval Date(s):	

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

~~To classify all wounds according to the likelihood and degree of wound contamination at the time of surgical intervention.~~

~~B. **SUPPORTIVE DATA:**~~

~~1. The American College of Surgeons' definitions of Surgical Wound Infections (SWI) should be used for routine surveillance because of their current widespread acceptance and reproducibility.~~
~~2. A wound can be considered infected if purulent material drains from it, even if a culture is negative or not taken.~~
~~3. A positive culture does not necessarily indicate infection since many wounds, infected or not, are colonized by bacteria.~~
~~4. Infected wounds may not yield pathogens by culture because the pathogens are fastidious, culture techniques are inadequate, or the patient has been treated.~~

~~C. **CLASSIFICATIONS:**~~

~~1. CLEAN WOUND, *Class I*~~
~~a. Uninfected operative wounds in which no inflammation is encountered, and neither respiratory, alimentary, genitourinary tracts, nor oropharyngeal cavity is entered.~~
~~b. Cases are elective, primarily closed, and if necessary, drained with closed drainage.~~
~~c. Operative incisional wounds that follow non-penetrating (blunt) trauma should be included in this category if they meet the criteria.~~
~~2. CLEAN-CONTAMINATED WOUND, *Class II*~~
~~a. Operative wounds in which the respiratory, alimentary, or genitourinary tract is entered under controlled conditions and without unusual contamination.~~
~~b. Specifically, operations involving the biliary tract, appendix, vagina, and oropharynx are included in this category, provided no evidence of infection or major break in sterile technique is encountered.~~
~~c. All clean returns to surgery.~~
~~d. Any tube that involves a skin incision.~~
~~3. CONTAMINATED WOUNDS, *Class III*~~

a. Include open, fresh, accidental wounds, a chest tube, operations with major breaks in sterile technique or gross spillage from the gastrointestinal tract, and incisions in which acute, non-purulent inflammation is encountered.

4. DIRTY AND INFECTED WOUNDS, *Class IV*
   a. These include old traumatic wounds with retained devitalized tissue and those that involve existing clinical infection or perforated viscera. This definition suggests that the organisms causing postoperative infection were present in the operative field before the operation.
5. UNKNOWN
   a. This classification will be used when the status of a wound cannot be determined utilizing the above criteria.
6. NOT APPLICABLE
   a. When there is no wound, i.e. for such procedures as:
      i. Closed reductions (where there is no break in the skin)
      ii. Examination Under Anesthesia (EUA)
      iii. Esophageal Dilatation

D. DOCUMENTATION:

Wound classification of operations shall be recorded on the Intraoperative Record using Arabic numbers 1, 2, 3, 4, 5 and 6 only.

Tri-City Medical Center	Women and Newborn Services (WNS)
PROCEDURE:	**SKIN TO SKIN CONTACT AFTER BIRTH**
Purpose:	To define the provision of skin to skin contact between mother, father and/or identified individual by the family and infant following birth.
Supportive Data:	Early skin-to-skin contact (~~SSC~~**STS**) is a recommended best practice for healthy term newborns because ~~SSC~~ **STS** provides both newborns and mothers with numerous health benefits. Evidence shows that placing infants skin-to-skin with their mothers immediately after birth increases the success and lengthens the duration of breastfeeding, promotes bonding, and facilitates thermoregulation. ~~SSC~~ **STS** can also be accomplished with another individual identified by the family, if the mother is unable to experience this for whatever reason.

A. **CONTENT**:

1. Initiation of ~~SSC~~ **STS** as soon as possible after birth (vaginal or cesarean birth) shall be supported as a standard of practice if the infant is asymptomatic, no contraindications are present, and mother and infant are medically stable.
2. If the mother is Hepatitis B or Human Immunodeficiency Virus (HIV) positive, infant should be bathed as soon as possible and receive necessary medications per protocols prior to implementing ~~SSC~~**STS**.
3. Contraindications to immediate skin to skin include, but are not limited to:
   a. A mother who received general anesthesia
   b. A mother who has postpartum hemorrhage concerns
   c. An infant with a five minute APGAR score of 6 or less
   d. A premature infant less than 35 weeks gestation.

B. **PROCEDURE**:

1. Dry and stimulate infant following Neonatal Resuscitation Program (NRP) protocol and place infant prone on the mother's chest wearing only a hat and/or diaper.
2. The mother will have on no clothing/sheets/blankets between herself and the infant to disrupt the ~~SSC~~**STS**. The infant should be able to access the mother's breasts with no interference from any bras, gowns, etc.
3. A warm blanket will be laid over the infant and mother once the infant is placed skin to skin.
4. Continue uninterrupted ~~SSC~~**STS** until the first breastfeeding occurs. (First breastfeeding should occur within the first hour of life).
   a. After the first breastfeeding, ~~SSC~~**STS** will continue as long as mother desires and is feasible for the infant.
5. In the case where the mother chooses to formula feed, the initial period of ~~SSC~~**STS** will last at least one hour. (The infant should still feed within the first hour of life).
6. In the case of Cesarean **(C/S)** birth, the infant will be placed skin to skin with the mother in the Operating Room (OR) as soon as possible after birth and after the initial resuscitation and evaluation at the warmer by the resuscitation team. The infant will not go from C/S birth directly to ~~SSC~~**STS** without assessment from the resuscitation team.
   a. Mother's ~~left~~ arm will be unsecured from arm board at the initiation of ~~SSC~~**STS** and infant should be positioned in a way that does not interfere with her airway and the surgical site.
   b. ~~SSC~~**STS** will continue in the OR as long as mother is able to maintain contact and infant remains stable.
   c. The Transitional care nurse will remain with the infant during ~~SSC~~**STS** and is responsible for removing the infant if the mother or infant becomes unstable.
   d. Upon arrival to the recovery room, uninterrupted ~~SSC~~**STS** will continue until the first breastfeeding occurs.

Department Review	Department of OB/GYN	Perinatal Collaborative Practice	Department of Pediatrics	Department of Anesthesiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
08/16	06/17	07/17	08/17	03/18	n/a	05/18		

e. If mother is unable to provide ~~SSC~~**STS** in the OR, she may designate the father, a family member, or other support person to provide ~~SSC~~**STS**.
   i. If anyone other than the mother is to provide ~~SSC~~**STS**, it must be done in the recovery room on **Labor& and Delivery** in a stationary chair.
   ii. The individual identified, will be offered a hospital gown to wear with gown opening to the front and asked to remove shirt, bra, etc. to ensure infant is able to be positioned skin to skin.
   iii. Efforts should be made to ensure privacy with ~~either~~ a privacy curtain, portable screen, and/ or individual seated in a position facing away from traffic patterns.

7. Routine newborn procedures (measurements, initial assessment, medications, bathing) will be postponed until after the first feeding. Infant monitoring, vital signs (temperature, heart rate, respiratory rate), and assessment can continue while the infant is skin to skin with the mother/ identified support person.
8. If mother and infant require initial separation, staff shall ensure skin to skin and initiation**s** of breastfeeding begin/resume as soon as medically possible.
9. If infant demonstrates any signs of distress, requires further assessment/interventions, or if mother is unable to provide ~~SSC~~**STS** and no one has been identified to provide ~~SSC~~**STS**, the infant shall be brought to the warmer by delivering provider or nurse and the "Care of the Newborn Standardized Procedure should be implemented.

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Nitrofurantoin Suspension Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

Situation: Nitrofurantoin suspension routinely expires on the shelf in the Pharmacy department.

Background: Nitrofurantoin is an antibiotic primarily used for the treatment of uncomplicated urinary tract infections.

Assessment:

- Nitrofurantoin suspension (230 mL) bottles cost $315 each
- Usage history revealed that there have been zero orders for this product in the last 3 years
- Sulfamethoxazole/Trimethoprim (Septra) is a first-line formulary alternative for uncomplicated cystitis and is available in suspension form

Recommendation(s):

- The Pharmacy Service recommended that nitrofurantoin suspension be removed from the formulary given lack of use in several years and the availability of formulary alternatives
- P&T approved the recommendation to remove this drug from the TCMC formulary at its May meeting