TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
July 26, 2018 – 1:30 o'clock p.m.
Assembly Room 1 - Eugene L. Geil Pavilion
Open Session – Assembly Rooms 2&3
4002 Vista Way, Oceanside, CA 92056

The Board may take action on any of the items listed below, unless the item is specifically labeled "Informational Only"

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Approval of agenda		
3	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Closed Session portion of the Agenda. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors.	3 min.	Standard
4	Oral Announcement of Items to be Discussed During Closed Session (Authority: Government Code, Section 54957.7)		
5	Motion to go into Closed Session		
6	Closed Session	**2 Hours**	
	a. Conference with Legal Counsel – Existing Litigation (Authority Government Code Section 54956.9(d)1, (d)4 1) Timothy Pruitt v Tri-City Healthcare District Case No.: 37-2016-00041494-CU-MM-NC 2) Leonie K Hall v Tri-City Healthcare District Case No. 16-cv-01693-GPC-AGS		
	b. Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d) 2 (4 Matters)		
	c. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	d. Approval of prior Closed Session Minutes		
7	Motion to go into Open Session		

Note: Any writings or documents provided to a majority of the members of Tri-City Healthcare District regarding any item on this Agenda will be made available for public inspection in the Administration Department located at 4002 Vista Way, Oceanside, CA 92056 during normal business hours.

Note: If you have a disability, please notify us at 760-940-3347 at least 48 hours prior to the meeting so that we may provide reasonable accommodations.

	Agenda Item	Time Allotted	Requestor
8	Open Session		
	Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.		
9	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) .		
10	Roll Call / Pledge of Allegiance	3 min.	Standard
11	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
12	Educational Session – a) Board Fiduciary Duties Related to the Employee Pension Plan	15 min.	General Counsel
13	Report from TCHD Foundation – Glen Newhart, Chief Development Officer	10 min.	Standard
14	Report from Chief Executive Officer	10 min.	Standard
15	Report from Chief Financial Officer	10 min.	Standard
16	Report from Chief Governmental & External Affairs Officer	10 min.	Standard
17	New Business a) Consideration to cast the ballot on behalf of the district in CSDA's 2018 Board of Director's election for Seat A in Southern Network	5 min.	Chair
18	Old Business – None		
19	Chief of Staff a. Consideration of July Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on July 23, 2018 b. Consideration of NP Standardized Procedures: 1) Cardiology 2) Gastroenterology 3) Hospitalist 4) Interventional Radiology 5) Neonatal 6) Neurology 7) OB/GYN 8) Orthopedic & Spine Institute 9) Psychiatry Division 10) Psychiatry Division/CSU	5 min.	Standard

	Agenda Item	Time Allotted	Requestor
	c. Consideration of Ortho Tech Privilege Card Revision d. Consideration of Continuing Education Mission Statement.		
20	Consideration of Consent Calendar (1) Board Committees ***(1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar.*** ***(2) All items listed were recommended by the Committee.*** ***(3) Requested items to be pulled require a second.***	5 min.	Standard
	A. Community Healthcare Alliance Committee Director Nygaard, Committee Chair *(No meeting held in July, 2018)*		CHAC Comm.
	B. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 0 *(No meeting held in July, 2018)*		FO&P Comm.
	C. Professional Affairs Committee Director Grass, Committee Chair *(Committee minutes included in Board Agenda packets for informational purposes)* 1) **Patient Care Policies and Procedures** a) Assessing and Managing Patients at Risk for Suicide b) Bronchoscopy Nursing c) Incentive Spirometer (IS) Instruct and Monitoring d) Interdisciplinary Plan of Care (IPOC) e) Malignant Hyperthermia Management Procedure f) Pre-Bronchoscopy Procedure h) Pronouncement of Death Procedure i) Siemens Rapidpoint Procedure 2) **Unit Specific - Infection Control** a) Standard and Transmission-Based Precautions 3) **Unit Specific – NICU** a) Peripheral Arterial Line (PAL) Insertion, Maintenance and Removal Of 4) **Unit Specific – Pharmacy** a) Automatic IV to Oral Conversion b) Decreasing Medication Errors c) Drug Samples d) Emergency Medication Tray for Crash Cart e) Employee Theft or Impairment Policy f) Floor Stock g) Formulary System		PAC

	Agenda Item	Time Allotted	Requestor
	h) Hours of Operation and Authorized Access to the Pharmacy i) Labelling Standards j) Medication Dispensing/ Distribution k) Medication Error Reduction Plan (MERP) l) Medication Ordered STAT and at Specified Time Intervals m) Patients Use of Herbals and Natural Remedies n) Pharmacy and Therapeutics Committee o)Technician Checking Technician Program **5) <u>Unit Specific - Surgical Services</u>** a) Surgery Blood in Ice Chests Procedure **6) <u>Unit Specific - Women and Newborn Services</u>** a) Hearing Screening Program: Newborn and Infants b) Newborn Hearing Screening: Inpatient and Outpatient Hearing Screening of Newborn and Infants Using Biologic Equipment c) Newborn Hearing Screening: Scheduling Outpatient Hearing Screening d) Newborn Hearing Screening: State of California Reporting **D. Audit, Compliance & Ethics Committee** Director Schallock, Committee Chair Open Community Seats – 0 *(Committee minutes to be included in August Board Agenda packet due to timing of meeting)* **1) <u>Administrative Policies & Procedures</u>:** a) 8610-562 – Ethics in Provision of Services b) 8750-596 – Identity Theft (Red Flag Rules) (2) Minutes – Approval of: a) Regular Board of Directors Meeting – June 28, 2018 b) Special Board of Directors Meeting – June 28, 2018 c) Special Board of Directors Meeting – June 26, 2018 (3) Meetings and Conferences – None (4) Dues and Memberships - None a) ACHD Member Dues $25,750.00		Audit, Comp. & Ethics Comm. Standard
21	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
22	Reports (Discussion by exception only) (a) Dashboard – None (b) Construction Report – None (c) Lease Report – (June, 2018) (d) Reimbursement Disclosure Report – (June, 2018) (e) Seminar/Conference Reports – None (f) Clinical Contract Performance Report	0-5 min.	Standard
23	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually, to address the Board	5-10 minutes	Standard
24	Additional Comments by Chief Executive Officer	5 min.	Standard

	Agenda Item	Time Allotted	Requestor
25	Board Communications (three minutes per Board member)	18 min.	Standard
26	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session	2hours/ 15 min.	
27	Oral Announcement of Items to be Discussed During Closed Session		
28	Motion to Return to Closed Session (if needed)		
29	Open Session		
30	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
31	Adjournment		

Teri Donnellan

F: vote=simplyvoting.com@email2.simplyvoting.com on behalf of Neil McCormick-CSDA <vote@simplyvoting.com>
Sent: Monday, July 09, 2018 8:00 AM
To: Teri Donnellan
Subject: Reminder: 2018 Board of Directors Election - Voting

Dear Teri Donnellan / SOUTHERN NETWORK:

Your district is a CSDA Regular Member in good standing and, as the main contact on file for the district, you are receiving this official electronic ballot to cast one vote on behalf of your district in CSDA's 2018 Board of Director's election for Seat A in SOUTHERN NETWORK. It is up to each district to determine their own process in terms of selecting a candidate to vote for in the election. In some cases the main contact will cast the vote solely while in others it is brought to the full Board of Directors for discussion and selection with the vote then cast by the main contact.

To vote, please visit: https://CSDA.simplyvoting.com/

Then enter your specific login information:

Elector ID - S1156
Password - 567V9

Or follow this link to access the ballot directly:
h[redacted]//CSDA.simplyvoting.com/auth.php?e=S1156&mac=754ad1a2d741c509d703

You may view and print candidate information through the above link, but must cast your vote electronically through the system. **The deadline to cast your district's vote is August 10, 2018.**

Ballots will be counted and confirmed on August 13.

Should you have any questions, please feel free to contact Beth Hummel at CSDA – 916-442-7887 or bethh@csda.net

Thank you!

Unsubscribe

Click here to report this email as spam.

CSDA

Online Voting

California Special Districts Association

Districts Stronger Together

Home | How It Works | Logout **Teri Donnellan**

Electronic Ballot - 2018 CSDA Board of Directors Election, (Seat A) Southern Network

Please vote for your choice

Choose **one** of the following candidates:

- Jo MacKenzie (Incumbent)
- Joseph Kelly

☐ **Jo MacKenzie** [view details]

☐ **Joseph Kelly** [view details]

Continue Cancel

This is the online voting system of CSDA. Powered by Simply Voting.

California Special
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2018 CSDA BOARD CANDIDATE INFORMATION SHEET

The following information MUST accompany your nomination form and Resolution/minute order:

Name: Jo MacKenzie

District/Company: Vista Irrigation District

Title: President, Board of Directors

Elected/Appointed/Staff: Elected

Length of Service with District: 26 years

1. **Do you have current involvement with CSDA (such as committees, events, workshops, conferences, Governance Academy, etc.):**
   - President 2011, Vice President 2010, Treasurer 2008-2009
   - CSDA Legislative Advocate of the Year 2010
   - Finance Corporation 2007-present, President 2012, 2013, 2015- present
   - Special District Leadership Foundation Board of Directors, Treasurer 2014-present
   - Fiscal and Audit Committees; Membership Committee 2011- present
   - Legislative Committee 2004-present; Chair, 2006-2010 and 2012
   - San Diego Chapter, Board of Directors 1993-present, President 1998-2000
   - Graduate of CSDA Governance Academy
   - Attend Annual Conference and Legislative Days

2. **Have you ever been associated with any other state-wide associations (CSAC, ACWA, League, etc.):**
   - ACWA: Past Board Director; Local Government, Chair 2014-2015 and Membership Committees
   - ACWA Region 10 Board, Vice Chair, Alternate Chair, Director 1997-2010
   - Special District Official of the Year by PublicCEO 2011

3. **List local government involvement (such as LAFCO, Association of Governments, etc.):**
   - San Diego LAFCO, 1994-present, Current Chair; served on Advisory Committee for 14 years
   - CALAFCO Board member
   - Served on City of San Marcos Planning and Traffic Commissions
   - Personally initiated the City of San Marcos Budget Review Committee in 1980, Chair 1996-2006

4. **List civic organization involvement:**
   - San Marcos Chamber of Commerce, Lifetime Ambassador
   - Graduate Leadership 2000, Cal State San Marcos
   - Soroptimist International

****Candidate Statement-**Although it is not required, each candidate is requested to submit a candidate statement of no more than 300 words in length. **Any statements received in the CSDA office after May 31, 2018 will not be included with the ballot mailing.**

Re-Elect Jo MacKenzie to CSDA Southern Network, Seat A

With a passion for and proven experience in leading special districts, I would be honored to continue serving on the CSDA Board of Directors as your Southern Network "Seat A" representative.

During my CSDA Board tenure, special districts have gained recognition as the third leg of local government. It is important that CSDA continues to be the voice of California's special districts. I remain dedicated to CSDA's mission and, if re-elected, I pledge to continue building on CSDA's foundation of educational programs, legislative advocacy, and public outreach. I believe my leadership and public service experience, my commitment to fiscal responsibility, and my comprehensive LAFCO and special districts knowledge makes me a qualified candidate for CSDA Seat A Director, Southern Network.

CSDA Experience:

- Board of Directors – President 2011, V.P. 2010, Treasurer 2008-2009
- Legislative Advocate of the Year 2010
- Legislative Committee 2004-present – Chair 2006-2010, 2012
- Finance Corporation 2007-present – President 2012, 2013, 2015-present
- Committees 2011-present – Fiscal & Audit, Membership
- SDLF Board of Directors – Treasurer 2014-present
- San Diego Chapter, Board of Directors 1993-present – President 1998-2000
- Governance Academy Graduate
- Conference, Special District Legislative Days – annual

Leadership Experience:

- ACWA – Director & Local Government Committee Chair 2014-2015, Membership Committee, Region 10 Board 1997-2010
- CALAFCO Director
- San Diego LAFCO 1994-present – currently Chair, 14 years on Advisory Committee
- Vista Irrigation District (VID*) Director 1992-present – was a principal negotiator for the San Luis Rey Water Rights Settlement Agreement between VID, five Indian Bands, the City of Escondido, & the Federal Government

Recognition, Community Service:

- PublicCeo Special District Official of the Year 2011
- CSDA Legislative Advocate, 2012
- City of San Marcos – Planning & Traffic Commissions, Budget Review Committee Chair 1996-2006
- San Marcos Chamber of Commerce, Lifetime Ambassador
- Leadership 2000 Graduate, Cal State San Marcos
- Soroptimist International

Teri Donnellan

From: Jo MacKenzie <mackgroup@cox.net>
Sent: Wednesday, July 11, 2018 2:51 PM
To: Teri Donnellan
Cc: 'Julie Nygaard'
Subject: FW: CSDA BOARD OF DIRECTORS ELECTIONS 2018 --San Diego
Attachments: Jo MacKenzie--2018 campaign-info statement.docx

Good Afternoon Teri.

As your district's Contact person, I wanted to follow up with you as to whether or not you received the email from Neil McCormick, CSDA CEO, on Monday, June 18. A number of districts did not receive the email. That email contained all the information you needed to vote in the election for the CSDA Board of Directors.

If you **did not** get the email, please call Beth Hummel, CSDA Administrative Assistant, at 916-442-7887 so you can vote. The emails you're receiving from the company administering the elections will stop!

I am running for re-election to the CSDA Board of Directors. I have attached my re-election information for you and your board's review. I am presently serving on the CSDA Board of Directors, Membership Committee and Legislation Committee on which I served as Chair for 5 years. I believe that my leadership has been instrumental in the successes of CSDA. I would like to continue serving on the Board as we move the Association forward providing more services for special districts.

The CSDA Board of Directors appointed me a couple years ago to the Special District Leadership Foundation Board of Directors which oversees scholarship awards to ALL independent special districts with annual budgets less than $8M. These scholarships can be used to attend any of the CSDA Conferences, workshops, symposiums or webinars. I tried to find your district's budget online, but your 'search button' didn't take me there!! SO, if your budget is less than $[illegible], please check out the Special District Leadership Foundation's website for more information---sdlf.org.

The next event is the CSDA **Annual Conference in Indian Wells, September 24-27, 2018.** There are scholarship dollars available in the Educational Allowance Fund.

If you have any questions or want additional information, please don't hesitate to call or email.

I would appreciate your district's vote, as every vote counts?

Thanks,
jo

Jo MacKenzie, Past President
California Special Districts Association
1578 Palomar Drive
San Marcos, CA 92069
760-743-7969

mackgroup@cox.net

California Special
Districts Association
CSDA *Districts Stronger Together*

2018 CSDA BOARD CANDIDATE INFORMATION SHEET

The following information MUST accompany your nomination form and Resolution/minute order:

Name: *Joseph Kelly*

District/Company: *Big Bear Airport District*

Title: *Director*

Elected/Appointed/Staff: *Elected Member - Board of Directors*

Length of Service with District: *3.5 years*

- **Do you have current involvement with CSDA (such as committees, events, workshops, conferences, Governance Academy, etc.):**

2016 Special District Leadership Academy
2018 Special District Leadership Academy
Association of San Bernardino County Special Districts Membership

- **Have you ever been associated with any other state-wide associations (CSAC, ACWA, League, etc.):**

Institute for Local Government - Public Engagement Certificate and Subscriber
Jefferson Madison Society, President

- **List local government involvement (such as LAFCo, Association of Governments, etc.):**

Contributor in Numerous Events/Meetings of:
City of Big Bear Lake
Bear Valley Municipal Water District
Big Bear Community Services District
Bear Valley Healthcare District
Bear Valley Unified School District

- **List civic organization involvement:**

Better Big Bear
Bear Valley Historical Society
Big Bear Business Bunch
Big Bear Pilots Association

****Candidate Statement –** Although it is not required, each candidate is requested to submit a candidate statement of no more than 300 words in length. **Any statements received in the CSDA office after May 31, 2018 will not be included with the ballot.**

Joseph Kelly, Director
Big Bear Airport District

A Message from Joseph Kelly
Candidate for the California Special Districts Association
Board of Directors

Hello, I am Joseph Kelly, your candidate for the California Special Districts Association (CSDA) Board of Directors. As an elected official, I understand the concept of serving our constituents. When elected to the CSDA Board, I will serve you.

CSDA is our "go to" organization, for training, support, data, answers and legislative outreach. During my tenure on the Big Bear Airport District Board of Directors, I have drawn on many of the resources provided by our membership in CSDA. These resources will not only continue, but get better with my input in Sacramento.

Technical innovations, communication and legislative support is what I bring to the table. I have no complaints about CSDA. To the contrary, I only seek to add my voice to make CSDA an ever improving association. I ask for your vote, the vote of your agency,
to elect me to the CSDA Board of Directors.

Special Districts like yours provide vital services to a major portion of California.
We as representatives require the support CSDA provides to help us carry out our responsibilities. We serve in every type of district from small rural areas to large metropolitan areas. One thing in common is that our constituents rely on us to provide services, without fail; and we are held accountable.

Each district faces its own challenges. In addition to these, some general concerns to me are:

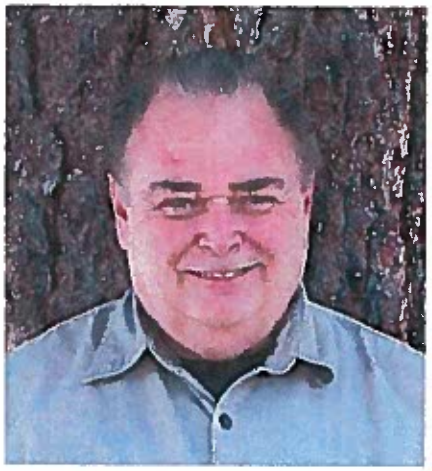
- UNFUNDED MANDATES from Sacramento which are growing
- PREVAILING WAGE regulations impact on districts which don't have the large base of contractors
- NETWORKING AND COMMUNICATION between agencies to find solutions to problems in common
- ENCOURAGING INPUT from Special Districts as to their needs from CSDA

(spartanizer@live.com) *The opinions expressed herein are those of the candidate*

Teri Donnellan

F[illegible]: spartanizer live.com <Spartanizer@live.com>
S[illegible]: Monday, July 16, 2018 9:45 PM
Subject: CSDA Primary Contact

CSDA Primary Contact, please forward my message to all members of your governing board. Your email was provided to me by the CSDA to contact voting members. Thank you.



Dear Fellow Board Member,

You and I serve the public, on our respective boards. Sometimes we get complaints; sometimes we get compliments, but compliments are less frequent for most agencies. Folks just don't come out unless they're concerned. The Big Bear Airport District recently had a rash of compliments. One neighbor thanked us for our noise reduction efforts; another complimented us on trees we had to remove for safety reasons.

Your situations may be very different, rate increases, changes in services, staffing, equipment or budgets. Whatever it is, the public can be understood for their concerns. I have found great success with dedicated public outreach and engagement. It's a two way street.

One of my mentors, said that if you serve people before they hire you, they know that you will serve them after you're hired. I want to serve you, on the board of the California Special Districts Association.

I ask for your input now, for what should be brought to Sacramento. Time flies; and we're already well into the election process for the CSDA board. If elected, I will always welcome your input as your representative in the CSDA Southern Network. And, I welcome your input now. You can email me at Spartanizer@live.com.

An organization is only as good as we make it. It's you and me on the line with the public. I hope to help continue the ever improving CSDA.

If your agency has not yet voted for your choice of CSDA board member, please schedule a vote as soon as possible. Let your voice be heard in Sacramento.

I respectfully ask for your vote to be a member of the CSDA board. And please contact me now with your input. Thank you.

Sincerely,

Joseph Kelly

Director - Big Bear Airport District.

My personal email: Spartanizer@live.com

Click here to report this email as spam.

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
July 11, 2018

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 7/27/2018 – 6/30/2020)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 7/27/2018 through 6/30/2020:

- **CHIAO, Hellen MD/Gastroenterology (North County Gastroenterology)**
- **DELANEY, Michael MD/Neurology(North County Neurology)**
- **FISCHER, Andrew MD/Emergency Medicine (TeamHealth)**
- **ONTIVEROS RAMIREZ, Jorge MD/Emergency Medicine (TeamHealth)**
- **PATEL, Lance MD/Anesthesiology (ASMG)**
- **RAYAN, Hany MD/Anesthesiology (ASMG)**
- **SHABRANG, Cyrus MD/Radiology (San Diego Imaging)**
- **VASHISHTA, Rishi MD/Anesthesiology (ASMG)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
July 11, 2018

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 8/01/2018 -7/31/2020)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 8/01/2018 through 7/31/2020, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- BOONJINDASUP, Aaron, MD/Urology/Provisional
- CHOUDRY, Bilal, MD/Neurology/Active
- GONZALES, Michelle, MD/Internal Medicine/Refer and Follow
- JAUREGUI, Nicholas, MD/Family Medicine/Provisional
- KOBAYASHI, Gary, MD/Family Medicine/Refer and Follow
- KROL, Thomas, MD/Gastroenterology/Active
- LE, Yung, MD/Internal Medicine/Active
- LEE, Dandy, MD/Anesthesiology/Active
- MAHIL, Amreesh, MD/Anesthesiology/Provisional
- MCCLAY, Edward, MD/Oncology/Active
- NAUDIN, Veronica, MD/Pediatrics/Active Affiliate
- PHILLIPS, Jason, MD/Urology/Active
- RASH, Dominique, MD/Oncology/Provisional
- RAYAN, Sunil, MD/General/Vascular Surgery/Active Affiliate
- SHETH, Manish, MD/Psychiatry/Active
- VELESRUBIO, Felisa, MD/Internal Medicine/Active Affiliate
- WANG, Chunyang, MD/Neurology/Active
- ZHU, Shiyin, MD/Anesthesiology/Provisional

Attachment B

UPDATE TO PREVIOUS REAPPOINTMENT:

- TERRAMANI, Thomas, MD/General & Vascular Surgery/Active

RESIGNATIONS: (Effective date 7/31/2018 unless otherwise noted)

Automatic:

- MCHALE, Michael, MD/Psychiatry

Voluntary:

- FLORES-DAHMS, Kathleen, MD/Radiology
- GHARIBIANIANS, Nareg, MD/Anesthesiology
- JACKSON, Michelle, MD/Dermatology/Allergy
- MAU, Nicole, MD/Dermatology/Allergy
- MELDEN, Mark, DO/Psychiatry
- PARDO, Patricia, MD/Anesthesiology
- ROTUNDA, Sherry, MD/Dermatology/Allergy
- WILTSE, Lise, MD/Anesthesiology

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
July 11, 2018

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS
PRIVILEGE RELATED CHANGES

VOLUNTARY RELINQUISHMENT OF PRIVILEGES

- VILCHIS, Caroline MD — Urology

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given six months from the last reappointment date to complete their outstanding proctoring, and given an additional six month period after that one. These practitioners failed to meet the proposed deadline and are approved for an additional 3 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by October 31, 2018 would result in these privileges automatically relinquishing.

- COHEN, David, MD — Cardiology
- GUTIERREZ, Miguel MD — Emergency Medicine
- HIGGINS, Steven MD — Cardiology
- KOCH, Richard MD — Emergency Medicine
- LEONARD, Lisa MD — OB/GYN
- LI, Xiangli MD — Internal Medicine
- MARQUART, Elizabeth MD — Emergency Medicine
- PREGERSON, David MD — Emergency Medicine

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
July 11, 2018

Attachment C

PROCTORING RECOMMENDATIONS (Effective 7/31/18, unless otherwise specified)

- ANAKWENZE, Okechukwu MD — Orthopedic Surgery
- GUTIERREZ, Miguel MD — Emergency Medicine
- HOWE, Steven MD — Cardiothoracic Surgery
- KABRA, Ashish MD — Cardiology
- POLLEMA, Travis DO — Cardiothoracic Surgery
- RUELAZ, Robert MD — Cardiology
- VANFLEET, Robert MD — Teleradiology
- VILCHIS, Caroline MD — Urology
- WISEMAN, Stephen MD — Anesthesiology

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT
July 16, 2018

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 7/27/2018 – 4/30/2020)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 7/27/2018 through 4/30/2020:

- **BROWN, Kaley PA-C/Surgery**
- **KWAN, Jaclyn PA-C/Surgery**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 2 of 3
July 16, 2018

Attachment B

ADDITIONAL PRIVILEGE REQUEST (Effective 07/31/2018, unless otherwise specified)
The following practitioners requested the following privilege(s) and met the initial criteria for the privilege(s)

- **ALLEN, Matthew PA-C** — **Allied Health Professional**
- **CARLTON, Vivian PA-C** — **Allied Health Professional**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 3 of 3
July 16, 2018

Attachment C

PROCTORING RECOMMENDATIONS (Effective 7/31/18, unless otherwise specified)

None

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT – 1 of 3
July 16, 2018

Attachment B

BIENNIAL REAPPRAISALS: (Effective Dates 8/1/2018 – 7/31/2020)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 8/1/2018 through 7/31/2020, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- **COWAN, John, PA-C/Allied Health Professional**
- **HUANG, Stephanie, PA-C/Allied Health Professional**
- **Kolt, Thomas, PA-C/Allied Health Professional**
- **Rice, William, PA-C/Allied Health Professional**
- **Spencer, Matthew, PA-C/Allied Health Professional**

ANNUAL EVALUATIONS: The following providers have received annual evaluations and have been recommended for continued AHP membership.

- Allen, Matthew G., PA-C
- Alston, Vickie S., CNM
- Ballantine, Katherine, CNM
- Brockman, Joe B., PA-C
- Brownsberger, Richard N., PA-C
- Carlton, Vivian W., PAC
- Chase, Nicole J., PAC
- Choquette, Alicia G., PA
- Coco, Kathleen M., CNM
- Hermann, Linda, PAC
- Hermanson, Kathleen H., PA
- Huang, Stephanie K., PAC
- Inocelda, Andrew G.
- Karver-Christenson, Elyse S., CNM
- Kaur, Manpreet, PAC
- Laforteza, Jozelle B., NP
- Leviel, Linda H., CNM
- Lister, Crystal J., CNM
- Martinez, Melinda W., PAC
- Mateo, Marie E., CNM

Attachment B

- Memeo, Kelly L., NP
- Olson, Lindsey D., PAC
- Perlman, Tamara L., CNM
- Pregerson, Heather A., PAC
- Rice, William M., PAC
- Schillinger, Stephan B., PAC
- Schroeder, Mary L., CNM
- Scott, Katie L., PAC
- Silverwood, Cristie D., NP
- Stabler, Holly, PAC
- Wallace, Stephanie, PA-C
- Weary, Yong S., CNM

RESIGNATIONS:

Automatic

- **BRYON, Jill, NP/Allied Health Professional**

Voluntary

- **MCQUEEN, Paula, CNM/Allied Health Professional**

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Cardiology
Standardized Procedures

Approvals

Cardiology Division (Signature): David Sigel 6/8/18

Medicine Department (Signature): [signature] 4/13/18

Interdisciplinary Practice Committee (Date): 7/16/18

Medical Executive Committee (Date): _____

Board of Directors (Date): _____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

1. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

2. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

3. Standardized procedures are maintained in the allied professional's file in the medical staff office.
   a) All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
   b) Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

1. SETTING

The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

2. SCOPE OF NP PRACTICE (FUNCTIONS)

The Cardiology NP will:

a) Assume responsibility for the *Cardiac* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
   i) Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.

b) Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.

c) Order medications as included in the Cardiology division Cerner Power Plans.

   i) The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

   ii) The NP orders the medication and documents the information into the chart and in the clinical notes.

   iii) If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

d) Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

e) Obtain psychiatric and medical histories and perform overall health assessment for any presenting problem.

f) Order and interpret specific laboratory studies for the patient as included in the Cardiology division Power Plans.

g) Provide or ensure case management and coordination of treatment.

h) Make referrals to outpatient primary care practitioners, and/or Mental Health Physicians for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

i) Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

j) Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

k) Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

l) Formulate recommendations to improve mental health care and patient outcomes.

m) Provide patient health education related to medications, psychiatric conditions and health issues.

3. The Nurse Practitioners will have access to the following PowerPlans:

~~a) The PowerPlans for the Cardiology Division are as follows:~~

~~a)~~a. CARD ACS, CP, CAD

~~b)~~b. CARD CHF Beta Blockers and Calcium Channel Blockers

~~c)~~c. CARD Cath Lab PTCA Stent

~~d)~~d. CARD Cath Lab Post Procedure

~~e)~~e. CARD Cath Lab Pre Procedure

~~f)~~f. CARD Elective Cardioversion Post

~~g)~~g. CARD Elective Cardioversion Pre

~~h)~~h. CARD Heart Failure

~~i)~~i. CARD Integrilin

~~j)~~j. CARD Post Cath Lab Teach (subphase)

~~k)~~k. CARD Transesophageal Echocardiogram PRE

~~l)~~l. CARD Pericardiocentesis

III. MANAGEMENT OF CONTROLLED SUBSTANCES

1. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

2. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.
   a) Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.
      i) This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.
   b) When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the division of cardiology.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

1. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.

2. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.

3. No physician shall provide concurrent supervision for more than four NPs.

4. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.

5. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.

a) Additional Supervision occurs as described below under "Quality Improvement."

6. Supervisor notification and consultation is obtained under the following circumstances:
   a) Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
   b) Acute exacerbation of a patient's situation;
   c) History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
   d) Patient refusal to undergo a medical examination or psychiatric evaluation and/or appropriate medical monitoring.
   e) Upon request of the patient, another clinician or Supervisor.
   f) Upon request of the NP.
   g) The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

1. Education and training:
   a) Master's degree in Nursing from an accredited college or university; AND
   b) Completion of an approved Adult, Child, or Family Nurse Practitioner program.
2. Licenses and Certification:
   a) Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
   b) Currently certified by the State of California as a Nurse Practitioner;
   c) Possession of a California State-issued medication Furnishing Number;
   d) Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
   e) ACLS in accordance with the specialty requirement.
   f) CNOR Certification if assisting in surgery.

VI. QUALITY IMPROVEMENT

1. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
   a) The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
   b) The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
   c) NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.

d) The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.

e) The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

2. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   a) Documentation of participation in relevant continuing education activities.

VII. Practice Prerogatives

1. As determined by the NP – Cardiology and the NP Cardiovascular Health Institute Card.

Acknowledgement Statements:
I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC. As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Gastroenterology
Standardized Procedures

Approvals

Gastroenterology Division (Signature): _____ 6/18

Medicine Department (Signature): _____ 7/11/18

Interdisciplinary Practice Committee (Date): 7/16/18

Medical Executive Committee (Date): _____

Board of Directors (Date): _____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

1. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

2. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

3. Standardized procedures are maintained in the allied professional's file in the medical staff office.
   a) All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
   b) Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

1. SETTING

The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

2. SCOPE OF NP PRACTICE (FUNCTIONS)

The Gastroenterology NP will:

a) Assume responsibility for the *Gastroenterology* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
   i) Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP

responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.

b) Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.

c) Order medications as included in the Medicine Department Cerner Power Plans.

   i) The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

   ii) The NP orders the medication and documents the information into the chart and in the clinical notes.

   iii) If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

c) Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

d) Obtain psychiatric and medical histories and perform overall health assessment for any presenting problem.

e) Order and interpret specific laboratory studies for the patient as included in the Neurology Power Plans.

f) Provide or ensure case management and coordination of treatment.

g) Make referrals to outpatient primary care practitioners, and/or Mental Health Physicians for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

h) Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

i) Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

j) Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

k) Formulate recommendations to improve mental health care and patient outcomes.

l) Provide patient health education related to medications, psychiatric conditions and health issues.

3. The Nurse Practitioners will have access to the following PowerPlans:

~~m.) The PowerPlans for the Gastroenterology are as follows:~~

- GI Bleed
- GI Diverticulitis
- GI H pylori Eradication
- GI Liver Diagnosis Workup
- GI Pancreatitis
- GI Post Endoscopy Inpatient
- GI Pre Endoscopy Inpatient
- GI Prophylaxis

III. MANAGEMENT OF CONTROLLED SUBSTANCES

1. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

2. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.
   a) Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.
      i) This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.
   b) When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the Department of Medicine.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

1. Supervision for purposes of this standardized policy is defined as supervision by an MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.

2. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.

3. No physician shall provide concurrent supervision for more than four NPs.

4. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.

5. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
   a) Additional Supervision occurs as described below under "Quality Improvement."

6. Supervisor notification and consultation is obtained under the following circumstances:
   a) Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
   b) Acute exacerbation of a patient's situation;
   c) History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
   d) Patient refusal to undergo a medical examination or psychiatric evaluation and/or appropriate medical monitoring.
   e) Upon request of the patient, another clinician or Supervisor.
   f) Upon request of the NP.
   g) The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

1. Education and training:
   a) Master's degree in Nursing from an accredited college or university; AND
   b) Completion of an approved Adult, Child, or Family Nurse Practitioner program.
2. Licenses and Certification:
   a) Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
   b) Currently certified by the State of California as a Nurse Practitioner;
   c) Possession of a California State-issued medication Furnishing Number;
   d) Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
   e) BLS or ACLS in accordance with the specialty requirement.
   f) CNOR Certification, if assisting in surgery.

VI. QUALITY IMPROVEMENT

1. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
   a) The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
   b) The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
   c) NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
   d) The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.

e) The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

2. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   a) Documentation of participation in relevant continuing education activities.

VII. Practice Prerogatives

1. As determined by the NP – Gastroenterology Privilege Card.

Acknowledgement Statements:
I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC. As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Hospitalist
Standardized Procedures

Approvals

Medicine Department (Signature): _____ 6/13/18

Interdisciplinary Practice Committee (Date): 7/16/18

Medical Executive Committee (Date): _____

Board of Directors (Date): _____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

1. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

2. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

3. Standardized procedures are maintained in the allied professional's file in the medical staff office.
   a) All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
   b) Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

1. SETTING

The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

2. SCOPE OF NP PRACTICE (FUNCTIONS)

The Hospitalist NP will:

a) Assume responsibility for the *Hospitalist* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
   i) Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.

b) Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.

c) Order medications as included in the Medicine Department Cerner Power Plans.

   i) The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

   ii) The NP orders the medication and documents the information into the chart and in the clinical notes.

   iii) If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

c) Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

d) Obtain psychiatric and medical histories and perform overall health assessment for any presenting problem.

e) Order and interpret specific laboratory studies for the patient as included in the Hospitalist Power Plans.

f) Provide or ensure case management and coordination of treatment.

g) Make referrals to outpatient primary care practitioners, and/or Mental Health Physicians for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

h) Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

i) Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

j) Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

k) Formulate recommendations to improve mental health care and patient outcomes.

l) Provide patient health education related to medications, psychiatric conditions and health issues.

3. The Nurse Practitioners will have access to the following PowerPlans:

~~m) The PowerPlans for the Hospitalist are as follows:~~

- ADMIT Standard Mediciations
- AM Labs General

- ANES CVS PostOp
- Admission to ICU ACS, CP, CAD Multi Phase
- Admission to ICU CHF Multi Phase
- Admission to ICU DKA Multi Phase
- Admission to ICU Gastrointestinal Multiphase
- Admission to ICU General Multiphase
- Admission to ICU Hemorrhagic Stroke
- Admission to ICU Ischemic Stroke Multi Phase
- Admission to ICU Pulmonary Multi Phase
- Admission to ICU Sepsis (Severe) Multi Phase
- Admission to ICU Therapeutic Hypothermia Post Arrest MP
- Admission to ICU tPA/Ischemic Stroke Multi Phase
- Admission to MS Ischemic Stroke Multi Phase
- Admission to MedSurg Gi Multi Phase
- Admission to MedSurg General Multi Phase
- Admission to MedSurg Pulmonary Multiphase
- Admission to Telemetry ACS, CP, CAD Multi Phase
- Admission to Telemetry CHF Multi Phase
- Admission to Telemetry Gastrointestinal Multiphase
- Admission to Telemetry General Multi Phase
- Admission to Telemetry Pulmonary Multi Phase
- Alcohol (Ethylene & Methanol) Toxicity Peds
- Alcohol (Ethylene & Methanol) Toxicity Adult
- Alcohol and Benzodiazepine Detoxification SubPhase (Decision to Admit)
- Discharge Patient
- KEO Feed Tub Insertion
- Palliative Care
- Stool Studies SubPhase
- Sub Phase Admit to OPOBS/Extended Recovery
- Sub Phase ED Core Measure AMI
- Sub Phase ICU
- Sub Phase Telemetry
- Sub Plan Medically Monitored Transfer

- Sub Plan Telemetry Transfer
- SubPhase ACS, CP, CAD (Decision to Admit)
- SubPhase ACS, CP, CAD (Floor)
- SubPhase Admit Standard Medications (Decision to Admit)
- SubPhase COPD/Asthma (Decision to Admit)
- SubPhase DKA (Decision to Admit)
- SubPhase DKA (Floor Orders)
- SubPhase GI Bleed (Decision to Admit)
- SubPhase Heart Failure (Decision to Admit)
- SubPhase Heart Failure (Floor)
- SubPhase Pancreatitis (Decision to Admit)
- SubPhase Pneumonia (CAP)ICU Decision to Admit)
- SubPhase Pneumonia (CAP) NON-ICU (Decision to Admit)
- SubPhase Pneumonia (HAP) Admission (Decision to Admit)
- SubPhase Severe Sepsis (Decision to Admit)
- SubPhase Stroke – Hemorrhagic (Decision to Admit ICU)
- SubPhase Stroke – Hemorrhagic (Decision to Admit Non ICU)
- SubPhase Stroke – Hemorrhagic (Floor Orders)
- SubPhase Stroke – Ischemic (Decision to Admit)
- SubPhase Stroke – Ischemic (Floor)
- SubPhase Stroke – tPA Ischemic ICU (Decision to Admit)
- SubPhase Stroke – tPA Ischemic Stroke NON ICU (Decision to Admit)
- Subphase Admit Standard Medications (Floor)
- Subphase COPD/Asthma (Floor)
- Subphase Electrolyte Replacement (Decision to Admit)
- Subphase Severe Sepsis (Floor)
- Transfer to IC DKA Diabetic Ketoacidosis
- Transfer to Intensive Care (ICU)
- Transfer to Lower Level of Care – Adult
- Transfer to Medical Surgical Care
- Transfer to Telemetry Care
- Tub Feeding – ICU
- VTE (Venous Thromboembolism) Prophylaxis

- VTE (Venous Thromboembolism) Treatment
- VTE Prophylaxis and Treatment
- VTE Prophylaxis and Treatment Other (Floor Orders)
- Percutaneous Gastrostomy (Requesting) Tube Placement
- Discharge to Interfaculty (Adult)
- Enteral Feedings
- Severe Sepsis
- Subphase Severe Sepsis (Floor)
- AM Labs General
- ICU Enteral Feeding
- KEO Feed Tube Insertion

III. MANAGEMENT OF CONTROLLED SUBSTANCES

1. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

2. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.
   a) Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.
      i) This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.
   b) When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the Department of Medicine.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

1. Supervision for purposes of this standardized policy is defined as supervision by an MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.

2. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.

3. No physician shall provide concurrent supervision for more than four NPs.

4. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.

5. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
   a) Additional Supervision occurs as described below under "Quality Improvement."

6. Supervisor notification and consultation is obtained under the following circumstances:
   a) Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
   b) Acute exacerbation of a patient's situation;
   c) History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
   d) Patient refusal to undergo a medical examination or psychiatric evaluation and/or appropriate medical monitoring.
   e) Upon request of the patient, another clinician or Supervisor.
   f) Upon request of the NP.
   g) The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

1. Education and training:
   a) Master's degree in Nursing from an accredited college or university; AND
   b) Completion of an approved Adult, Child, or Family Nurse Practitioner program.

2. Licenses and Certification:
   a) Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
   b) Currently certified by the State of California as a Nurse Practitioner;
   c) Possession of a California State-issued medication Furnishing Number;
   d) Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
   e) BLS or ACLS in accordance with the specialty requirement.
   f) CNOR Certification, if assisting in surgery.

VI. QUALITY IMPROVEMENT

1. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
   a) The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
   b) The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.

c) NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.

d) The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.

e) The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

2. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   a) Documentation of participation in relevant continuing education activities.

VII. Practice Prerogatives

1. As determined by the NP – Hospitalist Card.

Acknowledgement Statements:
I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC. As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Interventional Radiology
Standardized Procedures

Approvals

Radiology Department (Signature): _____ 6/13/18

Interdisciplinary Practice Committee (Date): 7/16/18

Medical Executive Committee (Date): _____

Board of Directors (Date): _____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

1. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

2. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

3. Standardized procedures are maintained in the allied professional's file in the medical staff office.
   a) All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
   b) Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

1. SETTING

The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

2. SCOPE OF NP PRACTICE (FUNCTIONS)

The Interventional Radiology NP will:

a) Assume responsibility for the *Interventional Radiology* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
   i) Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.

b) Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.

c) Order medications as included in the Interventional Radiology Cerner Power Plans.

   i) The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

   ii) The NP orders the medication and documents the information into the chart and in the clinical notes.

   iii) If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

d) Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

e) Obtain psychiatric and medical histories and perform overall health assessment for any presenting problem.

f) Order and interpret specific laboratory studies for the patient as included in the Interventional Radiology Power Plans.

g) Provide or ensure case management and coordination of treatment.

h) Make referrals to outpatient primary care practitioners, and/or Mental Health Physicians for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

i) Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

j) Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

k) Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

l) Formulate recommendations to improve mental health care and patient outcomes.

m) Provide patient health education related to medications, psychiatric conditions and health issues.

3. **The Nurse Practitioners will have access to the following PowerPlans:**

~~n) The PowerPlans for Interventional Radiology are as follows:~~

~~a)~~a. IR Intra Specialized Orders

~~b)~~b. IR Intra Tunneled Procedure Medication Orders

c)c. IR Intra Vascular Procedure Medication Orders

d)d. IR Lung Biopsy Multiphase

e)e. IR Lung Biopsy Post Procedure

f)f. IR Lung Biopsy Pre Procedure

g)g. IR MRI with Sedation Multiphase

h)h. IR Percutaneous GU/GI Drainage Multiphase

i)i. IR Port/Tunneled Catheter Multiphase

j)j. IR Port/Tunneled Catheter Post Procedure

k)k. IR Port/Tunneled Catheter Pre Procedure

l)l. IR Stroke and Neurovascular Intervention Post Procedure

m)m. IR Stroke and Neurovascular Intervention Pre Procedure

n)n. IR Stroke/Neurovascular Intervention Multiphase

o)o. IR TIPS Multiphase Plan

p)p. IR Thrombolysis Intervention Post Procedure

q)q. IR Tube Check Multiphase

r)r. IR Tube Check Post Procedure

s)s. IR Tube Check Pre Procedure

t)t. IR Vertebral Augmentation Post Procedure

u)u. IR Vertebral Augmentation Pre Procedure

III. MANAGEMENT OF CONTROLLED SUBSTANCES

1. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

2. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.
   a) Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.
      i) This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.
   b) When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the Department of Radiology.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

1. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.

2. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.

3. No physician shall provide concurrent supervision for more than four NPs.

4. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.

5. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
   a) Additional Supervision occurs as described below under "Quality Improvement."

6. Supervisor notification and consultation is obtained under the following circumstances:
   a) Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
   b) Acute exacerbation of a patient's situation;
   c) History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
   d) Patient refusal to undergo a medical examination or psychiatric evaluation and/or appropriate medical monitoring.
   e) Upon request of the patient, another clinician or Supervisor.
   f) Upon request of the NP.
   g) The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

1. Education and training:
   a) Master's degree in Nursing from an accredited college or university; AND
   b) Completion of an approved Adult, Child, or Family Nurse Practitioner program.
2. Licenses and Certification:
   a) Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
   b) Currently certified by the State of California as a Nurse Practitioner;
   c) Possession of a California State-issued medication Furnishing Number;
   d) Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
   e) BLS or ACLS in accordance with the specialty requirement.

f) CNOR Certification if assisting in surgery.

VI. QUALITY IMPROVEMENT

1. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
   a) The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
   b) The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
   c) NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
   d) The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.
   e) The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

2. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   a) Documentation of participation in relevant continuing education activities.

VII. Practice Prerogatives

1. As determined by the NP – Interventional Radiology Card.

Acknowledgement Statements:
I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC. As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Neonatal
Standardized Procedures

Approvals

Neonatology Division (Signature): _____ 6/12/18

Pediatrics Department (Signature): _____ 6/13/18

Interdisciplinary Practice Committee (Date): 7/16/18

Medical Executive Committee (Date): _____

Board of Directors (Date): _____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

1. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

2. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

3. Standardized procedures are maintained in the allied professional's file in the medical staff office.
   a) All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
   b) Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

1. SETTING

The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

2. SCOPE OF NP PRACTICE (FUNCTIONS)

The Neonatal NP will:

a) Assume responsibility for the *Neonatal* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
   i) Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.

b) Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.

c) Order medications as included in the Neonatal Cerner Power Plans.

   i) The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

   ii) The NP orders the medication and documents the information into the chart and in the clinical notes.

   iii) If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

d) Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

e) Obtain psychiatric and medical histories and perform overall health assessment for any presenting problem.

f) Order and interpret specific laboratory studies for the patient as included in the Neonatal Power Plans.

g) Provide or ensure case management and coordination of treatment.

h) Make referrals to outpatient primary care practitioners, and/or Mental Health Physicians for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

i) Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

j) Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

k) Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

l) Formulate recommendations to improve mental health care and patient outcomes.

m) Provide patient health education related to medications, psychiatric conditions and health issues.

3. The Nurse Practitioners will have access to the following PowerPlans:

~~a) The PowerPlans for NICU are as follows:~~

~~a) NICU Acyclovir~~

~~b)~~a. NICU Admission _1

~~c) NICU Amphotericin Liposomal~~

~~d) NICU Caffeine Citrate Initiation~~

~~e) NICU Diflucan~~

~~f) NICU Decadron DART~~

~~g)~~b. NICU Feeding

~~h) NICU Flagyl~~

c. NICU Follow Up Labs

~~i)~~d. NICU HSV Work Up

~~j) NICU Gentamicin~~

~~k)~~e. NICU IV Fluids/PICC Line Insertion

~~l) NICU Meropenem~~

~~m)~~f. NICU Neonatal Abstinence Syndrome

~~n)~~g. NICU PICC Line Insertion

~~o) NICU Phenobarbital~~

~~p)~~h. NICU Pre Eye Exam Medication Orders

~~q)~~i. NICU Respiratory

~~r) NICU Sepsis Work Up~~

~~s) NICU Treatment for HIV Exposure~~

~~t)~~j. NICU Vaccines

~~u) NICU Vancomycin~~

k. NICU CSF Labs

~~v)~~l. Ped Hyperbilirubinemia

~~w)~~m. SP NICU Newborn Medications - Nursing

III. MANAGEMENT OF CONTROLLED SUBSTANCES

1. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

2. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.
   a) Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.
      i) This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.
   b) When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the Division of Neonatology.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

1. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.

2. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.

3. No physician shall provide concurrent supervision for more than four NPs.

4. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.

5. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
   a) Additional Supervision occurs as described below under "Quality Improvement."

6. Supervisor notification and consultation is obtained under the following circumstances:
   a) Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
   b) Acute exacerbation of a patient's situation;
   c) History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
   d) Patient refusal to undergo a medical examination or psychiatric evaluation and/or appropriate medical monitoring.
   e) Upon request of the patient, another clinician or Supervisor.
   f) Upon request of the NP.
   g) The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

1. Education and training:
   a) Master's degree in Nursing from an accredited college or university; AND
   b) Completion of an approved Adult, Child, or Family Nurse Practitioner program.

2. Licenses and Certification:
   a) Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
   b) Currently certified by the State of California as a Nurse Practitioner;
   c) Possession of a California State-issued medication Furnishing Number;

d) Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.

e) NRP~~BLS or ACLS~~ in accordance with the specialty requirement.

f) CNOR Certification if assisting in surgery.

VI. QUALITY IMPROVEMENT

1. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
   a) The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
   b) The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
   c) NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
   d) The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.
   e) The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

2. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   a) Documentation of participation in relevant continuing education activities.

VII. Practice Prerogatives

1. As determined by the NP – Neonatal Card.

Acknowledgement Statements:
I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC. As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Neurology
Standardized Procedures

Approvals

Neurology Division (Signature): _____ 6/13/18

Medicine Department (Signature): _____ 6/13/18

Interdisciplinary Practice Committee (Date): 7/16/18

Medical Executive Committee (Date): _____

Board of Directors (Date): _____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

1. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

2. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

3. Standardized procedures are maintained in the allied professional's file in the medical staff office.
   a) All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
   b) Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

1. SETTING

The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

2. SCOPE OF NP PRACTICE (FUNCTIONS)

The Neurology NP will:

a) Assume responsibility for the *Neurology* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
   i) Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.

b) Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.

c) Order medications as included in the Medicine Department Cerner Power Plans.

   i) The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

   ii) The NP orders the medication and documents the information into the chart and in the clinical notes.

   iii) If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

c) Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

d) Obtain psychiatric and medical histories and perform overall health assessment for any presenting problem.

e) Order and interpret specific laboratory studies for the patient as included in the Neurology Power Plans.

f) Provide or ensure case management and coordination of treatment.

g) Make referrals to outpatient primary care practitioners, and/or Mental Health Physicians for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

h) Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

i) Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

j) Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

k) Formulate recommendations to improve mental health care and patient outcomes.

l) Provide patient health education related to medications, psychiatric conditions and health issues.

3. **The Nurse Practitioners will have access to the following PowerPlans:**

~~m) The PowerPlans for the Neurology are as follows:~~

- Neuro Heparin (Stroke)
- Neuro Intrathecal Medication Trial

- Neuro Post Operative Multi Phase
- Neuro Stroke – Hemorrhagic
- Neuro Stroke – Ischemic
- Neuro Ventriculostomy (ICP) Management
- Neuro Video EEG Monitoring

III. MANAGEMENT OF CONTROLLED SUBSTANCES

1. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

2. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.
   a) Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.
      i) This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.
   b) When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the Department of Medicine.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

1. Supervision for purposes of this standardized policy is defined as supervision by an MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.

2. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.

3. No physician shall provide concurrent supervision for more than four NPs.

4. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.

5. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
   a) Additional Supervision occurs as described below under "Quality Improvement."

6. Supervisor notification and consultation is obtained under the following circumstances:
   a) Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
   b) Acute exacerbation of a patient's situation;

c) History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.

d) Patient refusal to undergo a medical examination or psychiatric evaluation and/or appropriate medical monitoring.

e) Upon request of the patient, another clinician or Supervisor.

f) Upon request of the NP.

g) The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

1. Education and training:
   a) Master's degree in Nursing from an accredited college or university; AND
   b) Completion of an approved Adult, Child, or Family Nurse Practitioner program.
2. Licenses and Certification:
   a) Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
   b) Currently certified by the State of California as a Nurse Practitioner;
   c) Possession of a California State-issued medication Furnishing Number;
   d) Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
   e) BLS or ACLS in accordance with the specialty requirement.
   f) CNOR Certification, if assisting in surgery.

VI. QUALITY IMPROVEMENT

1. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
   a) The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
   b) The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
   c) NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
   d) The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.
   e) The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.
2. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   a) Documentation of participation in relevant continuing education activities.

VII. Practice Prerogatives

1. As determined by the NP – Neurology Card.

Acknowledgement Statements:
I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC. As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – OB/GYN
Standardized Procedures

Approvals

OB/GYN Department (Signature): Sandra Lopez 6/13/18

Interdisciplinary Practice Committee (Date): 7/16/18

Medical Executive Committee (Date): _____

Board of Directors (Date): _____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

1. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

2. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

3. Standardized procedures are maintained in the allied professional's file in the medical staff office.
   a) All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
   b) Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

1. SETTING

The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

2. SCOPE OF NP PRACTICE (FUNCTIONS)

The OB/GYN NP will:

a) Assume responsibility for the *OB/GYN* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
   i) Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.

b) Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.

c) Order medications as included in the OB/GYN Cerner Power Plans.

   i) The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

   ii) The NP orders the medication and documents the information into the chart and in the clinical notes.

   iii) If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

d) Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

e) Obtain psychiatric and medical histories and perform overall health assessment for any presenting problem.

f) Order and interpret specific laboratory studies for the patient as included in the OB/GYN Power Plans.

g) Provide or ensure case management and coordination of treatment.

h) Make referrals to outpatient primary care practitioners, and/or Mental Health Physicians for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

i) Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

j) Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

k) Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

l) Formulate recommendations to improve mental health care and patient outcomes.

m) Provide patient health education related to medications, psychiatric conditions and health issues.

3. The Nurse Practitioners will have access to the following PowerPlans:

~~n) The PowerPlans for OB are as follows:~~

~~a)~~a. OB Admit to L&D C-Section

~~b)~~b. OB Admit to Postpartum C Section

~~c)~~c. OB GYN Pre Operative Hold

~~d)~~d. OB GYN Pre Operative Education

~~e)~~e. OB Pre-Op Teach Labs

~~f)~~f. OB Tubal Ligation Pre/Intra Orders

~~g)~~g. Discharge Women's

~~h)~~h. OB 2016 L&D C-Section

~~i)~~i. OB 2016 Postpartum C Section

~~j)~~j. OB 2016 Postpartum Vaginal Delivery

~~k)~~k. OB 2016 Tubal Ligation Pre/Intra Orders

III. MANAGEMENT OF CONTROLLED SUBSTANCES

1. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

2. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.
   a) Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.
      i) This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.
   b) When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the Department of OB/GYN.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

1. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.

2. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.

3. No physician shall provide concurrent supervision for more than four NPs.

4. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.

5. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
   a) Additional Supervision occurs as described below under "Quality Improvement."

6. Supervisor notification and consultation is obtained under the following circumstances:
   a) Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
   b) Acute exacerbation of a patient's situation;
   c) History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
   d) Patient refusal to undergo a medical examination or psychiatric evaluation and/or appropriate medical monitoring.
   e) Upon request of the patient, another clinician or Supervisor.
   f) Upon request of the NP.
   g) The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

1. Education and training:
   a) Master's degree in Nursing from an accredited college or university; AND
   b) Completion of an approved Adult, Child, or Family Nurse Practitioner program.
2. Licenses and Certification:
   a) Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
   b) Currently certified by the State of California as a Nurse Practitioner;
   c) Possession of a California State-issued medication Furnishing Number;
   d) Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
   e) BLS or ACLS in accordance with the specialty requirement.
   f) CNOR Certification if assisting in surgery.

VI. QUALITY IMPROVEMENT

1. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
   a) The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
   b) The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
   c) NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
   d) The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.

e) The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

2. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   a) Documentation of participation in relevant continuing education activities.

VII. Practice Prerogatives

1. As determined by the NP – OB/GYN Card.

Acknowledgement Statements:
I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC. As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Orthopedic & Spine Institute
Standardized Procedures

Approvals

Orthopedic Division (Signature): _____ MD 6/6/18

Surgery Department (Signature): _____

Interdisciplinary Practice Committee (Date): 7/16/18

Medical Executive Committee (Date): _____

Board of Directors (Date): _____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

1. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

2. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

3. Standardized procedures are maintained in the allied professional's file in the medical staff office.
   a) All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
   b) Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

1. SETTING

The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

2. SCOPE OF NP PRACTICE (FUNCTIONS)

The Orthopedic & Spinal Institute NP will:

a) Assume responsibility for the *Orthopedic & Spinal Institute* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.

   i) Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.

b) Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.

c) Order medications as included in the Orthopedic division Cerner Power Plans.

   i) The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

   ii) The NP orders the medication and documents the information into the chart and in the clinical notes.

   iii) If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

d) Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

e) Obtain psychiatric and medical histories and perform overall health assessment for any presenting problem.

f) Order and interpret specific laboratory studies for the patient as included in the Orthopedic division Power Plans.

g) Provide or ensure case management and coordination of treatment.

h) Make referrals to outpatient primary care practitioners, and/or Mental Health Physicians for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

i) Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

j) Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

k) Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

l) Formulate recommendations to improve mental health care and patient outcomes.

m) Provide patient health education related to medications, psychiatric conditions and health issues.

3. The Nurse Practitioners will have access to the following PowerPlans:

~~n) The PowerPlans for the Orthopedic Division are as follows:~~

~~a)~~a. ORTHO Cervical Spinal Fusion Post Op Multi Phase

~~b)~~b. ORTHO Hip Fracture Post Operative Multi Phase

c)c. ORTHO Lumbar Spinal Fusion Post Op Multi Phase

d)d. ORTHO Post Operative

e)e. ORTHO Pre Operative

f)f. ORTHO Radiographs Lower Extremity

g)g. ORTHO Radiographs Upper Extremity

h)h. ORTHO Spine PostOp

i)i. ORTHO Spine PreOp

III. MANAGEMENT OF CONTROLLED SUBSTANCES

1. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

2. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.
   a) Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.
      i) This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.
   b) When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the division of orthopedic surgery.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

1. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.

2. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.

3. No physician shall provide concurrent supervision for more than four NPs.

4. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.

5. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
   a) Additional Supervision occurs as described below under "Quality Improvement."

6. Supervisor notification and consultation is obtained under the following circumstances:
   a) Emergent conditions requiring prompt medical intervention after stabilizing care has been started.

b) Acute exacerbation of a patient's situation;

c) History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.

d) Patient refusal to undergo a medical examination or psychiatric evaluation and/or appropriate medical monitoring.

e) Upon request of the patient, another clinician or Supervisor.

f) Upon request of the NP.

g) The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

1. Education and training:
   a) Master's degree in Nursing from an accredited college or university; AND
   b) Completion of an approved Adult, Child, or Family Nurse Practitioner program.
2. Licenses and Certification:
   a) Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
   b) Currently certified by the State of California as a Nurse Practitioner;
   c) Possession of a California State-issued medication Furnishing Number;
   d) Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
   e) BLS or ACLS in accordance with the specialty requirement.
   f) CNOR Certification if assisting in surgery.

VI. QUALITY IMPROVEMENT

1. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
   a) The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
   b) The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
   c) NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
   d) The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.
   e) The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

2. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   a) Documentation of participation in relevant continuing education activities.

VII. Practice Prerogatives

1. As determined by the NP – Orthopaedic & Spine Institute Card.

Acknowledgement Statements:
I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC. As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Psychiatry Division
Standardized Procedures

Approvals
Psychiatry Division (Signature): _____ 6/7/18

Medicine Department (Signature): _____ 6/13/18

Interdisciplinary Practice Committee (Date): _____ 7/16/18

Medical Executive Committee (Date): _____

Board of Directors (Date): _____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

1. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

2. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

3. Standardized procedures are maintained in the allied professional's file in the medical staff office.
   a) All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
   b) Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

1. SETTING

The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

2. SCOPE OF NP PRACTICE (FUNCTIONS)

The Psychiatry Division NP will:

a) Assume responsibility for the *Psychiatry* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
   i) Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.

b) Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.

c) Order medications as included in the Psychiatry division Cerner Power Plans.

   i) The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

   ii) The NP orders the medication and documents the information into the chart and in the clinical notes.

   iii) If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

d) Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

e) Obtain psychiatric and medical histories and perform overall health assessment for any presenting problem.

f) Order and interpret specific laboratory studies for the patient as included in the Psychiatry division Power Plans.

g) Provide or ensure case management and coordination of treatment.

h) Make referrals to outpatient primary care practitioners, and/or Mental Health Physicians for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

i) Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

j) Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

k) Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

l) Formulate recommendations to improve mental health care and patient outcomes.

m) Provide patient health education related to medications, psychiatric conditions and health issues.

3. The Nurse Practitioners will have access to the following PowerPlans:

~~n) The PowerPlans for the Psychiatry Division are as follows:~~

a) 5150 Order/Sub Phase

b) Alcohol and Benzodiazepine Detoxification SubPhase (Decision to Admit)

c) BHU Admission
d) BHU Alcohol and Benzodiazepine Detoxification
e) BHU Anxiety
f) BHU Bipolar-Mania
g) BHU Clozapine Titration
h) BHU Depression
i) BHU Emergency Medications
j) BHU Invega Sustenna
k) BHU Nicotine Smoking Cessation Plan
l) BHU Opiate Detox
m) BHU Psychosis
n) BHU Standard Admission Medications
o) BHU Suboxone Taper Off
p) Discharge BHU (NEW)
q) Discharge BHU Patient

III. MANAGEMENT OF CONTROLLED SUBSTANCES

1. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

2. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.
   a) Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.
      i) This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.
   b) When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the division of Psychiatry.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

1. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.

2. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.

3. No physician shall provide concurrent supervision for more than four NPs.

4. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.

5. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
   a) Additional Supervision occurs as described below under "Quality Improvement."

6. Supervisor notification and consultation is obtained under the following circumstances:
   a) Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
   b) Acute exacerbation of a patient's situation;
   c) History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
   d) Patient refusal to undergo a medical examination or psychiatric evaluation and/or appropriate medical monitoring.
   e) Upon request of the patient, another clinician or Supervisor.
   f) Upon request of the NP.
   g) The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

1. Education and training:
   a) Master's degree in Nursing from an accredited college or university; AND
   b) Completion of an approved Adult, Child, or Family Nurse Practitioner program.

2. Licenses and Certification:
   a) Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
   b) Currently certified by the State of California as a Nurse Practitioner;
   c) Possession of a California State-issued medication Furnishing Number;
   d) Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
   e) BLS or ACLS in accordance with the specialty requirement.
   f) CNOR Certification if assisting in surgery.

VI. QUALITY IMPROVEMENT

1. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
   a) The NP will complete clinical quality review reports when necessary and inform appropriate personnel.

b) The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.

c) NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.

d) The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.

e) The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

2. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   a) Documentation of participation in relevant continuing education activities.

VII. Practice Prerogatives

1. As determined by the NP – Psychiatry Division Card.

Acknowledgement Statements:
I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC. As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Psychiatry Division/CSU
Standardized Procedures

<u>Approvals</u>
Psychiatry Division (Signature): _____ 6/7/18

Medicine Department (Signature): _____ 6/13/18

Interdisciplinary Practice Committee (Date): 7/16/19

Medical Executive Committee (Date): _____

Board of Directors (Date): _____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

1. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

2. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

3. Standardized procedures are maintained in the allied professional's file in the medical staff office.
   a) All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
   b) Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

1. SETTING

The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

2. SCOPE OF NP PRACTICE (FUNCTIONS)

The Psychiatry Division NP will:

a) Assume responsibility for the *Psychiatry* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
   i) Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.

b) Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.

c) Order medications as included in the Psychiatry division Cerner Power Plans.

   i) The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

   ii) The NP orders the medication and documents the information into the chart and in the clinical notes.

   iii) If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

d) Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

e) Obtain psychiatric and medical histories and perform overall health assessment for any presenting problem.

f) Order and interpret specific laboratory studies for the patient as included in the Psychiatry division Power Plans.

g) Provide or ensure case management and coordination of treatment.

h) Make referrals to outpatient primary care practitioners, and/or Mental Health Physicians for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

i) Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

j) Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

k) Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

l) Formulate recommendations to improve mental health care and patient outcomes.

m) Provide patient health education related to medications, psychiatric conditions and health issues.

3. **The Nurse Practitioners will have access to the following PowerPlans:**

~~n) The PowerPlans for the Psychiatry Division are as follows:~~

~~a)~~a. CSU Admit Orders by Psychiatry

~~b)~~b. Discharge CSU

~~c)~~c. ED CSU Emergency Medications

III. MANAGEMENT OF CONTROLLED SUBSTANCES

1. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

2. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.
   a) Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.
      i) This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.
   b) When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the division of Psychiatry.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

1. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.

2. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.

3. No physician shall provide concurrent supervision for more than four NPs.

4. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.

5. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
   a) Additional Supervision occurs as described below under "Quality Improvement."

6. Supervisor notification and consultation is obtained under the following circumstances:
   a) Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
   b) Acute exacerbation of a patient's situation;
   c) History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
   d) Patient refusal to undergo a medical examination or psychiatric evaluation and/or appropriate medical monitoring.
   e) Upon request of the patient, another clinician or Supervisor.

f) Upon request of the NP.

g) The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

1. Education and training:
   a) Master's degree in Nursing from an accredited college or university; AND
   b) Completion of an approved Adult, Child, or Family Nurse Practitioner program.
2. Licenses and Certification:
   a) Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
   b) Currently certified by the State of California as a Nurse Practitioner;
   c) Possession of a California State-issued medication Furnishing Number;
   d) Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
   e) BLS or ACLS in accordance with the specialty requirement.
   f) CNOR Certification if assisting in surgery.

VI. QUALITY IMPROVEMENT

1. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
   a) The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
   b) The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
   c) NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
   d) The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.
   e) The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.
2. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   a) Documentation of participation in relevant continuing education activities.

VII. Practice Prerogatives

1. As determined by the NP – Psychiatry Division Card.

Acknowledgement Statements:
I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC. As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date

Tri-City Medical Center

Delineation of Privileges

Orthopedic Technician - ~~2/17~~5/18

Provider Name:

Request	Privilege	Action MSO Use Only

CRITERIA:

Initial and Reappointment:
1. Certified by the National Board for Certification of Orthopedic Technologists
2. Documentation of participation in relevant continuing education activities.
3. BLS or ACLS

Proctoring: Six (6) cases

INTRAOPERATIVE RETRACTIONS:

___ Retract Tissue or organs by use of hand ___

___ Place or hold surgical retractors ___

___ ~~Manage all instruments in the operative field~~ ___

INTRAOPERATIVE HOMOSTASIS

___ Aspiration of blood and other fluids from the operative site ___

___ Sponge wounds or other areas of dissection ___

INTRAOPERATIVE WOUND CLOSURE:

___ Apply surgical dressing ___

OTHER:

___ Assist with applying casts, braces, or plaster splints ___

APPLICANT:
I agree to exercise only those services granted to me. I understand that I may not perform any functions within Tri-City Medical Center that are not specifically approved by the appropriate Department/Division and the Interdisciplinary Practice Committee.

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

*Note - Applicant is responsible for obtaining Sponsoring Physician's Signature and completion of below:

SPONSORING PHYSICIAN:
As sponsoring physician of this Allied Health Professional, I agree to be held responsible for his/her performance while providing services at Tri-City Medical Center

_____
Print Name of Sponsoring Physician

_____
Sponsoring Physician Signature

Tri-City Medical Center

Delineation of Privileges

Orthopedic Technician - ~~2/17~~5/18

Provider Name:

Request	Privilege	Action MSO Use Only

_____

Date

I certify that I have reviewed and evaluated the applicant's request for clinical privileges and other supporting information, and that the recommendations as noted below have been made with all pertinent factors considered.

Approval:

_____

Division/Department Signature

_____

Date

Tri-City Medical Center
MEDICAL STAFF

CONTINUING MEDICAL EDUCATION
MISSION STATEMENT
~~2015-2016~~2018-2019

Tri-City ~~Medical Center's~~Healthcare District's purpose is to support, foster, and direct comprehensive, cost-effective, high quality patient care.

As an accredited provider of Continuing Medical Education (CME), we provide quality educational opportunities that increase clinical awareness of illness and disease among potentially high-risk populations and enhance the knowledge base and clinical competency of physicians affiliated with Tri-City ~~Medical Center~~Healthcare District. At ~~TCMC~~TCTD, we enable our physicians to practice more effectively and efficiently in our community.

The expected results of Tri-City ~~Medical Center's~~Healthcare District's CME Program are improved physician performance and competence with the goal of producing better patient outcomes. A variety of outcomes assessments ~~will~~ may be used to collect and analyze data. Assessment tools include a post-knowledge assessment through evaluation ~~as well as~~ and may include follow up surveys as to specific changes in practice. In some activities, a pre-post assessment or patient outcome data may be utilized. The results of the findings from multiple methodologies will be used as an educational needs assessment for future CME activities and overall CME Program improvement.

The CME mission is congruent to the mission statement of Tri-City ~~Medical Center~~Healthcare District in its commitment to promote an organization-wide commitment to quality of care, on-going performance improvement, education, and the evaluation of outcomes that enhance our patient care.

Community Healthcare & Alliance Committee (No meeting held in July, 2018)

Finance, Operations & Planning Committee
(No meeting held in July, 2018)

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
July 12, 20118

Members Present: Director Leigh Anne Grass, Director Laura Mitchell, Director RoseMarie Reno and Dr. Souza.

Non-Voting Members Present: Steve Dietlin, CEO, Scott Livingstone, COO , Sharon Schultz, CNE/ Sr. VP, Susan Bond, General Legal Counsel and Carlos Cruz, Chief Compliance Officer.

Others Present: Emma Hilbourn, Tori Hong, Lisa Mattia, Debra Feller, Priscilla Reynolds, Jean Stepohenson, Steve Young, Merebeth Richins, Jeff Surowiec, Patricia Guerra and Karren Hertz.

Members Absent: Dr. Ma, Dr. Contardo and Dr. Johnson.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Grass called the meeting to order at 12:03 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 Mitchell and seconded by Dr. Souza.	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 June 2018.	Director Grass called for a motion to approve the minutes from June 14, 2018.	Director Mitchell approved and Dr. Souza seconded the motion to approve the minutes from June 2018.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Patient Care Services** 1. Assessing and Managing Patients at Risk for Suicide 2. Bronchoscopy Nursing 3. Incentive Spirometer (IS) Instruct and Monitoring 4. Interdisciplinary Plan of Care (IPOC) 5. Malignant Hyperthermia Management Procedure	It was noted that the BHU and CSU policies will remain in force. Since the Columbine Suicide Society was mentioned in this policy, Director Grass requested to have this entity be added as a reference to this policy. There is no discussion on this policy. Director Mitchell asked if nursing staff participate in this procedure but Sharon said that RNs don't usually go. There is no discussion on this policy. Director Laura Mitchell asked if Pharmacy is involved in mixing the medication commonly used in anesthesia. Tori mentioned that the Pharmacy had stopped doing that. It was also mentioned that Dr. Johnson had reviewed and approved this policy.	**ACTION:** The Patient Care policies and procedures were approved except for the Pain Management policy which was pulled out for further review. Director Reno moved and Director Mitchell seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
6. Pain Management Policy	The Pain Management policy is being pulled out as there are a few changes needed in the pain assessment part.		
7. Pre-Bronchoscopy Procedure	There was no discussion on this policy.		
8. Pronouncement of Death Procedure	There was a recommendation to add MD designee as one of the authorized people who can do a pronouncement of death on a patient.		
9. Siemens Rapidpoint Procedure	There was no discussion on this policy.		
Unit Specific **Infection Control** 1. Standard and Transmission-Based Precautions	There was no discussion on this policy.	**ACTION:** The Infection Control policy and procedure was approved. Director Mitchell moved and Director Reno seconded the motion to approve this policy moving forward for Board approval.	Patricia Guerra
NICU 1. Peripheral Arterial Line (PAL) Insertion, Maintenance and Removal Of	The only change in this policy is the addition of needleless device as stated by NICU educator Emma Hilbourn.	**ACTION:** The NICU procedure was approved. Director Reno moved and Director Mitchell seconded the motion to approve this policy moving forward for Board approval.	Patricia Guerra
Pharmacy 1. Automatic IV to Oral	It was clarified that the powder form of the	**ACTION:** The Pharmacy policies	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Conversion	medications used in IV are mostly not available anymore.	were approved. Director Mitchell moved and Dr. Souza seconded the motion to approve the Pharmacy policies moving forward for Board approval.	
2. Decreasing Medication Errors	There was no discussion on this policy.		
3. Drug Samples	There was no discussion on this policy.		
4. Emergency Medication Tray for Crash Cart	There was no discussion on this policy.		
5. Employee Theft or Impairment Policy	Tori further explained that drug diversion applies to any medication.		
6. Floor Stock	Tori Hong reported that floor stock medications are still present for those units that doesn't have pyxis machines.		
7. Formulary System	There was no discussion on this policy.		
8. Hours of Operation and Authorized Access to the Pharmacy	There was no discussion on this policy.		
9. Labelling Standards	There was no discussion on this policy.		
10. Medication Dispensing/ Distribution	There was no discussion on this policy.		
11. Medication Error Reduction Plan (MERP)	There was no discussion on this policy.		
12. Medication Ordered STAT and at Specified Time Intervals	There was no discussion on this policy.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
13. Patients Use of Herbals and Natural Remedies	There was no discussion on this policy.		
14. Pharmacy and Therapeutics Committee	There was no discussion on this policy.		
15. Technician Checking Technician Program	There was no discussion on this policy.		
Surgical Services			
1. Surgery Blood in Ice Chests Procedure	There was no practice change in this policy; a minor labelling issue was identified and corrected. It was also stated that the blood storage should be 1-6 degrees and action is only necessary when the blood product is sent back to the Lab.	**ACTION:** Patricia Guerra will check to the OR Committee Chair regarding the specific procedure involving this policy. Upon completion, this policy was agreed to be approved by all and is moving forward for Board approval as moved by Dr. Souza and seconded by Director Mitchell.	Patricia Guerra
Women and Newborn Services			
1. Hearing Screening Program: Newborn and Infants 2. Newborn Hearing Screening: Inpatient and Outpatient Hearing Screening of Newborn and Infants Using Biologic Equipment 3. Newborn Hearing Screening: Scheduling	There was no discussion on all the policies for WNS.	**ACTION:** The removal of Nitrofurantpoin suspension was approved and is moving forward for Board approval as moved by Director Mitchell and seconded by Director Schallock.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	12:57 PM.		
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 1:30 PM.		Director Grass

PROFESSIONAL AFFAIRS COMMITTEE
July 12, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Assessing and Managing Patients at Risk for Suicide Policy	3 Year Review, Practice Change	Approved with Revisions
2. Bronchoscopy Procedure	3 Year Review, Practice Change	Approved
3. Incentive Spirometer (IS) Instruct and Monitoring	3 Year Review, Practice Change	Approved
4. Interdisciplinary Plan of Care IPOC	3 Year Review, Practice Change	Approved
5. Malignant Hyperthermia Management Procedure	3 Year Review, Practice Change	Approved
6. Pain Management Policy	3 Year Review, Practice Change	PULLED
7. Pre-Bronchoscopy Procedure	DELETE	Approved
8. Pronouncement of Death Procedure	3 Year Review, Practice Change	Approved with Revisions
9. Siemens Rapidpoint Procedure	Practice Change	Approved
Infection Control		
1. Standard and Transmission-Based Precautions - IC 5	Practice Change	Approved
NICU		
1. Peripheral Arterial Line Insertion, Maintenance and Removal of	Practice Change	Approved
Pharmacy		
1. Automatic I.V. to Oral Conversion	Practice Change	Approved
2. Decreasing Medication Errors	3 Year Review	Approved
3. Drug Samples	3 Year Review, Practice Change	Approved
4. Emergency Medication Tray for Crash Cart	3 Year Review	Approved
5. Employee Theft or Impairment Policy	3 Year Review, Practice Change	Approved
6. Floor Stock	3 Year Review, Practice Change	Approved
7. Formulary System	3 Year Review, Practice Change	Approved
8. Hours of Operation and Authorized Access to the Pharmacy	3 Year Review	Approved
9. Labeling Standards	3 Year Review, Practice Change	Approved
10. Medication Dispensing/Distribution	3 Year Review, Practice Change	Approved
11. Medication Error Reduction Plan (MERP)	Practice Change	Approved
12. Medications Ordered STAT and at Specified Time Intervals	3 Year Review, Practice Change	Approved

PROFESSIONAL AFFAIRS COMMITTEE
July 12, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
13. Patients Use of Herbals and Natural Remedies	3 Year Review	Approved
14. Pharmacy and Therapeutics Committee	3 Year Review	Approved
15. Technician Checking Technician Program	3 Year Review, Practice Change	Approved
Surgical Services		
1. Surgery Blood in Ice Chests Procedure	3 Year Review, Practice Change	Approved
Women & Newborn Services		
1. Hearing Screening Program: Newborn and Infants	3 Year Review, Practice Change	Approved
2. Newborn Hearing Screening: Inpatient and Outpatient Hearing Screening of Newborn and Infants Using Biological Equipment	3 Year Review, Practice Change	Approved
3. Newborn Hearing Screening: Scheduling Outpatient Hearing Screening	3 Year Review, Practice Change	Approved
4. Newborn Hearing Screening: State of California Reporting	3 Year Review, Practice Change	Approved

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 1/07

SUBJECT: ASSESSING AND MANAGING PATIENTS AT RISK FOR SUICIDE

REVISION DATE: 11/09; 06/10; 5/13

~~POLICY NUMBER: III.J~~

Department Approval:	**04/18**
Clinical Policies & Procedures Committee Approval:	**~~06/13~~05/18**
Nursing Executive Committee Approval:	**~~07/13~~05/18**
Medical Executive Committee Approval:	**~~09/13~~06/18**
Professional Affairs Committee Approval:	**~~10/13~~07/18**
Board of Directors Approval:	**10/13**

A. **PURPOSE:**

1. To identify patients who are at risk for suicide, including identification of specific factors and features which may increase or decrease the risk.
2. To ensure the immediate safety needs of patients identified as at risk for suicide are met in the most appropriate care setting.
3. To ensure the organization provides information to individuals and their family members for management of crisis situations.

B. **DEFINITIONS:**

1. **Suicide Risk Screening:** An evaluation performed by a clinician to assist in the decision to initiate a Psychiatric consult for an in-depth Suicide Risk Assessment.
2. **Suicide Risk Assessment:** An in-depth assessment completed by a qualified mental health professional using a tool which identifies risk and protective factors. Qualified mental health professionals include:
   a. Psychiatrists
   b. Psychologists
   c. Licensed Independent Practitioners (LIP), masters level or above, with specific clinical or practice privileges.
   d. Clinical Social Workers
   e. Registered Nurses (RNs) working in a behavioral health setting
   f. **Psychiatric**~~Behavioral Health~~ Liaisons working in the Emergency Department, **medical floor, or Crisis Stabilization Unit.**

C. **PROCEDURE:**

1. A suicide risk screen will be performed on admission by a qualified professional (RN, physician and/or clinical social worker) to determine whether a suicide risk assessment by a qualified behavioral health professional is clinically indicated. The results and follow-up will be documented in the patient's medical record.
2. An initial suicide risk assessment shall be performed in the following areas:
   a. **Emergency Department:** If the patient answers yes to feeling suicidal today during the suicide risk screening, a referral will be made to the **Psychiatric**~~Behavioral Health~~ Liaison. An assessment tool will be used that includes identification of specific factors and features that may increase or decrease the risk of suicide by the completion of the Emergency Department visit.
   b. **Crisis Stabilization Unit (CSU): An assessment will be conducted that identifies the patient at high, moderate, or low risk for self-harm and directs interventions, at time of admission or as soon thereafter as possible.**

~~a.~~i. **CSU will use the Columbia Suicide Severity Rating Scale (C-SSRS).**

~~b.~~c. **Behavioral Health Unit**: An assessment will be conducted that identifies the patient at high, moderate, or low risk for self-harm and directs interventions, at time of admission or as soon thereafter as possible~~, and, in all cases, within the first 24 hours of admissions.~~

~~c.~~d. **Intensive Outpatient Program:** An assessment tool will be used that identifies the patient at high, moderate, or low risk for self-harm by completion of the initial intake visit.

~~d.~~e. **Inpatient Areas:** If the patient answers yes to feeling suicidal today during the suicide risk screening, the RN will notify the Psychiatric Liaison.

i. The Psychiatric consult will be performed by the psychiatrist/nurse practitioner, or **Psychiatric**~~behavioral health liaison~~ **Liaison.**

ii. The admitting physician will be responsible for obtaining a psychiatric consult.

3. Reassessment of suicide risk will be completed by a qualified mental health professional, as is clinically indicated, to determine if there is an increase or decrease in risk in the following areas:

a. **Emergency Department**: If the patient stay exceeds 24 hours, and as dictated by changes in the patient's condition.

~~a.~~b. **Crisis Stabilization Unit: Every shift (every 12 hours), at time of discharge, and as dictated by changes in the patient's condition.**

~~b.~~c. **Behavioral Health Unit**: Every shift (every 12 hours), at time of discharge, and as dictated by changes in the patient's condition.

~~c.~~d. **Intensive Outpatient Program**: As clinically indicated.

~~d.~~e. **Inpatient Areas**: If patient is identified as suicidal, the psychiatrist/nurse practitioner, or **Psychiatric**~~behavioral health liaison~~ **Liaison** will perform the reassessment.

4. Patients who have been identified as a suicide risk will receive services in an established plan of care that meets their immediate safety needs and ensures the services are provided in the most appropriate care setting. The scope and nature of the services will depend on the assessed level of risk and lethality.

a. **Emergency Department**: The ~~behavioral health~~**Psychiatric Liaison,** ~~liaison, emergency room~~**emergency room** physician, and/or the on-call psychiatrist shall evaluate patients determined to have a moderate or high lethality suicide risk to determine the appropriate level of care for psychiatric stabilization after medical clearance has been obtained

i. Patients considered as low risk will have a follow-up disposition completed as clinically determined on an individual basis. The **Psychiatric**~~behavioral health~~ Liaison will give the appropriate referrals as needed for follow-up psychiatric stabilization. **The Psychiatric Liaison will complete a safety plan, as clinically indicated, with patient participation. The original safety plan will be given to the patient, and a copy will be placed in the health record.**

~~i.~~

b. **Crisis Stabilization Unit: Patients considered** ~~as moderate to high~~ **at risk shall be closely observed every 5 minutes, evaluated for one-to one observation (1:1) level of care, and frequently reevaluated so** ~~that~~ **the safest level of care can be determined. A safety plan will be implemented by RN~~,~~ or Psychiatric Liaison, as clinically indicated. The RN or Psychiatric Liaison will assist the patient in completing the safety plan.~~,~~ T~~t~~he original safety plan will be given to the patient~~,~~ and a copy will be placed in the health record.**

~~b.~~c. **Behavioral Health Unit: Patients considered as moderate to high risk shall be closely observed, evaluated for one-to-one observation (1:1) level of care, and frequently reevaluated so that the safest level of care can be determined.** A safety plan will be implemented by the RN**, as clinically indicated.** ~~or behavioral health liaison assessing the patient at risk for suicide.~~ The RN ~~or behavioral health liaison~~ will assist the patient in completing the safety plan. The original safety plan will be given to the patient, and a copy will be placed in the **health** ~~medical record.~~**record.**

~~c.~~d. **Intensive Outpatient Program**: Patients considered as moderate to high risk shall be closely observed and frequently reevaluated so that the safest level of care can be determined.

~~d.~~e. **Inpatient Areas**: If a patient requires ongoing acute medical care, the patient may be admitted to an inpatient care unit to treat the medical condition, and placed on one-to-one observation (1:1) with a sitter as clinically indicated.

i. In the Intensive Care Unit (ICU), use of a sitter is based on assessment and evaluation of the patient.

5. Patients, caregivers or family members (when clinically appropriate) shall be provided with the Tri-City Medical Center Behavioral Health Unit Crisis Hotline at 877-299-0664 (toll-free number) for emergency crisis services in the event that these services are needed, **in addition to the Suicide Prevention Lifeline at 800-273-8255.** ~~.~~The information will be provided prior to discharge or transfer from the care setting.
   a. Contact Social Services for additional resources as needed.

D. **REFERENCE(S):**
1. **Columbia Suicide Severity Rating Scale**
~~a.~~2. **https://suicidepreventionlifelone.org**

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**BRONCHOSCOPY NURSING**
Purpose:	**To identify the roles and responsibilities of the primary, procedural, and recovery Registered Nurse (RN) when caring for patients requiring a bronchoscopy.** ~~To standardize the role of the Nurse or Respiratory Care Practitioner in setting up, cleaning, handling specimens and assisting the physician with bronchoscopies. Clarify patient assessment responsibilities for monitoring of moderate sedation.~~
Supportive Data:	**Bronchoscopy is a diagnostic or therapeutic procedure used to examine the tracheobronchial tree through a lighted tube, aspirate of bronchial secretions, remove foreign bodies, and obtain biopsy specimens. Bronchoscopy may be an emergent or elective procedure.** ~~Bronchoscopy is the examination of the tracheobronchial tree through a lighted tube. The fiberoptic scope has lumens for aspiration of bronchial secretions, visualization, retrieving foreign bodies and biopsy specimens. Bronchoscopy may be an emergency or elective procedure and is performed for diagnostic or therapeutic reasons.~~
Equipment:	~~See Attachment~~ **Personal Protective Equipment** **Cardiac Monitor** **Transport Monitor (if applicable)** **End-tidal Carbon Dioxide Monitor with Tubing** **Oxygen Devices with Tubing** **Vital Sign Machine with Pulse Oximeter** **Infusion Pump** **Crash Cart with Defibrillator or Automated External Defibrillator (AED)** **Suction Device and Suction Tubing** **Yankauer**

A. **DEFINITIONS**:

1. Diagnostic Bronchoscopy: **Performed** ~~Primarily used~~ to diagnose and assess pulmonary status through visualization and obtaining specimens via biopsies, brushings or washings. ~~Must be performed in an airborne precautions room or private room with a HEPA filtration system.~~
   a. **Diagnostic bronchoscopies must be performed in a negative airflow room (143, 243, 387, 443, 487, or the Bronchoscopy Suite) exceptions include:**
      i. **Patient is intubated and on a ventilator**
      ~~1.~~ii. **Patient is in a private room with a High-efficiency particulate arrestance (HEPA) filtration system.**
2. Therapeutic Bronchoscopy: **Performed** ~~Primarily used~~ to remove retained secretions. Must be performed in a private room **or Bronchoscopy Suite.**
   ~~2.~~a. **A negative airflow room is not required, but must be performed in a private room.**
3. Primary Nurse: **Registered Nurse (RN) assigned primary care of a patient and responsible for preparing the patient for bronchoscopy as outlined in the Patient Care Services: Universal Protocol Procedure.**
   ~~3. Nurse responsible for preparing patient for bronchoscopy~~.
4. Procedural ~~Registered Nurse (RN)~~: **RN qualified to implement PCS: Sedation/Analgesia Used During Therapeutic or Diagnostic Procedure.**
   ~~4. RN with Advanced Cardiac Life Support (ACLS) and ECG interpretation skills responsible for providing care and monitoring during the procedure.~~
      ~~a. For outpatient areas, an RN with ACLS and ECG interpretation skills must be readily available.~~

Department Review	Clinical Policies & Procedures Committee	Nursing Executive Committee	Division of Pulmonary	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
09/12, 05/17	10/12, 07/17	10/12, 07/17	06/18	n/a	01/12, 06/18	02/13, 07/18	02/13

5. Assisting Personnel: ~~Nurse or Respiratory Care Practitioner (RCP) assisting with the bronchoscopy.~~ **Staff assisting a physician during bronchoscopy procedure. Examples include:**
   - **a. Inpatient: Respiratory Care Practitioner (RCP)**
   - **b. Outpatient: Endoscopy/Surgical staff**
   - ~~b. RCP assists for inpatients~~
   - ~~c. Endoscopy/Surgical staff assists for outpatients~~
6. Recovery RN: RN responsible for recovering patient post procedure. ~~The RN must be ACLS and have ECG interpretation skills.~~
7. **Procedural Assessment: Pre-procedure, intra-procedure, immediate-post procedure assessment requirements performed by procedural and recovery RNs.**

B. **POLICY:**

1. **The primary RN is responsible for notifying their unit Assistant Nurse Manager (ANM)/relief charge of the pending scheduled bronchoscopy as soon as possible.**
2. **The Acute Care Services (ACS) and Progressive Care Unit (PCU) ANM/relief charge is responsible for contacting the Telemetry ANM/relief charge as soon as possible, when informed by the primary RN or bronchoscopy orders are obtained.**
   - **a. The Telemetry ANM/relief charge will assign the role of procedural RN to the Telemetry PRN RN or designee.**
   - **b. When Telemetry RNs are not available to assist with inpatient bronchoscopies, the Intensive Care Unit (ICU) ANM/relief charge will be notified.**
   - **c. Telemetry staff RNs will notify the Telemetry PRN RN or designee when orders are received for a bronchoscopy. The Telemetry PRN RN or designee will notify the Telemetry ANM/relief charge.**
3. **The Telemetry ANM/relief charge will notify the Post Anesthesia Care Unit (PACU) charge RN to make arrangements for ACS and PCU patients to be recovered in the PACU by a PACU RN.**
   - **a. Telemetry patients will be returned to their assigned room to be recovered by the Telemetry procedural RN.**
   - **b. Outpatient bronchoscopies are recovered in PACU by PACU staff.**
4. **The inpatient procedural RN will:**
   - **a. Contact the PACU RN prior to the start of the procedure to provide an estimation of the completion time of the bronchoscopy.**
   - **b. Contact the PACU RN at the end of the procedure, prior to transport to provide hand-off for ACS and PCU patients.**
5. **All inpatient ACS and PCU patients will be recovered in PACU by PACU staff.**
   - **a. When PACU cannot assist with the recovery of ACS or PCU patients, the Telemetry procedural RN will recover the patient in their assigned inpatient room.**

~~B.~~6. **The Telemetry Procedural RN may not recover patients at any time in the Bronchoscopy Suite.**

C. **SCHEDULING:**

1. **Inpatients:**
   - **a. The ordering physicians will contact the Lead RCP to schedule the bronchoscopy procedure.**
   - **b. The primary RN will:**
     - **i. Ensure the order for bronchoscopy is entered in the Electronic Health Record (EHR).**
     - ~~i.~~ii. **Contact the ANM/relief charge as soon as possible, to allow sufficient time for the Telemetry ANM/relief charge to initiate post-procedure recovery arrangements for ACS and PCU patients.**
   - ~~b. For inpatients, physicians call the Lead RCP at 760-802-1974 or pager 760-926-0344 to schedule the bronchoscopy procedure.~~

~~i. Diagnostic bronchoscopies must be performed in a Negative Airflow room (Bronchoscopy Suite, 143, 243, 287, 387, 443, or 487) unless the patient is intubated and on a ventilator.~~
~~ii. Therapeutic bronchoscopies may be done in a private room.~~
~~iii. Bronchoscopy RN is available Monday – Friday 0800 to 1600 at 760-802-2012~~
~~1) Bronchoscopies performed in the Intensive Care Unit (ICU) shall be assisted by the ICU RN.~~
~~iv. After hours, weekends and holidays the RCP shall notify the Telemetry or ICU Assistant Nurse Manager (ANM) that an RN is needed to assist with the bronchoscopy procedure.~~
~~1) The Telemetry or ICU ANM or designee shall:~~
~~a) Assign a qualified RN as the procedural RN to monitor the patient.~~
~~b) Arrange with Post Anesthesia Care Unit (PACU) at extension 7264 the recovery of the patient when the bronchoscopy is complete and the Procedural RN needs to return to his/her unit.~~

2. Outpatient:
a. The ordering physician will schedule the procedure with Surgery scheduling.
b. The physician will coordinate outpatient fluoro-bronchs with Radiology and Endoscopy or Surgery.
c. Bronchoscopies requiring C arm/Fluoroscopy are coordinated between the Imaging Departments.
~~c. For Outpatient bronchoscopies, the ordering physician will schedule the procedure with Surgery scheduling.~~
~~i. The physician will coordinate outpatient fluoro-bronchs with Radiology and Endoscopy or Surgery.~~
~~ii. Bronchoscopies requiring C arm/Fluoroscopy are coordinated between the Imaging Departments.~~

~~2. Bronchoscopies are performed in the 2nd Floor Bronchoscopy suite (preferred), with the following exceptions:~~
~~a. Outpatient Bronchoscopy with Fluoroscopy, patient is not suspected to have TB performed in the OR.~~
~~b. Inpatient, in private room, not suspected to have TB: Performed in patient room if necessary.~~
~~c. Inpatient, suspected TB, in negative air flow room: Performed in patient room.~~
~~d. Inpatient, Fluoroscopy needed (and cannot fit equipment in patient room): Performed in OR with HEPA filters in place and in use.~~
~~e. Inpatient, suspected TB, Fluoroscopy needed: Endoscopy Suite in OR with staff in use of appropriate PPE and HEPA filters in place and in use.~~

D. <u>PRIMARY RN RESPONSIBILITIES:</u>
1. Pre-Procedure:
a. The primary RN is responsible for completing the Pre-Procedure verification process per the Patient Care Services: Universal Protocol Procedure.
b. Primary Nurse shall:
i. Ensure patient has a patent intravenous (IV) access and the ordered IV solution is infusion via an infusing pump.
ii. Ensure an end-tidal carbon dioxide (ETCO2) module and oxygen tank is available for transport
iii. Telemetry units: if bronchoscopy will be performed in a patient room, ensure the following equipment is also available:
a) Electronic vital sign machine
b) Suction equipment
c) Crash cart readily available
d) Bedside cardiac monitor

c. Ensure pre-procedure medications are ordered and listed on the Medication Administration Record (MAR).
d. Administer pre-procedure medications as ordered prior to the arrival of the procedural RN.
   i. On-call medications will be administered by the procedural RN.
e. Complete the Pre-Procedure~~al~~ Checklist.
f. Provide hand-off communication to the procedural RN.
g. Prepare the patient for transport, if the bronchoscopy is to be performed in the Bronchoscopy Suite.
   i. Coordinate with the procedural RN to arrange transport of the patient.
   ii. Transport patient via bed with oxygen, if applicable.
h. Document the Off-Unit Transfer in Cerner.

2. Post-procedure primary RN responsibilities:
   a. Receive hand-off report from the PACU or Telemetry procedural RN.
   b. Assess the patient per orders. A focus assessment may include, but is not limited to the following:
      i. Level of consciousness
      ii. Breath sounds
      iii. Vital signs (blood pressure, heart rate, respiratory rate, oxygen saturation continue) to monitoring as ordered
         1) Telemetry patients – monitor cardiac rate and rhythm
   c. Maintain Nothing by Mouth (NPO) status until patient is fully awake and advanced diet is ordered.
   d. Implement falls prevention per Patient Care Services: Fall Risk Procedure and Unit Specific Fall Precautions Procedure.
   e. Monitor patient for increased mucus production, shortness of breath, difficulty swallowing, decreases or increases in heart rate (HR) and arrhythmias on cardiac monitoring units.
      i. Anticipate minimal bleeding if brushings or biopsies were obtained.
   f. Document the patient's arrival to the unit, assessment findings, and vital signs in the medical record.
   g. Notify the procedure physician if the patient complains of shortness of breath, an increase in bloody mucus, and/or new onset arrhythmias.

E. <u>PROCEDURAL RN RESPONSIBILITIES</u>

1. Perform immediate pre-procedure, intra–procedure, and post-procedure task and assessments as outlined in Patient Care Services: Sedation/Analgesia Used During Therapeutic or Diagnostic Procedures.
2. Document immediate pre-procedure, intra procedure, and post-procedure task and assessments in the medical record.
3. Inpatients recovery and transport process:
   a. Contact a LTT to assist with transporting the patient.
   b. Provide hand-off report to PACU for ACS and PCU patients.
      i. If a bed is not available in PACU, transport the patient to their assigned inpatient room.
      ii. Recovery monitoring of the patient will be provided by the procedural RN, until a bed is available in PACU or until patient returns to their pre-sedation Aldrete level.
   c. Telemetry patients will be transported to their assigned inpatient room and recovered by the procedural RN.
      i. Provide hand-off communication~~report~~ to the primary RN when patient maintains their pre-sedation RASS level.
4. Post-procedure monitoring requirements:

a. **Monitor patient's outcomes per the Patient Care Services: Sedation/Analgesia Used During Therapeutic or Diagnostic Procedures and as follows:**
   i. **Increase in bloody secretions**
   ii. **Hypoxia**
   iii. **New onset cardiac arrhythmias**
   iv. **Bronchospasms**
   v. **Hypotension**
   vi. **Signs of respiratory distress**
   vii. **Vomiting or complaint of nausea**
   viii. **Difficulty maintaining pre-sedation level of consciousness**
b. **Maintain NPO status as ordered.**
c. **Obtain chest x-ray per order.**

~~3.~~**5.** Outpatients:
a. Discharge patient as outlined in the **Patient Care Services**: Sedation/Analgesia Used During Therapeutic or Diagnostic Procedures: Post Procedure Care, Documentation, and Discharge

~~I.~~F. RELATED DOCUMENT(S):

~~4.~~**1.** Patient **Care Services Procedure: Fall Risk Procedure and Score Tool**
2. Patient Care Services Procedure: Sedation/Analgesia Used During Therapeutic or Diagnostic
3. Patient Care Services Procedure: Universal Protocol

~~D.~~G. REFERENCES:

~~Mosby's Nursing Skills Online Procedures. (2009) "Bronchoscopy: Assisting". Retrieved from TCMC Intranet June 22, 2010.~~
1. Urden, L.D., Stacy, K.M., & Lough, M.E. (2014). Critical care nursing: Diagnosis and management. (7th ed). Elsevier. St. Louis: MO

~~BRONCHOSCOPY SET-UP & ASSIST~~

~~Personal Protective Equipement (PPE):~~

- ~~Yellow gowns x 3~~
- ~~Cone mask (Yamanaka)~~
- ~~N95 respirator or other approved device for each member of the team~~
- ~~Eye protection: goggles and face shields~~
- ~~Sterile gloves: 7 ½ & 8~~
- ~~Clean drape, towel or chux~~

~~EQUIPMENT:~~

- ~~Bronchoscope, large or small~~
- ~~Disposable suction valve~~
- ~~Disposable biopsy valve~~
- ~~Atomizer~~
- ~~Atomizer 'Y' with green small bore tubing attached~~
- ~~0_2 flowmeter and Christmas tree~~
- ~~0_2 double adapter~~
- ~~Suction bottle, Gomco~~
- ~~Suction tubing, 6 ft and 18 ft x1 each~~
- ~~Yankauer suction tip~~
- ~~Luken's trap x 2~~
- ~~Emesis basin x 2~~
- ~~2 x 2 clean gauze x 6 - 8~~
- ~~Lidocaine 2% jelly~~
- ~~Med-Neb Nebulizer~~
- ~~Lidocaine 2% multi-dose vial 20 mL x 2~~
- ~~Lidocaine 4% ampule, cmLs~~
- ~~Slip tip 10 mL syringe x 6~~
- ~~Slip tip 35 mL syringe x 2~~
- ~~Luer lock 12 mL needleless syringe x 2~~
- ~~Epinephrine 1:10,000 units/mL, syringe~~
- ~~10 ml vial of NS x 1~~
- ~~250 mL bottle of 0.9% NaCl (NS)~~
- ~~Sterile specimen cup~~
- ~~Phenylephrine 1% nasal spray, 1 bottle~~
- ~~Medication and solution labels~~
- ~~Pulse oximeter~~
- ~~Bedside cardiac monitor for monitoring heart rhythm and blood pressure~~
- ~~O_2 Nasal Cannula~~
- ~~O_2 mask~~
- ~~Crash cart on stand-by with AED/Defibrillator available for patient transport post procedure~~

~~SPECIMENS:~~

- ~~Pencil~~
- ~~Permanent marker~~
- ~~Paperclip (optional)~~
- ~~Container of slides x 1 box~~
- ~~Test tube rack with red top test tube filled with NS x 1~~
- ~~Cytology bronch brush x 2~~
- ~~95% alcohol for fixing cytology smears (black top) x 2~~
- ~~Bronch biopsy forceps~~
- ~~10% formalin pre-filled containers x 2~~
- ~~Wang transbronchial cytology needle~~
- ~~50% alcohol cytology preservative for fine needle aspirations (green soln)~~
- ~~Bartlett brush~~
- ~~Port-a-cul swab and vacutainer serum~~
- ~~Sterile wire cutter scissors~~

~~FORMS:~~

- ~~Bronchoscopy and Needle Biopsy Orders~~
- ~~Physician Pre-Procedure/Sedation Assessment (MD)~~
- ~~Bronchoscopy Procedure Note by MD (yellow)~~
- ~~Consent for Operative or Other Procedure~~
- ~~Sedation Flow Sheet~~
- ~~Sedation/Analgesia Audit (green)~~
- ~~Microbiology Lab Slip~~
- ~~Cytology Lab Slip~~

~~POST-PROCEDURE:~~

- ~~Disinfectant wipes~~
- ~~50 mL H20 with enzymatic cleaner~~
- ~~Bronch cleaning brush~~

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**INCENTIVE SPIROMETER (IS) INSTRUCT AND MONITORING**
Purpose:	To identify the Respiratory Care Practitioner (RCP) and Registered Nurse (RN) roles for providing instructions and monitoring patients requiring an IS.

A. DEFINITION:

1. Incentive Spirometer (IS) – a device used to encourage and assist patients at risk for pneumonia, post-operative pulmonary complications, and patients with declining pulmonary status to breathe deeply to achieve normal vital capacity. The device provides a visual feedback to patients about the depth of their breaths.

B. POLICY:

1. A physicians order is required for an IS.
2. Patients at risk for postoperative pulmonary complications (i.e., patients undergoing surgical procedures involving abdomen or thorax and patients with conditions predisposing to development of atelectasis, including immobility and abdominal binders) should have an order for an IS. Examples include but are not limited to the following:
   a. Abdominal Surgery
   b. Thoracic Surgery
   c. Prolonged bed rest
   d. Post-operative patients with Chronic Obstructive Pulmonary Disease (COPD)
   e. Presence of a thoracic or abdominal binder
   f. Restrictive lung defeat associated with a dysfunctional diaphragm or involving respiratory musculature
   g. Patients with an inspiratory capacity of less than (<) 2.5 liters
   h. Patients with neuromuscular disease
   i. Patients with pain level interfering with their ability to take deep breaths
3. RCPs and RNs will work collaborative to ensure patients are provided instructions for the use of an IS.
   a. RCPs will provide the initial education and two follow-up treatments with education.
      i. If RCP is unavailable to provide initial education, the primary RN assigned to the patient is responsible for ensuring education is provided.
   b. RCPs and RNs will use the teach-back method to assess the patient's understanding of the instructions provided.
4. RCPs and RNs will review **Online~~Mosby's~~** Skills: Incentive Spirometry Procedure.

C. PROCEDURE:

1. RCP Role
   a. Identify patient's predicted volume based on gender, age, and height.
   b. Mark the predicted volume with a permanent marker on the IS to inform the patient and RNs.
      i. Approximate the patient's predicted value using clinical judgment when the patient's age and height are not within the predicted values chart.
   c. Inform patient the mark represents the goal they should achieve
   d. Instruct patient to cough to expectorate phlegm.
      i. Ensure patients with surgical incisions splint using a pillow.
   e. Provide hand-off to the RN after the initial education and the two subsequent treatments are completed.
   f. Document in the Electronic Health Record (EHR)
      i. Patient's responses to the treatments

Department Review	Clinical Policies & Procedures Committee	Nursing Executive Council	Division of Pulmonary	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
~~NEW~~03/18	9/14, 04/18	10/14, 04/18	05/15, 06/18	n/a	06/15, 06/18	08/15, 07/18	8/15

ii. Patient's ability to participate with their therapy
iii. Hand-off provided

2. RN Role
   a. Obtain hand-off from RCP
   b. Ensure education is provided if task not completed by RCP
   c. Review **Online Skills** ~~Mosby's~~ Incentive Spirometry Procedure for the following:
      i. Indications and contraindications
      ii. Expected and unexpected outcomes
      iii. Education topics
      iv. Patient instructions for use of the IS
   d. Encourage patient to use IS at least 5-10 times every hour while awake or as ordered.
   e. Assess patient's understanding of the instructions for using an IS using teach-back
   f. Document the use of IS each shift as appropriate
      i. Education provided to patient
      ii. Patient's response to using the IS
         1) Volumes achieved
         2) Frequency of use
      iii. Patient's ability to participate
3. Hand-off Process
   a. RCP and RN hand-off shall consist of the following:
      i. Patient's response to therapy
      ii. Predicted volume
      iii. Actual volume
      iv. Additional information appropriate to patient

D. REFERENCE LIST:

1. Agency of Healthcare Research and Quality (AHRQ). (nd). National guideline clearinghouse: Incentive spirometry, 2011. Retrieved from http://www.guideline.gov/content.aspx?id=34793
2. American Association for Respiratory Care (AARC). (2011). Clinical practice guidelines, incentive spirometry: 2011. *56(10):* 1600-4
3. Elsevier Inc. (2006-2014). Mosby's skills: Incentive spirometry. Retrieved from Tri-City Medical Center (TCMC) Intranet.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 08/01

SUBJECT: Interdisciplinary Plan of Care (IPOC)

REVISION DATE(S): 06/03, 06/05, 01/08, 05/11, 05/12, 05/15

~~**POLICY NUMBER: IV.G**~~

Department ~~Review~~Approval:	**02/18**
Clinical Policies & Procedures Committee Approval:	**~~01/15~~05/18**
Nursing Executive Council Approval:	**~~03/15~~05/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~03/15~~06/18**
Professional Affairs Committee Approval:	**~~05/15~~07/18**
Board of Directors Approval:	**05/15**

A. **POLICY:**

1. An **Interdisciplinary Plan of Care** (IPOC) shall be initiated (electronically or paper per unit practice) ~~**(ED)**by the primary Registered Nurse (RN)~~ within **eight (8)** ~~four (4)~~ hours of a patient's arrival to an inpatient care area.
2. The IPOC shall include standards of care identified as appropriate based on the patient's diagnosis, medical condition, and/or need.
   ~~a. For inpatient's with a long length of stay (one month or greater), spending time outdoors will be considered~~
3. The IPOC shall have measurable outcomes with specific interventions to meet the patient's inpatient and discharge needs.
   ~~2.~~**a.** The following factors shall be considered when developing and/or updating the IPOC:
      ~~a.~~**i.** Disease Process/Physician's Order
      ~~b.~~**ii.** Biophysical
      ~~c.~~**iii.** Psychosocial
      ~~d.~~**iv.** Spiritual/cultural
      ~~e.~~**v.** Functional
      ~~f.~~**vi.** Safety
      ~~g.~~**vii.** Knowledge Deficit
      ~~h.~~**viii.** Discharge Needs
      ~~i.~~**ix.** Referrals to Interdisciplinary Departments
      ~~ii.~~**x.** Additional aspects obtained from the patient assessment
   b. For any high risk factors, that specific IPOC(s) will be initiated upon admission to an inpatient care area.
4. The primary **Registered Nurse** (RN) shall discuss the IPOC with the patient and their caregiver, **(if applicable)**~~(~~ every shift, and **as the occasion arises** (PRN).
5. The IPOC shall be reviewed and updated every shift, and as needed. The primary RN shall:
   a. Consider the appropriateness of interventions not addressed within the last 48 hours, discontinue as needed.
6. When a patient is transferred to another nursing unit, the receiving RN shall review the existing plans for appropriateness and update or discontinue plans initiated on the transferring as needed. The receiving RN shall initiate additional plans as needed based on the patient's transferring assessment.

~~7. The patient's discharge needs shall be assessed on admission, every shift, and PRN.~~

~~3. The IPOC shall be updated prior to discharge ensuring all open outcomes are addressed.~~

B. **REFERENCE(S):**

1. The Joint Commission Handbook (**2017**~~2014~~), **Provision of Care, Treatment and Services** Standard ~~PC.02.02.11~~

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**MALIGNANT HYPERTHERMIA MANAGEMENT**
Purpose:	To provide guidelines for the Registered Nurse caring for ~~the adult or adolescent/pediatrica~~ patient at risk for or presenting with Malignant Hyperthermia.
Supportive Data:	Malignant Hyperthermia Association of the United States (MHAUS) MH Hotline: 1-800-644-9737
Equipment:	Malignant Hyperthermia Cart ~~(~~ **located in Operating Room (OR) and Obstetrics Post Anesthesia Care Unit (OB-PACU)** Crash Cart ~~ECG~~**Cardiac** Monitor Pulse Oximeter Electronic temperature measuring device with appropriate probes for measuring central temperature Capnography Ice ~~Maker~~ **Refrigerated Normal Saline IV fluids (at least 10 liters)** Refrigerated Normal Saline irrigation Hypothermia unit Blood collection tubes for ~~Laboratory~~ **laboratory** tests Criticore Foley machine CVP line set Alaris Infusion Pump ~~A~~ **Arterial** Line Set

A. **DEFINITION:**

1. Malignant Hyperthermia (MH) is a **rare, life-threatening complication that may arise from medications commonly used in anesthesia. MH is most frequently triggered by inhalation anesthetics (e.g., Desflurane, Sevoflurane, Isoflurane, and Halothane) and succinylcholine, but it may also be induced by trauma, strenuous exercise, or emotional stress. MH is genetically transmitted and the incidence of MH increases in patients with central core disease and some muscular dystrophies.**
2. **MH syndrome begins with a hypermetabolic condition in skeletal muscle cells that involves altered mechanisms of calcium function at the cellular level.** ~~hypermetabolic crisis involving the skeletal muscle system. The rare genetic condition occurs most frequently during administration of general anesthesia, and may be triggered in affected individuals after exposure to volatile inhalation anesthetics (Desflurane, Sevoflurane, Isoflurane, and Halothane), or the depolarizing muscle relaxant Succinylcholine.~~ The triggering agent causes a series of chain reactions in the body resulting in sustained muscle contraction, increasing body temperature, and massive production of lactic acid and carbon dioxide. ~~Mortality depends on how high the temperature rises.~~ Onset is acute and rapid in progression.~~, and death can occur in 15 minutes to one hour.~~ Early diagnosis **and intervention** ~~before the temperature rises significantly~~ is critical. **Signs of MH may occur during induction or maintenance of anesthesia, although MH can occur postoperatively or after repeated exposures to anesthesia.**

B. **PROCEDURE:**

1. **Patients are screened pre-operatively for personal and familial history of MH. Prepare for an MH susceptible patient in the following manner:**
   a. **Bring the MH cart to the OR/treatment area.**
   b. **Remove ~~or disconnect~~ anesthetic vaporizers from the anesthesia machine. If unable to remove ~~or disconnect~~ the vaporizers, tape them in the OFF position.**

Department Review	Clinical Policies & Procedures Committee	Nurse Executive Committee	~~Patient Quality Care Committee~~	Department of Anesthesiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
7/09,5/12, 04/18	7/12, 05/18	05/18	~~8/12~~	05/18	n/a	8/12, 06/18	8/12, 07/18	8/12

c. **Flush volatile anesthesia vapors from the anesthesia machine according manufacturer's instructions for use (IFU).**
d. **Replace the carbon dioxide absorbent in the anesthesia machine.**
e. **Replace the anesthesia circuit and reservoir bag.**

~~1.~~**2.** Monitor for the following ~~early~~ signs **and symptoms** of MH:

a. **Increasing end-tidal carbon dioxide ($ETCO_2$) despite hyperventilation**
b. **Tachycardia**
c. **Tachypnea (may not be seen in a paralyzed patient)**
d. **Muscle stiffness (trunk or total body rigidity)**
e. Masseter ~~muscle~~ spasm or ~~rigidity~~**trismus**
f. **Hypoxia and dark (desaturated) blood in the operative field (if applicable)**
g. **Unstable or elevated blood pressure**
~~a.~~**h. Cardiac dysrhythmias**

~~Unexplained tachycardia~~
~~Unexplained increase in exhaled CO2~~

~~b.~~**i. Changes in CO_2 absorbent (temperature, color change)** ~~Hot, discolored soda lime canister on anesthesia machine~~

~~Generalized muscle rigidity~~
~~Tachypnea~~

j. **Mixed respiratory and metabolic acidosis (note: MH can occur without significant metabolic acidosis)**
~~c.~~**k.** Skin flushed, mottled, cyanotic, or diaphoretic
l. **Rising body temperature (1-2°C every 5 minutes)**
m. **Myoglobinuria**
n. **Hyperkalemia, hypercalcemia, lactic** ~~academia~~**acidemia**
o. **Pronounced elevation in creatine kinase (CK) level**

~~Biochemical changes:~~
~~Increased pCO2~~
~~Acidosis (respiratory, metabolic)~~
~~Hyperkalemia~~
~~Hyper or hypocalcemia~~
~~Hyperglycemia~~

~~Monitor for the following late signs of MH:~~
~~Core body temperature increase (may rise 1-2°C every 10 minutes)~~
~~Dark red or brown urine~~
~~Biochemical changes:~~
~~Elevated CK (peaks 12-24 hours after episode)~~
~~Myoglobinuria~~
~~Increase in liver enzymes~~
~~Prolonged PT/PTT~~
~~Decreased platelet count~~

~~Confirm diagnosis by obtaining ABG's~~

~~2.~~**3.** Immediate interventions **upon diagnosis of MH**:

a. **Notify surgeon/procedural physician to** ~~S~~stop the procedure as soon as possible **and the anesthesia provider shall discontinue MH triggering agents (i.e., volatile inhalation anesthetic agents and succinylcholine)**~~;~~**. For emergency procedures,** continue with non-triggering anesthetic **technique.** ~~technique if emergency~~

~~Discontinue all volatile inhalation anesthetic agents and succinylcholine.~~

b. Hyperventilate with 100% oxygen at flows of 10L/minute or more **to flush volatile anesthetics and lower $ETCO_2$.**
   i. **If available, insert activated charcoal filters into the inspiratory and expiratory limbs of the breathing circuit.**
   ~~a.~~**ii.** ~~(~~Do not **waste time changing** ~~change~~ the breathing circuit and CO_2 absorbent~~)~~.
c. **Call for all available help.**

d. **For MH onset occurring outside of Surgical Services, call Code Blue and notify Surgery of the MH emergency. Request Surgery to send the MH cart and available staff to assist.**

~~b.~~e. **For MH onset occurring in Surgical Services,** ~~A~~alert the **OR** Assistant Nurse Manager (ANM)/~~ or~~ designee and Unit Secretary of the MH emergency. They will:

i. Recruit all available staff (recommend at least ten additional staff members), including RN's, techs, and transporters.

ii. Page "Any available anesthesiologist STAT" to appropriate area for assistance.~~ in placing additional intravenous (IV) lines, arterial catheter, or central lines.~~

~~ii.~~iii. **Code Blue may be called if additional assistance is required.**

f. **Call MHAUS MH Hotline (1-800-644-9737) for expert consultation, as needed.**

i. Send MH cart (from Surgery ~~Case Cart~~**Equipment** Room or OB-PACU) and Crash Cart to treatment area. **The MH cart contains the initial dose of dantrolene sodium (~~Dantrium®/Revonto®~~) and other necessary supplies.**

~~ii.~~g. Call pharmacy for all available **dantrolene sodium (~~Dantrium®/Revonto®~~)** ~~Dantrolene~~ **to be sent STAT to the treatment area**~~immediately~~.

~~iii.~~h. Send for **at least 10 liters of** ~~all~~ refrigerated normal saline for infusion (located in Open Heart refrigerators, ED ~~and~~**or** ICU).~~ Ten (10) liters should be available.~~

~~iv.~~i. ~~Designate an anesthesia tech or RN to s~~**S**et-up pressure lines for ~~insertion of~~ an arterial line, central line, and/or pulmonary artery catheter.

~~v.~~j. Designate three (3) nurses/**designees** to mix **dantrolene sodium (~~Dantrium®/Revonto®~~)** ~~Dantrolene~~ in rapid assembly line preparation. (**Initial** ~~D~~dose is 2.5~~-10~~mg/kg IV, **to be given rapidly through large-bore IV, if possible.**~~average initial adult dose requires 10 vials~~):

i. **Each 20mg vial of dantrolene sodium (~~Dantrium®/Revonto®~~) is reconstituted with 60mL sterile water for injection (without a bacteriostatic agent). There are 3 grams of mannitol in each 20mg vial of dantrolene sodium (~~Dantrium®/Revonto~~).**

ii. **To mix dantrolene sodium (~~Dantrium®/Revonto®~~) in rapid, assembly line fashion:**

1) First nurse/**designee** draws up sterile water and injects 60mL into each 20mg vial of **dantrolene sodium (~~Dantrium®/Revonto®~~)** ~~Dantrolene~~.

2) Second nurse/**designee** shakes the vials to dissolve (not readily soluble).

3) Third nurse/**designee** draws up the **dantrolene sodium (~~Dantrium®/Revonto®~~)** ~~Dantrolene~~ ready for administration.

~~vi.~~k. Send for hypothermia unit (located in ED and ICU).

~~vii.~~l. Send bags and buckets of ice to treatment area (from **an** ice machine; **-in the OR this is located in the central core** behind OR 5/~~ & 6~~)

~~viii. Notify perfusionist to stand by with By-Pass Pump.~~

~~ix.~~m. Designate nurse to record **assessments, treatments,** events, and medications **administered (including** times given and doses).

~~3.~~4. Treat~~ment~~ **the patient** per physician's/**AHP** orders:

a. Administer **dantrolene sodium (~~Dantrium®/Revonto®~~)** ~~Dantrolene~~ **rapid** IV **push** (~~via~~ **through** ~~central line if available~~**large-bore IV, if possible**), starting with 2.5mg/kg, **per physician/AHP order.**~~.~~

i. **Dantrolene sodium (~~Dantrium®/Revonto®~~) should be repeated until signs of MH are reversed, per the order of the treating physician/AHP. More than 10mg/kg (up to 30mg/kg) of dantrolene sodium (~~Dantrium®/Revonto®~~) may be necessary.**

~~Given every 2-3 minutes until symptoms resolve or cumulative dose of 10mg/kg is reached. Given as rapid IV push.~~

b. **Treat metabolic acidosis with bicarbonate, per physician/AHP order. It is recommended to start with 1-2mEq/kg if blood gas values are not yet available.**

c. **Cool the patient if core temperature reaches greater than 39°C:**

i. **Ensure external warming sources (i.e., forced-air warming unit, warm blankets) are removed from the patient.**
ii. **Apply ice to body surfaces (head, axillae, groin, patient's side). Gel cold packs are located in the MH cart refrigerator for immediate application. Additional bags of ice may be utilized as necessary.**
iii. Infuse refrigerated Normal Saline (0.9%) **intravenously** at a rate of 1 ~~L~~liter every 10 minutes ~~for~~**x** 3 ~~L~~liters. **Refrigerated Normal Saline is** ~~(L~~located in the MH ~~C~~cart ~~R~~refrigerator~~)~~. **DO NOT administer Lactated Ringer (LR) solution, which may contribute to acidosis.**
iv. **Lavage open body cavities with cold saline, as applicable.**
v. **Utilize other cooling techniques per the order of the treating physician/AHP. Examples of other cooling techniques include:**
   1) **Insert a nasogastric tube and lavage with cold saline irrigation.**
   2) **Insert a rectal tube and lavage with cold saline irrigation.**
   3) **Apply a hypothermia unit/cooling blanket.**
~~b.~~vi. **Discontinue cooling measures if the patient's temperature drops lower than 38°C and falling to prevent hypothermia. Resume cooling measures if the temperature begins to rise again.**

d. **Treat dysrhythmias per physician/AHP order, including anti-arrhythmic agents and defibrillation as necessary. Avoid calcium channel blockers, which may cause hyperkalemia or cardiac arrest in the presence of dantrolene sodium.**
e. **Treat hyperkalemia per physician/AHP order, including:**
   i. **Hyperventilation**
   ii. **Bicarbonate 1-2mEq/kg IV (maximum dose of 50mEq)**
   ~~c.~~iii. **Calcium chloride 10mg/kg IV (maximum dose of 2000mg) or calcium gluconate 30 mg/kg IV push (Maximum dose 3,000 mg) ~~10-50mg/kg IV~~ for life threatening hyperkalemia**
   ~~i.~~iv. **Regular insulin 10 units IV push plus Dextrose 50% 50 mL IV push**
   v. **Check glucose levels hourly**

~~b.~~f. **Continue to monitor $ETCO_2$, blood gas values (venous blood gas values may document hypermetabolism earlier than arterial values), electrolytes, creatine kinase (CK), core temperature, coagulation studies, and serum studies as ordered by the physician/AHP. Treat as ordered by the physician/AHP.** ~~Send blood samples for ABG's, electrolytes, enzymes, coags, etc. frequently for medical management, as ordered.~~ Monitor lab results for:
   i. Blood gases:
      1) Decreased pH
      2) Decreased partial pressure of oxygen (PaO_2)
      3) Increased partial pressure of carbon dioxide ($PaCO_2$)
   ii. Electrolyte studies:
      1) Increased potassium **(K^+)**
      2) Increased calcium
      3) Increased magnesium
      4) Decreased sodium
   iii. Coagulation studies:
      1) Prolonged prothrombin time (PT)
      2) Prolonged partial thromboplastin time (PTT)
      3) Decreased platelets
   iv. Serum studies:
      1) Increased creatine phosphokinase (CPK)
      2) Increased myoglobin
      3) Increased creatinine
      4) Increased glucose
      5) Increased lactate

6) Increased pyruvate
7) Increased lactic dehydrogenase
8) Increased aldolase

~~e.~~**g.** Prepare and assist ~~anesthesiologist~~ **physician/AHP** with insertion of arterial line **and central line**.

~~Prepare and assist anesthesiologist with insertion of central line(s).~~
~~Insert/assist with insertion of NG tube.~~
~~Insert rectal tube if needed.~~

h. Insert ~~3-way~~ temperature monitoring **indwelling** urinary catheter (**i.e.,** Criticore Foley) **and monitor urine output (amount and color)**.

i. **If urine output falls to less than 0.5mL/kg/hour, or CK and/or K^+ values rise more than transiently, induce diuresis to greater than 1mL/kg/hour, per physician/AHP order. It is recommended to administer bicarbonate to alkalinize urine and prevent myoglobinuria-induced renal failure.**

~~d.~~ii. **Administer furosemide (0.5mg-1mg/kg; maximum dose of 4020mg) per physician/AHP order, as needed to maintain urinary output.**

~~Monitor renal function:~~
~~Monitor urine output every 30 minutes.~~
~~Give IV fluids as ordered (do not use Lactated Ringers because it enhances metabolic acidosis).~~
~~Administer medications as ordered for urine output less than 2mL/kg/hour:~~
~~Furosemide (Lasix).~~
~~Mannitol.~~

~~i. Urine test strip to check for blood, as ordered.~~
~~Administer Sodium Bicarbonate to treat metabolic acidosis, as ordered.~~
~~Assist the anesthesiologist to monitor for arrhythmias:~~
~~Treat with anti-arrhythmic agents as ordered.~~
~~Defibrillate as appropriate.~~
~~DO NOT use calcium channel blocking agents (may cause hyperkalemia or cardiac arrest in the presence of Dantrolene).~~
~~Treat hyperkalemia with Regular Insulin and Dextrose 50% (give as ordered).~~
~~Initiate cooling the patient if core temperature greater than 39°C~~
~~Apply hypothermia unit.~~
~~Place ice packs in axilla and groin areas~~
~~Gel cold packs are located in the MH Cart refrigerator for immediate application.~~
~~Additional bags of ice to be obtained from ice machine.~~
~~Lavage open body cavities, bladder, stomach, or rectum with iced saline if temperature continues to rise (Cold saline irrigation available in Open Heart refrigerators).~~
~~Place patient on cardiopulmonary by-pass pump if above measures fail.~~
~~Discontinue cooling measures when temperature falls to 38°C (100.4°F) to prevent drift of temperature below 36°C. Resume cooling measures if temperature rises above 38°C.~~

~~d.~~i. Transfer patient to ~~PACU or~~ ICU after stabilized, **per physician/AHP order**.
~~Observation necessary in ICU for at least 36 hours after the MH Crisis, due to risk of reoccurrence.~~

C. **TREATMENT POST-MH CRISIS:**

1. **Continuously evaluate the patient for signs of MH relapse for at least 24 hours following cessation of acute phase MH. Signs of MH relapse include:**
   a. **Increasing muscular rigidity in the absence of shivering**
   b. **Inappropriate hypercarbia with respiratory acidosis**
   c. **Metabolic acidosis without other cause**
   d. **Inappropriate temperature rise**
2. **Immediately notify the physician/AHP for signs of MH relapse and implement interventions per physician/AHP orders.**

a. **25% of MH events relapse, which can be fatal. Do not delay treatment if MH relapse occurs.**

3. **Monitor the patient post-MH acute phase per physician/AHP orders. Monitoring recommendations post-MH acute phase include:**
   ~~2.~~a. ~~Monitor t~~Temperature, blood pressure, heart rate, and respirations every hour for 24 hours ~~after the crisis~~**post-acute phase**. May progress to every 4 hours, if stable.
   ~~3.~~b. **Frequent blood gases are recommended as per clinical signs. CK is recommended every six (6) hours, or less often as the values trend downward.** Monitor lab values for improvement of electrolyte imbalance, acidosis, enzyme elevations, renal damage, coagulopathies, etc. Report and treat abnormal values as ordered.
   ~~4.~~c. Assess for thrombophlebitis at peripheral IV sites from ~~Dantrium®/Revonto®~~ **(dantrolene sodium)**~~Dantrolene~~, and for possible bleeding coagulopathies.
   ~~5.~~d. Assess for alterations of neurological status. Report neurological deterioration.
   ~~6.~~e. Assess for residual muscle pain/swelling. Administer analgesia **as ordered** and provide appropriate comfort measures.
   ~~7.~~f. Monitor urine output. Report low urine output **and treat as ordered.**
4. ~~Dantrium®/Revonto® (d~~**Dantrolene sodium~~)~~ may be administered post-acute phase MH, per physician/AHP order.**
   a. **Recommended ~~Dantrium®/Revonto® (~~dantrolene sodium~~)~~ administration rate is 1 mg/kg IV every 4-6 hours, or 0.25 mg/kg/hour continuous infusion.**
   b. **~~Dantrium®/Revonto® (d~~Dantrolene sodium~~)~~ administration may be continued for 24 hours post-acute phase MH, or longer as clinically indicated.**
   c. **Discontinue ~~Dantrium®/Revonto® (~~dantrolene sodium~~)~~ administration per physician/AHP orders. Recommendations for ~~Dantrium®/Revonto® (~~dantrolene sodium~~)~~ discontinuation include:**
      i. **Consider increasing the interval between doses to every eight (8) hours or twelve (12) hours prior to discontinuation.**
      ii. **Consider discontinuation of ~~Dantrium®/Revonto® (~~dantrolene sodium~~)~~ if all of the following criteria are met:**
         1) **Metabolic stability for 24 hours**
         2) **Core body temperature is less than 38°C**
         ~~8.~~3) **CK is decreasing**
         4) **No evidence of myoglobinuria**
         ~~9.~~5) **Muscle is no longer rigid**~~Continue administration of Dantolene for 48 hours, as ordered.~~

~~10. Report signs and symptoms of reoccurrence of MH.~~

D. **PATIENT/FAMILY EDUCATION:**

1. **The physician/AHP shall ~~E~~explain the following to the patient/family:**
   ~~11.~~a. MH ~~Crisis~~ and therapeutic interventions~~.~~
   b. **Precautions for future surgeries/procedures**
   ~~12.~~c. **Genetic transmission of MH and ~~Explain~~** implications for first degree relatives.
2. **The physician/AHP shall complete the Adverse Metabolic Reaction to Anesthesia (AMRA) form at www.mhreg.org/registry. A follow-up letter should be sent to the patient and his/her primary care physician.**
~~1.~~3. **The patient/family shall be referred to the North American MH Registry and ~~Provide the following contact information for reporting in the MH registry:~~the Malignant Hyperthermia Association of the United States (MHAUS) for follow-up. Current MHAUS contact information is available at www.mhaus.org.**
   ~~The Malignant Hyperthermia Association of the United States (MHAUS)~~
   ~~11 East State Street~~
   ~~P.O. Box 1069~~
   ~~Sherburne, NY 13460-1069~~
   ~~1-800-986-4287~~

~~www.mhaus.org~~

E. **DOCUMENTATION:**

1. ~~Record~~**Document all patient** assessments, interventions, ~~and~~ responses **and medications administered** in the medical record
   ~~Record medications on the Medication Administration Record~~
2. Document patient and family education in the medical record
   ~~Include post ECG rhythm strips on Rhythm Strip Record or appropriate portion of the medical record.~~

F. **RELATED DOCUMENTS:**

1. **Malignant Hyperthermia Cart Checklist**

~~F.~~G. **REFERENCES:**

~~"AORN Malignant Hyperthermia Guideline", AORN Perioperative Standards and Recommended Practices, 2011 Edition.~~

1. **Rothrock, J. C. (2015). Alexander's Care of the Patient in Surgery (15th ed). St. Louis, MO: Elsevier.**
2. ~~1.~~ **"Emergency Therapy for Malignant Hyperthermia" (February 2015).** Malignant Hyperthermia Association of the United States (MHAUS). **Protocol ordered from www.mhaus.org.**
   ~~11 East State Street~~
   ~~P.O. Box 1069~~
   ~~Sherburne, NY 13460-1069~~
   ~~1-800-986-4287~~
   ~~www.mhaus.org~~

UNIT:_____ **TRI-CITY MEDICAL CENTER MALIGNANT HYPERTHERMIA CART CHECKLIST** MONTH/YR:_____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
TOP/SIDE OF CART																															
ICE BUCKETS & BAGS																															
LAVAGE SUPPIES																															
MH PROTOCOL																															
NEXT MEDICATION EXPIRATION DATE																															
CART LOCK # Check mark indicates unchanged from prior day																															
REFRIGERATOR LOCK # Check mark indicates unchanged from prior day																															
INITIALS OF PERSON CHECKING CART																															
REFRIGERATOR TEMPERATURE																															

INSTRUCTIONS
- Mark an "X" in the corresponding box for the observed temperature daily. Shaded area indicates that the temperature is outside the range; document corrective action.
- If temp is outside of acceptable range:
  1) Adjust thermostat and monitor results in one hour
  2) If not correct within one hour, notify Engineering at Extension 7148
  3) Relocate contents to an alternate location with appropriate temperature control
  4) Record actions taken and resolution

Temperature (°F)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
51																															
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DAY OF THE MONTH

PROBLEM/ACTION/RESOLUTION DOCUMENTATION – Record with reference to above date

Date	Problem	Action Taken	Resolution Achieved

Tri-City Medical Center

Distribution: Patient Care Services

PROCEDURE: **PRE- BRONCHOSCOPY PROCEDURE**

Purpose: To outline the process and the responsibilities of [illegible] Bronchoscopy Registered Nurse (RN) before a Br[illegible]

DELETE- incorporated in Patient Care Services: Bronchoscopy Procedure.

A. **PROCEDURE:**

1. Physicians call the Lead Respiratory Care Practitioner ([illegible]) to schedule an inpatient bronchoscopy procedure.
   a. Diagnostic bronchoscopies must be performed in a Negative Airflow room (Bronchoscopy Suite, 143, 243, 287, 387, 443, or 487) unless the patient is intubated and on a ventilator.
   b. Therapeutic bronchoscopies may be done in a private room.
   c. Bronchoscopy RN is available Monday-Friday 8:00am to 4:00pm. After hours, call Telemetry or Intensive Care Unit (ICU) Assistant Nurse Manager (ANM) / designee.
2. The Lead RCP **calls the Telemetry or ICU Assistant Nurse Manager who then arranges** shall arrange for a RN to assist with the bronchoscopy procedure.
3. The Telemetry or ICU ANM / designee shall assign a qualified RN [Advanced Cardiac Life Support (ACLS) RN with electrocardiogram (ECG) interpretation skills] to monitor the patient for all after hour procedures.
   a. The qualified RN assisting with the bronchoscopy shall monitor the patient during and after the procedure.
   b. Bronchoscopies performed in the ICU or in Telemetry shall be assisted by the ICU or Telemetry RN.
4. The primary nurse shall prepare the patient for transport if the bronchoscopy is to be done in the Bronchoscopy Suite (2 North).
   a. If the procedure is performed in Acute Care Services (ACS), the primary nurse shall gather the necessary equipment (i.e., portable cardiac monitor (DASH) and the bronchoscopy documentation forms).
5. The primary nurse must ensure there is a current progress note written by a physician within 24 hours before the bronchoscopy stating the condition of the patient before the bronchoscopy procedure.
   a. If a progress note does not reflect this, the Physician must sign the "Interval History and Physical Note" and place it in the patient's chart before the bronchoscopy procedure.
6. If the bronchoscopy is performed in the Bronchoscopy Suite, medications ordered by the physician must be obtained from the unit **Bronch** Pyxis **located in the Pulmonary department.**
7. The RN assisting with the procedure must complete the following documentation:
   a. Both sections of the Procedural Verification Checklist (Pre-Procedural and Procedural Phase)
   b. The Sedation Flow sheet
8. The RN assisting with the procedure shall:
   a. Contact the patient's primary nurse to obtain hand-off communication
   b. Verify the patient is ready for transport
   c. Contact the lift team to transport patient to the bronchoscopy suite
9. When the bronchoscopy is complete and the RN assisting with the procedure needs to return to his/her unit, the patient may be recovered in the Post Anesthesia Care Unit (PACU).
   a. The RN assisting with the procedure shall notify PACU to arrange recovery of the patient.
      i. Patients, who have undergone a diagnostic bronchoscopy, shall be placed in one of the enclosed isolation rooms in PACU, if respiratory isolation is ordered by physician.
      ii.i. PACU staff shall contact Engineering for a portable HEPA filter and for assistance with appropriate set up.

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Division of Pulmonary	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
9/05, 1/08; 6/09, 05/17	07/11, 07/17	08/11, 07/17	06/18	n/a	10/11, 06/18	11/11, 07/18	12/11

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**PRONOUNCEMENT OF DEATH**
Purpose:	To outline the appropriate steps in pronouncement of death.

A. **DEFINITION(S):**

1. Authorized Registered Nurse (RN): The RN who has been instructed on criteria for pronouncement of death who has successfully completed two (2) pronouncements of death in the presence of another authorized RN.
   a. Generally, Assistant Nurse Managers or Administrative Supervisors ~~make the pronouncements~~.
2. Death: Determined by the absence of a patient's neurological, circulatory, and respiratory function.

B. **POLICY:**

1. The primary nurse must notify the patient's attending physician **and consulting Physicians (i.e. surgeon)** of patient's death.
   a. It is the responsibility of the attending physician **or designee** to notify the patient's next of kin when the patient has died.
2. An authorized RN may pronounce the patient based on a telephone or written order from the attending physician.
   a. The authorized RN shall not be the patient's primary RN.
3. An authorized RN may pronounce death for patients with a Do Not Resuscitate (DNR) or Allow Natural Death order in all nursing units with the exception of Neonatal Intensive Care Unit (NICU) and the Emergency Department (ED).
   a. NICU patients may only be pronounced by physicians with NICU privileges.
4. The Emergency physician or attending physician shall pronounce full code patients.
   a. After a code, the physician needs to determine when to stop resuscitation measures and pronounce death

C. **PROCEDURE:**

1. Verify written physician orders to pronounce.
2. Assess the patient noting the absence of the following:
   a. Pupillary response to light
   b. Apical heart sounds/rate by auscultation for one minute
   c. Respirations by visual examination and auscultation for one minute
3. Document the date and time of pronouncement in the "Note upon Pronouncement" Power Form **in Cerner**.
4. ~~Document life-sharing was notified within 1 hour of death. Refer to Patient Care Services Release of Deceased.~~

D. ~~**FORM(S) AVAILABLE ON THE INTRANET:**~~

1. Initial Pronouncement of Death Verification ~~**Sample**~~

Department Review	Clinical Policies & Procedures Committee	Nursing Executive Council	Medical Staff Department/ Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
02/12, 10/17	09/12, 05/18	09/12, 05/18	n/a	n/a	10/12, 06/18	11/12, 07/18	12/12

Initial Pronouncement of Death Verification—~~Sample~~

Tri-City Medical Center

~~Initial~~ Pronouncement of Death Verification

Name_____ Employee ID _____

Title: _____ Department _____

INITIAL PRONOUNCEMENT OF PATIENTS

1. Medical Record _____

   Date Performed _____

   RN/MD Observer's Signature_____

INITIAL PRONOUNCEMENT OF PATIENTS

2. Medical Record _____

   Date Performed _____

   RN/MD Observer's Signature _____

Approved 8.12

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**SIEMENS RAPIDPOINT ~~405~~500**
Purpose:	The analysis of blood gases, electrolytes, ionized calcium, glucose, and hematocrit.
Supportive Data:	The Rapidpoint ~~405-~~**500** system uses potentiometry, amperometry, and conductance to measure the concentration of analyte in the sample. An electrochemical interaction between the analyte of interest and the sensor generates an electrochemical signal that is proportional to the amount of analyte in the sample. Potentiometry is the technology that measures the difference/ potential between two electrodes in a solution without applied current. Amperometry involves applying voltage to an electrode and then measuring the current generated. Conductance is the readiness with which a conducting substance transmits electrical current.
Equipment:	Rapidpoint ~~405-~~**500** Analyzer Syringe or Capillary ~~(balanced heparin or lithium heparin if not testing Ca++)~~**Tube**
Authorized to Perform Procedure:	Registered Nurse (RN), Respiratory Care Practitioner (RCP), Perfusionist, Anesthesia Technician, **Clinical Laboratory Scientist (CLS)**
NOTE:	For more detailed information regarding technology, reagents, calibration points, etc., please refer to the laboratory and/or manufacturer's user manual.

A. **CLINICAL SIGNIFICANCE:**

ANALYTE	Some Causes of Increased Values	Some Causes of Decreased Values
SODIUM	Dehydration Diabetes insipidus Salt poisoning Skin losses Hyperaldosteronism CNS disorders	Dilutional hyponatremia (cirrhosis) Depletional hyponatremia Syndrome of inappropriate ADH
POTASSIUM	Renal glomerular disease Adrenocortical insufficiency Diabetic Ketoacidosis (DKA) Sepsis In vitro hemolysis	Renal tubular disease Hyperaldosteronism Treatment of DKA Hyperinsulinism Metabolic alkalosis Diuretic therapy
CHLORIDE	Prolonged diarrhea Renal tubular disease Hyperparathyroidism Dehydration	Prolonged vomiting Burns Salt-losing renal disease Overhydration Thiazide therapy
IONIZED CALCIUM	Dehydration Hyperparathyroidism Malignancies Immobilization Thiazide diuretics Vitamin D intoxication	Hypoparathyroidism Early neonatal hypocalcemia Chronic renal disease Pancreatitis Massive blood transfusions Severe malnutrition
GLUCOSE	Diabetes mellitus Pancreatitis Endocrine disorders (e.g. Cushing's syndrome)	Insulinoma Adrenocortical insufficiency Hypopituitarism Liver disease

~~Revision Dates~~Department Review	Clinical Policies & Procedures Committee	Nursing Executive Council	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
06/09, 05/15, 04/18	07/11, 05/15, 05/18	08/11, 05/15, 05/18	03/16	n/a	10/11, 04/16, 06/18	11/11, 05/16, 07/18	11/11, 05/16

ANALYTE	Some Causes of Increased Values	Some Causes of Decreased Values
GLUCOSE	Drugs (e.g. steroids, thyrotoxicosis) Chronic renal failure Stress IV glucose infusion	Ethanol ingestion Reactive hypoglycemia Glycogen storage disease
pH	Respiratory alkalosis Metabolic alkalosis	Respiratory acidosis Metabolic acidosis
PCO_2	Acute Respiratory Acidosis: • Depression of respiratory center • Suppressed neuromuscular system • Pulmonary disorders • Inadequate mechanical ventilation Chronic respiratory acidosis • Decreased alveolar ventilation • Hypoventilation Compensation in metabolic alkalosis	Respiratory alkalosis: • Increased stimulation of respiratory center • Hypermetabolic states • Mechanical hyperventilation Compensation in metabolic acidosis
PO_2	Breathing oxygen-enriched air	Carbon-monoxide exposure Pulmonary disorders Myocardial infarction Congestive heart failure
HCO_3	Primary metabolic alkalosis Compensation in respiratory acidosis	Primary metabolic acidosis Compensation in respiratory alkalosis
HEMATOCRIT	Dehydration Burns Impaired ventilation Renal disorders	Hemolytic anemias Iron deficiency Marrow depression Blood loss

B. **SPECIMEN COLLECTION:**

1. Specimen Type:

Sample Type	Collection Device	Minimum Fill Volume	Preparation
Arterial blood	Syringe	200 microliters for 1.0 mL syringe 800 microliters for 3.0 mL syringe 1.5 mL for 5.0 ml syringe	Expel air from the syringe and cap it immediately after obtaining the sample.
Venous blood			
Capillary blood	Capillary tube	175 microliters balanced heparin tubes (Minimum is 100 microliters)	Fill the tube completely and cap it securely.

a. For whole blood samples, use syringe or capillary tube ~~containing balanced heparin~~. **For whole blood venous specimens submitted to the laboratory, use lithium heparin.** If ~~you~~ **staff** are ~~not~~ analyzing samples for ionized calcium~~,~~ ~~you can use~~ lithium heparin **can be used.**

b. Other anticoagulants, such as benzalkonium heparin, EDTA, citrate, oxalate, and fluoride significantly affect blood pH, sodium, potassium, chloride, and ionized calcium results.

c. Antimicrobial compounds such as silver sulfadiazine and chlorhexidine, which are found in some central venous catheters, significantly affect sodium results and may affect subsequent sample analyses. Do not collect venous samples for electrolytes analysis from a central venous catheter that contains silver sulfadiazine or chlorhexidine.

d. ~~You~~ **Staff** can introduce samples into the Rapidpoint ~~400~~ **500** system using the sample collection devices listed in the previous table.

2. Specimen Handling:
   a. Position any labels toward the back of the syringe barrel near the plunger so the label does not block the syringe from entering the system and cause it to fall off.
   b. Cap the sample device immediately after ~~you~~ collection ~~the sample~~ to avoid room air contamination.
   c. Analyze the sample as soon as possible to minimize oxygen consumption.
   d. Before ~~you analyze the sample~~**analysis**, roll the syringe or capillary tube between ~~your~~ palms and gently invert it several times to mix the sample thoroughly. Blood cells settle during storage, and if the sample is not well mixed before analysis, the Hematocrit results obtained can be falsely decreased or increased. Mix all samples using a consistent technique. **Ensure there are no air bubbles in the syringe after mixing.**
   e. Dispose of used sample devices in a biohazard contamination bag.
3. Known Interfering Substances:
   a. Always select the mixed venous sample button to analyze mixed venous samples. Samples collected from some pulmonary artery catheters can contain the benzalkonium ion that interferes with analysis and affects results.

Analyte	Interfering Substance	Concentration Tested	Level of Interference
Ionized Calcium	Salicylic Acid	50 mg/dL 30 mg/dL	.098 mM (6%) .046 mM (3%)
Sodium	Dobutamine Benzalkonium Heparin~~*~~ **Heparin Leo**	5 mg/dL **n/a** **800-850 U/mL**	6 mmol/L >50 mM **-12.6 mM**
Chloride	Salicylic Acid	50 mg/dL 20 mg/dL	9.5 mmol/L 1.8 mmol/L
Hematocrit	Dextran Leukocytes Protein Protein	3 g/dL 60,000 WBC cu/mm 12% 4%	5% 10% 4.9% -1.3%
Potassium	Benzalkonium Heparin		>0.15 mM

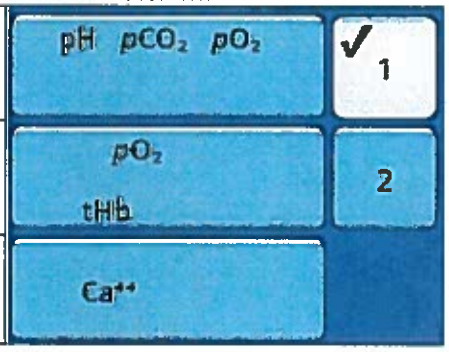
C. **PROCEDURE FOR RESPIRATORY PERSONNEL:**

1. Analyzing Patient Samples:
   a. Roll the syringe or the capillary tube between ~~your~~ palms and gently invert it several times to mix the sample thoroughly.
   b. Touch the button for the patient SAMPLE TYPE. A checkmark indicates the button is selected. (Default is arterial syringe).

i. **Arterial (syringe)**	
ii. **Capillary (175 microliters Cap tube)**	
iii. **Venous (syringe)**	
iv. **Mixed venous blood (this will only do a pO2)**	

~~i. Arterial (syringe)~~
~~ii. Capillary (175 microliters Cap tube)~~
~~iii. Venous (syringe)~~
~~iv. Mixed venous blood (this will only do a pO2)~~

c. Touch (~~deselect~~) **the panel of choice to perform testing.** ~~Any parameter that you do not want.~~ This is important ~~for~~ **so that RapidComm selects the appropriate test panel**~~the Lab to properly order the test~~ in Cerner. ~~The Rapidpoint is set up to default Arterial Blood Gases and Ionized Calcium.~~

ABG Panel **Neo ABG Panel**	
ABG Coox **Neo ABG Coox**	
Cord Blood Gas	

~~e. Touch ANALYZE~~

d. ~~When prompted, i~~Introduce the sample device into the sample port and touch the ~~CONTINUE~~ **START** button. The system aspirates the sample.
   i. Arterial or Venous: Place the syringe into the sample port.
   ii. Capillary: Insert the Capillary tube into the sample port until ~~you feel~~ it clicks into place.

e. When prompted, remove the sample device from the sample port and touch the CONTINUE button.

f. When prompted, enter the following demographic information.
   i. Touch the Patient ID field and key in the ~~specimen accession number (performed in ICU, ED, NICU)~~ **patient's FIN number (performed in ICU, ED, NICU, PACU and OR)**or the patient's ~~medical record number (performed in OR).~~**accession number (performed in Lab).**
   ii. Touch the Patient Name field and key in the patient Last Name.
   ~~iii. Touch the Operator ID field and key in employee identification number~~
   ~~iv.~~**iii.** Touch the Temperature field and key in the patient's temperature ~~(defaults to 37 C if no data entry).~~

g. Touch the right arrow to continue.

h. View the results. ~~The values for the results appear in yellow when analysis is still in progress. Select the Print Results Key for a printout.~~

i. Touch ~~the~~ CONTINUE when ~~you~~ finished viewing results. The instrument will wash and prepare for the next sampling.

j. **Open the RapidComm software to enter additional values (i.e. Draw Date & Time, Sample Site, Order Name, PCOM, FiO2/LPM, and Allen's Test).**

k. **If there are critical results, results will be displayed in red font and the Notified and Read Back field should be completed with the person receiving the results and credentials (i.e. Jane D, RN or Dr. Doe, MD); the Notified and Confirmed by field should be completed with the operator giving the results and credentials (i.e. J Doe, RCP); and the Notified Time field should be completed.**

~~i.~~**l. Once the results are reviewed, select OK for the results to record in Cerner.**

2. Recalling Patient Results: Use this procedure to view and print results for patient samples that have already been analyzed.

a. Touch the Recall button. The recall button is the "File Folder" icon located in the upper right hand corner of the screen.

i. Touch Patients: The list of patient samples appears.

ii. Touch the **desired** sample ~~you want~~ to view.

iii. Use the arrow keys to view additional samples. Select the sample.

iv. Touch the Results button to view the results.

1) Edit sample demographics by pressing the Edit button (for example, to change the temperature). If changed this will not be corrected in Cerner. The results have already been filed. To correct this in the computer, notify the laboratory.

2) To reprint results, touch the Print icon.

v. ~~You~~ **Staff** may search for a sample by patient by pressing the Search button.

1) Enter in the Accession or ~~Medical Record Number~~ **FIN number** and touch the green arrow.

3. Reporting Results:

a. Calculations: The Rapidpoint ~~400~~ **500** analyzer contains a microprocessor that performs all calculations required for reporting results.

b. Result Symbols:

↑	The result is above the patient range.
↓	The result is below the patient range.
-----↑	The result is above the reporting range. Send to Laboratory for analysis.
-----↓	The result is below the reporting range. Send to Laboratory for analysis.
-----?	The system has an atypical response when measuring this parameter and cannot report the result. Analyze the sample again. When this symbol appears for the HCT, it may indicate that the HCT result was not reported because Na failed Required QC or it was not performed
u	The HCT was not corrected for Na or K because the sensor is out of calibration, turned off, or beyond the reporting range. The system uses a default value of 140 mmol/L for Na or a value of 4 mmol/L for K to determine the HCT result.

c. Reference Intervals:

Analyte	Unit	Reference Range		Reportable Range
		Arterial	Venous	
Sodium	**mEq/L**	135 – 153		100–200
Potassium	**mEq/L**	3.5 – 5.3		0.5-15.0
Chloride	**mEq/L**	~~101–111~~**98-107**		65 – 140
Glucose	**mg/dL**	70 – 110		20 – 750
Ion-Calcium	**mg/dL**	4.5 – 4.9		0.80 – 20.0
pH		7.35 – 7.45		6.50 – 7.80

Analyte	Unit	Reference Range		Reportable Range
		Arterial	Venous	
PCO_2	mm/Hg	35 – 45		10 – 150
PO_2	mm/Hg	>80		10 – 700
Hematocrit	%PCV	Males (adult) 42 - 52 Female (adult) 37 - 47		12-75
HCO_3*	mEq/L	22 – 26		Calculated Results
TCO_2*	mEq/L			
BE*	mEq/L	(-2) – (+3)		
sO_2	%	94 -100	55-85 (sepsis >70)	
Hb	g/dL	Males (adult) 14 - 18 Female (adult) 12 - 16		

d. Critical Results:

i. Critical results represent an emergency condition and must be reported immediately to the patient's attending physician or nurse.

ANALYTE (units)	CRITICAL VALUE	
	LOW < or =	HIGH > or =
ADULTS		
Sodium (mEq/L)	120	170
Potassium (mEql/L)	2.9	6.1
Glucose (mg/dL)	40	450
Ionized Calcium (mg/dL)	3.0	6.3
pH	7.30	7.52
PCO_2 (mmHg) *when pH is >7.736	n/a	55*
PO2 (mm/Hg)	55	n/a
Hematocrit (%PCV)	20.0	60.0
TCO2 (mEql/L)	10	45
NEONATES		
pH	7.28	7.50
PCO_2 (mmHg)	25	60
PO2 (mm/Hg)	50	100

~~4. Verifying Patient Results in the Lab Information System (LIS)~~

~~a. Results inbound from the OR analyzers will not automatically cross over to the LIS. The result of the test BGP (for OR6) or other tests as indicated by the results must be ordered and resulted by the lab.~~

~~b. Tests performed on the Emergency Department (ED), Intensive Care Unit (ICU), or Neonatal Intensive Care Unit (NICU) will cross over into the LIS when identified with a valid accession number (indicated in the Patient ID field).~~

~~i. Log on to the LIS and open Accession Result Entry.~~

~~ii. Type in the accession number.~~

~~iii. Review results; append any necessary comments.~~

~~iv. Verify.~~

~~5.~~4. Maintenance

a. Cleaning and Disinfecting the Screen: Clean the touch screen as needed to remove dust, dirt, or splatters from the screen and disinfect the screen surface.
   i. Materials:
      1) Hospital-approved disinfectant wipe
      2) Lint-free cloth
   ii. If necessary, wring any excess liquid from the wipe so it is wet but not dripping.
   iii. Touch the Status button and then touch Clean Screen. The Clean screen appears for 20 seconds. This allows ~~you~~ **staff** to wipe the screen without activating any buttons. While the Clean Screen is displayed, wipe the screen with the wet wipe and then thoroughly dry the screen with the lint-free cloth to remove chemicals that may damage the screen.
   iv. Touch the Continue button to return to the Analysis screen.

b. Cleaning and Disinfecting the Exterior Surfaces: Clean the exterior surfaces as needed to remove dust, dirt, and splatter from the surfaces, and disinfect the surfaces.
   i. Materials:
      1) ~~Hospital-approved~~**Bleach** disinfectant wipe
      2) ~~Lint-free cloth~~**Alcohol Pad**
   ii. Caution: Do not wet the sample port or the sensor contacts for the measurement and Automatic QC cartridges. When cleaning surfaces do not spray cleaning solution or other fluids into or on the sample port or the area behind the cartridges. ~~Avoid liquid from Sani-wipes around the sample port.~~ The sensor contacts, which are located behind the cartridges, may be damaged if they get wet. Sensors inside the cartridge may be damaged if cleaning solution enters the sample port.
   iii. If necessary, wring any excess liquid from the wipe so it is wet but not dripping.
   iv. To disinfect the exterior surfaces: wipe, let remain wet for two minutes, then dry with a lint-free cloth.

c. Replacing the Printer Paper: Replace the printer paper when a pink stripe appears on the edge of the paper.
   i. Material:
      1) Printer paper
   ii. Grasp the latch on top of the touch screen and move the screen forward to expose the printer compartment.
   iii. Remove the old roll of paper:
      1) Open the printer compartment.
      2) If paper remains in the printer, tear off the paper below the printer. Caution: Do not pull the torn paper back through the printer. This can damage the printing mechanism.
      3) Turn the paper-advance knob clockwise to move the torn paper through the printer.
      4) Remove the old roll of paper.
      5) Save the spindle for use with the new roll of paper.
   iv. Install a new roll of paper:
      1) Note: When ~~you advance~~ **advancing** the paper, watch the paper move through the printer to ensure that it exits the printer correctly.
      2) Get a new roll of paper and remove the outer wrapper.
      3) Insert the spindle through the roll of paper and place the paper in the printer compartment. Ensure that the paper is tightly wound and the ends of the spindle fit into the grooves on the sides of the compartment.
      4) Insert the paper from the bottom of the roll through the back of the printer. The system advances the paper automatically if the previous roll of paper was empty.

5) Turn the paper-advance knob clockwise to move 2-3 inches of paper through the top of the printer.
6) Note: When ~~you close~~ **closing** the printer compartment, ensure that the edge of the printer paper extends beyond the top of the printer.
7) Close the printer compartment.
8) Note: The first report printed after installing a new roll of paper does not have the Rapidpoint 405 name printed at the top.
9) Adjust the position of the screen for viewing.

~~9)~~**d. Replacing the Air Filter**

~~10)~~**i. Pull the air filter carrier out of the instrument (located on the bottom back right of the instrument).**
~~11)~~**ii. Remove the filter from the carrier.**
~~12)~~**iii. Install a new air filter in the carrier.**
~~v.~~**iv. Reinstall the air filter carrier in the instrument.**

D. **CALIBRATION:**

1. The system performs calibrations automatically at prescribed intervals and with each sample if necessary.
2. The system automatically ~~calibrated~~ **calibrates** the sensors as follows:
   a. One-point calibrations are scheduled to occur regularly at 30-minute intervals between calibrations.
   b. Every fourth scheduled calibration is a two-point calibration.
3. No operator action is required for calibration. If necessary, the system can defer a calibration to analyze a sample. In this case the message informing ~~you~~ **staff** that the system is busy contains a STAT button that lets ~~you~~ **staff** interrupt the calibration. However, if the maximum time between automatic calibrations has elapsed, the system must complete the calibration before allowing sample analysis.
4. During calibration, if the system detects a problem for a parameter, the system repeats the calibration for as many as two times. The Additional Cal Required message appears on the printed report and in the events log. If the calibrations are not successful, the system turns the parameter off. ~~You~~ **Staff** can continue to obtain results for the other parameters. However, ~~you~~ **staff** must wait for the parameter to pass the next calibration to obtain results for the parameter the system turned off.
5. The system performs additional calibrations during sample analysis for the first four hours after ~~you~~ **staff** install a new measurement cartridge. These calibrations ensure that the cartridge is ready for sample analysis. When these additional calibrations are required, sample results do not update during analysis, analysis time is prolonged due to additional calibration.

E. **QUALITY CONTROL:**

1. The AutomaticQC (AQC) analysis option performs quality control analysis at the scheduled time and for the scheduled level. The cartridge contains all the levels of QC material needed to monitor system performance without operator intervention.
2. During AQC analysis, the system compares the results to the ranges for each parameter and identifies any results that are out of range. Any parameters that fail QC are turned off. The system repeats QC analysis if the first attempt fails and turns on any failed parameters that pass. Any parameters that fail the second QC analysis are turned off.
3. The system allows ~~you~~ **staff** to analyze a sample from the AQC cartridge in addition to the scheduled AQC. When ~~you~~ **staff** analyze an AQC sample, the results can affect parameter status. The system turns failed parameters on that pass QC analysis for the failed level and turns parameters off that do not pass QC analysis.
4. The system automatically sends the QC results to the ~~Rapidlink~~ **RapidComm** data management system. This is to be reviewed periodically by approved Laboratory personnel.

5. ~~You~~ **Staff** can interrupt AQC between levels if ~~you need to analyze~~ an urgent patient sample **needs to be analyzed**. Touch STAT on the AQC Results screen to delay analysis of the next level of QC material. When the system is ready, analyze ~~your~~ **the** patient sample. The system analyzes any remaining levels of QC after ~~you~~ **staff** finish.

~~5.~~

F. **PROCEDURE NOTES:**

1. Status of Parameter Buttons:

✓~~PH~~pH	Parameters with checkmarks are selected (Touch to deselect test)
~~PH~~pH	This parameter is available but not selected.
pH	This parameter is not available because the sensor is out of calibration.
pH QC PH	**This parameter is not available because the sensor is out of calibration and is unlikely to become available with further calibrations.** ~~PURPLE BUTTON: not available because Required QC was not performed.~~
pH QC ~~PH~~	YELLOW BUTTON: not available because the sensor has failed QC.
pH	**PURPLE BUTTON: not available because Required QC was not performed.**

~~1. The system reports only pO2 results for mixed venous samples. Because mixed venous samples collected from some pulmonary artery catheters can contain potentially interfering substances such as the benzalkonium ion that significantly affect the results of some parameters, only pO2 results are reported.~~

~~2. Use sample devices containing only calcium titrated (balanced) heparin or lithium heparin as the anticoagulant.~~

2. Send specimen to the laboratory if ~~you~~ **staff** have any questions concerning the operation or results of the Rapidpoint **500**.

3. **Proficiency Testing / Calibration Verification**
   - a. **Before performing CAP proficiency testing or Siemens CVM samples user defined slopes and offsets must be removed.**
   - b. **Following testing of these samples return the slopes and offsets to their calculated values.**
   - ~~3.~~c. **Calibration Verification must be performed every 6 months on each instrument.**
     - ~~4.~~i. **External QC**
     - ~~5.~~ii. **External QC must be run on each instrument every 30 days or when the measurement cartridge is replaced.**
     - ~~6.~~iii. **Run all three levels of Siemens RapidQC Complete.**
     - ~~7.~~iv. **Correlations**
     - v. **Every 6 months perform a correlation between the Rapidpoint 500 instruments and the Laboratory Chemistry and Hematology instruments.**

~~8.~~**4.** System Message: The system messages can appear as follows:
   - a. Messages can appear in a message box over the Analysis screen or over the Status screen.
   - b. Messages can appear in the events log at the Status screen or in the events log that ~~you~~ **staff** access from the Recall menu. For example, after ~~you~~ **staff** replace a depleted

wash/waste cartridge, the message about the cartridge no longer appears at the Status screen but remains in the events log that ~~you~~ **staff** access from the Recall menu.

c. The following table lists the messages in alphabetical order. Refer to the instrument manual page 4-24 for a description of probable cause and corrective action. Notify LAB or POC Coordinator if ~~you~~ **staff** have any questions with any of the following errors:

Message	Probable Cause and Corrective Action
AQC Cartridge Expired	Refer to Replacing the AutomaticQC Cartridge.
AQC Cartridge Not Valid	Unable to use the Cartridge.
AQC Connector is Open	Connector on the cartridge is open.
Additional Cal Required	A sensor experienced a calibration error.
Analysis is turned off by a remote computer.	Rapidlink data management system has turned off the system. Call LAB
Bubbles in the Sample.	The system cannot complete analysis due to bubbles or obstruction. Touch Continue to begin the sequence to clear the system. Replace the sample port when prompted. Analyze the sample again, ensuring that the sample has no bubbles.
Cal Overdue	Cal was delayed. The system must perform a calibration before ~~you~~ **staff** can analyze samples.
Cal Not Done	The system performs an extended calibration.
D2 Excessive Drift: **D3 Slope Error:** **D4 Offset Error:**	The system turned the parameter identified in the message off because the sensor exceeded calibration limits. Subsequent calibrations may make the parameter available again.
D21 Processing Error	A system error occurred. When prompted, shut down the system. Call technical assistance if appears again.
D23 Reagent Error: 1-8 or 10-13	Inadequate flow of one or more reagents. System may prompt ~~you~~ **staff** to replace the Wash/Waste or Measurement cartridges.
D23 Reagent Error: 9	Inadequate flow of one or more reagents. System may prompt ~~you~~ **staff** to replace the sample port or Wash/Waste or Measurement cartridges.
D24 AQC Material Error	Inadequate flow of QC materials
D33 Valve Error: 1	A problem with the valve inside the measurement cartridge.
D33 Valve Error: 2	A problem with the valve inside the measurement cartridge.
D35 Electronics Error: 1-13	Error in the electronic components.
D35 Electronics Error: 14	A problem with the door.
D38 Temp Error: 1	Error in the temperature controls system because of a problem with the fan.
D38 Temp Error: 2-13	Error can occur if a component in the temperature control system has failed.
D39 Obstruction	Obstruction or a sample not detected, and prompts ~~you~~ **staff** to replace the sample port.

Message	Probable Cause and Corrective Action
D40 Wash Not Detected	Fluidic components of a newly installed wash/waste cartridge have failed.
D41 No AQC Material Detected	Fluidic components of a newly installed wash/waste cartridge have failed.
D60 Communications Error	Error in communicating with the Rapidlink.
Door Error	Door not closed.
Insufficient Sample Volume.	The system cannot complete analysis. Touch Continue to begin the sequence to clear. Replace sample port when prompted.
M Cartridge Expired	Replace the Measurement and Wash/Waste Cartridges.
M Cartridge Not Valid	Expire cartridge was installed or not installed correctly as prompted.
No AQC Cartridge	Not installed
No M Cartridge	Not installed
No Paper in Printer	Out of paper.
No W Cartridge	Not installed
Out of Reporting Range:	The parameter shown is outside reporting range. Send specimen to lab.
QC Lot Not Defined	No Lot information is entered for QC
QC Material Expired	Define new lot of control
Question Result:	Atypical response when measuring parameter. Repeat.
Sensors Unavailable for QC	Out of calibration
System Error.	System will attempt to correct.
System Error. Power off and on	Electronic or processing error has occurred.
System require operator attention	- QC due ---- Cartridges are nearly expired or depleted ---- Failed QC
Temp Not Ready	Temperature of the sensor module is outside range.
Temp Out of Range	Does not report sample results
Temp Warning	New cartridge warming
The system detected an obstruction and cannot complete analysis.	Clot
The system did not detect a sample	No sample detected.
This password is expired.	~~You have exceeded your~~ **Staff** certification date **has been exceeded** and **staff** cannot access the system.
Uncorrected:	Hct not corrected because Na or K not calibrated.
Unrecoverable System Error.	Call for technical assistance.
Unsuccessful Connection.	Not connected to Rapidlink
W Cartridge Expired	Replace Wash/Waste Cartridge

G. **REFERENCE(S):**

1. "105951 Rev J." *Siemens Rapidpoint ~~400~~ **500** Series Operator's Manual*, ~~06/2008~~**2011-2013**. Print.

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL

ISSUE DATE: 11/99

SUBJECT: Standard and Transmission-Based Precautions

REVISION DATE(S): 10/05, 01/11, 09/15, 01/17

Department Approval:	**~~07/17~~04/18**
Infection Control Committee Approval:	**~~07/17~~04/18**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~06/18**
Professional Affairs Committee Approval:	**~~08/17~~07/18**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**

1. The Centers for Disease Control and Prevention (CDC) and the Hospital Infection Control Advisory Council (HICPAC) published the Guidelines for Isolation Precautions in Hospitals in 2007. Changes were made to include respiratory hygiene/cough etiquette practices. Masking for spinal procedures and application of PPE prior to entering the room of a patient in Droplet or Contact Precautions
2. The current guidelines continue to support two levels of precautions, Standard Precautions and Transmission-based Precautions. Standard Precautions are the primary strategies to be used in the care of all patients to protect both healthcare workers and patients. Transmission-based Precautions are designed only for the care of specified patients, or patients known or suspected to be infected or colonized with epidemiologically important pathogens transmitted via airborne, droplet, or contact with dry skin or contaminated objects.

B. **POLICY:**

1. For immunocompromised patients see Patient Care Services: Neutropenic Precautions Policy.
   a. Use Standard Precautions, with emphasis on hand hygiene.
   b. Private room preferred. If semi-private room is used, select a roommate with no identified infection, including respiratory tract, urinary tract, or skin/wound infection.
   c. A patient is not required to wear a standard surgical mask when out of the room.
2. Physicians' role
   a. If a patient is known or suspected to be infected with a highly transmissible disease, or if a patient is infected or colonized with an epidemiologically important microorganism, appropriate isolation precautions should be ordered for the patient.
   b. In addition to hand washing before and after patient contact, wearing gloves before and discarding gloves and washing hands after touching any body substance, physicians need to evaluate their interaction with patients, and use barriers such as masks, eyewear and gown based upon anticipated contact with infectious materials.
   c. Physicians should be aware of their current vaccination status regarding (rubella, measles, varicella, hepatitis B) and participate in the Medical Center's annual tuberculosis screening program. All physicians who have frequent contact with blood and body fluids should be immunized against hepatitis B.
3. The role of nurses and other direct care providers is to:
   a. Assure that isolation orders are entered and proper isolation signage is posted outside of the patients' room.
   b. Perform hand hygiene before and after patient contact, wearing gloves before and discarding gloves and washing hands after touching any body substance. Direct care providers need to evaluate their interaction with the patient and use barriers such as

masks, eyewear, and gown based upon possible and anticipated contact with infectious aerosols, splashes, vomitus, etc. that may result during the contact.

c. If a patient has a disease that requires Transmission-based precautions, the nurse is responsible to triage persons wishing to enter the patient's room.

d. Any direct care provider who uses reusable equipment for a patient in contact precautions is responsible to disinfect that item before it is used for another patient.

e. The nurse and or caregiver is responsible to communicate to receiving departments the isolation status of a patient. This is accomplished by completing the Off Unit Transfer/Assessment: Type of Isolation/Precautions in the electronic medical record (EMR)

4. All direct care providers need to know their own hepatitis B, chicken pox, rubella and measles status and participate in the Medical Center's annual TB skin testing program. This participation is required by the hospital.

5. All direct care providers who have frequent contact with blood or body fluids should be immunized against hepatitis B. Free hepatitis vaccination is a benefit of employment at Tri-City Medical Center.

6. Specimen Labeling

   a. Standard Precautions tell us to consider all bodily fluids as potentially infectious regardless of the patients' diagnosis. Standard precautions need to be utilized while handling all specimens. (In 1990, the Clinical Laboratory established formal policies requiring that all specimens be handled as if potentially infectious. To place "blood and body fluid precautions" on specimen conveys the notion to others to treat this particular specimen with caution, but other specimen without the labeling need not be handled as carefully. If needed, it is permissible to note the patient's diagnosis on laboratory requests, pathology requests, radiology request, etc. Please note that it is illegal in the state of California to note a person's HIV status on requests).

7. Handling of soiled linen from patients' rooms

   a. All linen must be handled in a consistent and identical manner because there are no "infectious linen" designations under Standard Precautions. All linen leaves the Medical Center in unmarked plastic bags. The contract laundry, also regulated by OSHA and the state, requires workers to wear protective barriers when handling soiled linen at all times. Linen should be handled minimally.

8. Dishware and eating utensils

   a. The combination of hot water and detergents used in dishwashers is sufficient to decontaminate dishware and eating utensils. Therefore, no special precautions are needed for dishware (e.g., dishes, glasses, cups) or eating utensils; reusable dishware and utensils may be used for patients requiring Transmission-Based Precautions.

9. Disposal of waste from patients' rooms

   a. All trash generated from individual patient rooms follow general hospital waste guidelines. If waste is saturated and/or dripping with blood place in the red "Biohazard" trash. See Infection Control Policy: Blood borne Pathogen Exposure Control Plan.

10. All closed system fluid filled containers (e.g., Pleur-evac, auto transfusion, etc.) are to be disposed of as follows:

    a. Obtain a red "biohazardous" plastic bag from the soiled utility room.

    b. Place the container into the bag and tie it securely by gathering the circumference and using a single knot to close the bag. Be sure to reinforce the bag if there is a leak or if leaking is anticipated.

    c. If a patient's room does not have a "biohazard" waste receptacle, carry the red bag to the soiled utility room and place it into the labeled biohazard barrel.

    d. All suction canister liners and tubing should be changed every 24 hours or when ¾ full, whichever comes first. Suction canisters liners may be emptied in the hopper or treated with a Liquid Treatment System (LTS). Once the contents solidify, the LTS, the canister liner and its contents are discarded in the regular trash.

11. Wound Dressings

a. All wound dressings are to be disposed of in a manner as to confine and contain any body fluids that may be present. Wound dressings dripping with blood or bloody body fluids should be discarded in a red biohazard bag and placed into the biohazard barrel. Dressings with small amount of blood can be disposed of in the regular trash. Examples of these are IV dressings, trach site dressings, bandaids, gauze or cotton balls used in fingerstick glucose testing,

b. Small dressings can be enclosed in a disposable glove used to remove the dressing. Pull the glove off inside out containing the dressing inside of it. The dressing and gloves can be discarded into the regular trash container in the patient's room.

C. **STANDARD PRECAUTIONS:**

1. Standard Precautions are designed to reduce risk of transmission of blood-borne pathogens transmission of pathogens to and from mucus membranes and non-intact skin.
   a. All blood, body fluids, secretions, excretions (except sweat) are handled as if potentially carrying bloodborne pathogens. Clean gloves are required when touching non-intact skin and mucus membranes.
2. Elements of Standard Precautions
   a. All personnel should implement Standard Precautions at all times regardless of the patient's diagnosis
   b. Hand Hygiene: See Infection Control Policy: Hand Hygiene
      i. Respiratory Hygiene/Cough Etiquette education of healthcare facility staff, patients, and visitors is accomplished through New Employee and Physician Orientation, the patient hand book and signage posted at cough etiquette stations provided throughout the hospital. Tissues are provided along with hand hygiene solution and adult and child sized masks in patient waiting areas throughout the hospital.
   c. Gloves
      i. Wear gloves when touching blood, body fluids, secretions, excretions, contaminated objects, mucous membranes and non-intact skin.
      ii. Change gloves between tasks and procedures on the same patient when moving from one body site to another.
      iii. Remove gloves after use, before touching uncontaminated items and environmental surfaces, and before going to another patient.
      iv. Decontaminate hands immediately after removing gloves.
   d. Masks, Eye/Face Shields
      i. Wear a mask, eye protection or a face shield to protect mucous membranes of the eyes, nose, and mouth during procedures and activities that are likely to create splashes or sprays of blood, body fluids, secretions and excretions. (See Infection Control Policy: Blood borne Pathogen Exposure Control Plan, Appendix: Standard Precautions: Personal Precautions Equipment Table)
      ii. Wear a mask for insertion of catheters or injection of material into spinal or epidural spaces via lumbar puncture procedures (e.g., myelogram, spinal or epidural anesthesia).
   e. Gown
      i. Wear gown or plastic apron to protect the skin and prevent soiling of clothing during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions or excretions or cause soiling of clothing.
3. Flowers and Potted Plants
      i. Designate care and maintenance of flowers and potted plants to staff not directly involved with patient care
      ii. If plant or flower care by patient-care staff is unavoidable, instruct the staff to wear gloves when handling the plants and flowers and perform hand hygiene after glove removal

4. Patient Care Equipment
   a. Handle used patient care equipment contaminated with blood, body fluids, secretions and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to other patients and the environment.
   b. Ensure that reusable equipment is properly cleaned and disinfected before it is used for the care of another patient.
   c. Single use items should be discarded.
5. Environmental Control
   a. Routine cleaning and disinfection of environmental surfaces, beds, bedrails, bedside equipment, and other frequently touched surfaces per protocol.
6. Safe injection practices – see Patient Care Services: Medication Administration policy. The following practices apply to the use of needles, cannulas that replace needles, and, where applicable intravenous delivery systems:
   a. Use aseptic technique to avoid contamination of sterile injection equipment.
   b. Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use.
   c. Multi-dose vials should be dedicated to a single patient whenever possible. If multidose vials must be used both the needle or cannula and syringe used to access the multidose vial must be sterile.
7. Do not keep multidose vials in the immediate patient treatment area and store in accordance with the manufacturer's recommendations; discard if sterility is compromised or questionable.

D. **TRANSMISSION-BASED PRECAUTIONS:**

1. Transmission-based Precautions are used in addition to Standard Precautions for diseases that require extra barriers to prevent transmission.
   a. Types of Transmission-based Precautions:
      i. Airborne Precautions
      ii. Droplet Precautions
      iii. Contact Precautions
   b. See Type and Duration of Precautions - Disease Specific (FKA Short Sheet).
   c. Communicate and notify receiving department/services if patient requires Transmission-based Precautions (i.e. Airborne, Contact or Droplet Precautions).
2. Airborne Precautions
   a. In addition to Standard Precautions, use Airborne Precautions for patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei.
   b. Place patient in an Airborne Infection Isolation room AIIR with at least 6-12 air exchanges per hour, HEPA filtration and negative pressure. If the AIIR rooms are not available Engineering can assist with a temporary set-up. Every effort must be made to place a patient in an AIIR within 5 hours of identification.
   c. Wear respiratory protection (N95 respirator or Powered Air Purifying Respirator) when entering the room. See the Infection Control Policy: ATD: Tuberculosis Control Plan for more information.
   d. Minimize patient dispersal of microorganisms by placing a surgical mask (not an N95 respirator) on the patient during transport.
3. Droplet Precautions
   a. In addition to Standard Precautions, use Droplet Precautions for a patient known or suspected to be infected with organisms that are transmitted by droplets
   b. Place the patient in a private room or cohort patients who have the same infection with the same microorganism.
   c. Wear masks when entering the patient room.
   d. Mask patients during transport.
4. Contact Precautions
   a. In addition to Standard Precautions, use Contact Precautions for specified patients

known or infected or colonized with epidemiologically important microorganism that can be transmitted via direct contact with the patient or equipment in the patients environment such as MRSA and VRE. (See Infection Control Policy: Management of Patients with MDRO's)

b. Place patient in a private room or cohort patients who are carrying the same microorganisms. When a private room is not available and cohorting is not achievable, consider the epidemiology of the microorganism and the patient population when determining patient placement. First try to select someone with no invasive lines (IV, central line, foley, trach, etc.) or open wound. If this is not possible, then select someone with an invasive line that carries a low risk of infection, such as a peripheral IV or NG tube. Consultation with infection control staff is advised when there are questions about patient placement.

c. Gloves
   i. Wear gloves whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient (e.g. medical equipment, bed rails) Don gloves upon entry into the room or cubicle.

d. Gowns
   i. Wear a gown whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient. Don gown upon entry into the room or cubicle.
   ii. Remove gown and gloves and observe hand hygiene before leaving the patient-care environment

e. Dedicate the use of non-critical equipment to a single patient, when possible

f. Clean and disinfect commonly used items before use of another patient with hospital approved disinfectant

g. Patient transport
   i. Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients on Contact Precautions. Don clean PPE to handle the patient at the transport destination.
   ~~i.~~

E. PREGNANT HEALTH CARE WORKERS:

1. **Pregnant healthcare workers are not more likely to contract infections from patients.**
2. **Unless a pregnant healthcare worker is susceptible to a patient's infection, the HCW will provide the same care as provided by non-pregnant worker.**
3. **Restricting pregnant HCW from caring for patients with potentially transmissible infections is considered only for patients with parvovirus B19 and for patients with respiratory syncytial virus infections who are receiving ribavirin aerosol.**

~~E.~~F. RELATED DOCUMENT(S):

1. Clinical Syndromes or Conditions Warranting Empiric Transmission- Based Precautions in Addition to Standard Precautions
2. Infection Control Considerations for High-Priority (CDC Category A) Diseases that May Result from Bioterrorist Attacks or are Considered to be Bioterrorist Threats
3. Infection Control Policy: ATD: Tuberculosis Control Plan
4. Infection Control Policy: Blood borne Pathogen Exposure Control Plan
5. Infection Control Policy: Ebola Plan
6. Patient Care Services Policy: Medication Administration
7. Patient Care Services Policy: Neutropenic Precautions
8. Recommendations for Application of Standard Precautions for the Care of All Patients in All Healthcare Settings
9. Type and Duration of Precautions - Disease Specific (FKA Short Sheet)

~~F.~~G. REFERENCE(S):

1. Centers for Disease Control and Prevention (2017). CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Setting. Retrieved from https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/index.html
2. Grota, P. (Ed.). (2014) APIC Text of Infection Control and Epidemiology (4th ed). Washington DC: Association for Professionals in Infection control and Epidemiology, Inc.
3. Sehulster LM, Chinn RYW, Arduino MJ, Carpenter J, Donlan R, Ashford D, Besser R, Fields B, McNeil MM, Whitney C, Wong S, Juranek D, Cleveland J. Guidelines for environmental infection control in health-care facilities. Recommendations from CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Chicago IL; American Society for Healthcare Engineering/American Hospital Association; 2004.
4. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007 http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf

Tri-City Medical Center	Women and Newborn Services Neonatal Intensive Care Unit (NICU)
PROCEDURE:	**PERIPHERAL ARTERIAL LINE (PAL): INSERTION, MAINTENANCE, BLOOD SAMPLING, AND REMOVAL OF**
Purpose:	To facilitate the efficient aseptic and complication free insertion of a peripheral arterial line for monitoring blood pressure and obtaining arterial blood samples.
Equipment:	Non-sterile Gloves 2% chlorhexidine gluconate swabs Infusion solution IV tubing transducer 3 ml syringe Leur-lock t-connector 22 or 24 gauge angiocatheter Tape Transparent dressing IV infusion pump Light source transilluminator IV board Cotton balls **Closed needleless Micro Draw Device** **1ml or 3ml Self-venting or aspirating syringe (with or without heparin-pending labs ordered)**

A. **POLICY:**

1. Placement of a peripheral arterial line is done by a physician or **A**allied ~~h~~**H**ealth ~~p~~**P**rofessional (AHP).
2. Transparent dressing will be placed over the site for stabilization and to allow continuous visualization of skin around catheter insertion site.
3. ~~Excessive extension of extremity is to be avoided to prevent occlusion of artery.~~
4. ~~3.~~ Fingertips or toes are to be exposed so that circulatory status can be monitored.
5. ~~4.~~ Usual infusion is ½ NS or NS with 1 unit heparin/ml at a rate of 0.5 to 1 ml/hour. Infusions into PALs should not exceed 1 ml/hour.
6. ~~5.~~ Infusion is to run continuously on an infusion pump with a transducer to monitor blood pressure.
6. **Arterial Waveform should be monitored per NICU Standards of Care.**
7. No medications, glucose, blood products, or any rapid bolus will be administered through a PAL.
8. The physician or AHP will be notified if there is blanching, cyanosis, circulatory compromise, bleeding, dampened waveform or difficulty drawing blood from the PAL.

B. **PROCEDURE (ASSISTING WITH PAL INSERTION):**

1. Perform hand hygiene.
2. Confirm patient identity using two-identifier system.
3. Immobilize patient with developmentally supportive methods, such as swaddling.
4. Attach syringe containing heparinized flush solution to leur-lock **split septum** T-connector and flush the connector.
5. **If transilluminator is being used,** ~~Dim~~ **dim** lights ~~if transilluminator is being used~~ to visualize artery.
6. Provide pain management as indicated.
7. Don non-sterile gloves.
8. Assist with immobilizing the extremity during catheter insertion.

Department Review	Department of OB/GYN	~~Division of Neonatology~~ Perinatal Collaborative Practice	Department of Pediatrics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors	~~Administration~~
05/14, 04/16, **01/18**	n/a	06/14, **02/18**	n/a	n/a	07/14, 08/16, **06/18**	08/14, 10/16, **07/18**	08/14, 11/16	

~~8.~~**a. A rolled cloth under the neonate's wrist may assist with proper positioning.**

9. Assist the physician ~~or~~/AHP as necessary with cleansing the area of insertion using 2% chlorahexidine gluconate for 30 seconds and allow to dry for ~~1 minute.~~**30 seconds.**
10. Assist physician ~~or~~ /AHP as necessary with securing the line.
11. Connect the flushed tubing with the ~~Luer-Lok~~**leur lock** adapter to the arterial catheter.
12. Assist with ~~taping or~~ placement of an occlusive dressing **and line securement.**
13. Apply an arm or foot board. Dressing ~~is applied in a manner as to display all digits as much as possible.~~ **should be applied to allow visualization of toes/fingertips as much as possible.**
14. Attach T-connector to **primed** transducer and IV tubing. Unclamp the T-connector and begin fluid administration **as ordered**.
~~14.~~**15. Connect the pressure cable from the arterial transducer to the bedside monitor.**
~~15.~~**16.** Discard used supplies in appropriate receptacles, remove gloves, and perform hand hygiene.
~~16.~~**17.** Documentation ~~of~~ insertion in patient's **electronic** medical record **including**:
    a. Cannula size and type
    b. Location of arterial site
    c. Date and time of procedure
    d. Characteristics of waveform on monitor
    e. Perfusion of extremity

C. **MAINTENANCE:**

1. Assess the ~~neurovascular and peripheral~~-vascular status of the cannulated extremity immediately after catheter insertion and hourly or more often if warranted.
2. **Calibration:**
    ~~2.~~**a.** The transducer is calibrated **upon insertion,** once a shift and PRN:
        ~~a.~~**i.** Open the transducer stopcock to air by turning it off to the patient and loosening the non-vented cap while maintaining ~~sterility~~**integrity of line**.
        ~~b.~~**ii.** Maintain transducer at the level of the infant's ~~right atrium~~**heart**.
        ~~c.~~**iii.** Press "zero" on the monitor**, and then wait for second beep that signals completion.**
        ~~d.~~**iv.** Replace cap and close stopcock to air**, thus opening line to infusion.** ~~by opening stopcock to infant.~~
3. **Troubleshooting:**
    ~~e.~~**a.** If waveform dampens:
        i. Check site- including distal circulation.
        ~~i.~~**ii.** Check connections.
        ~~ii.~~**iii.** Flush transducer if bubbles are present. **Turn line off to patient prior to flushing transducer. Ensure the bubbles do not continue towards patient.**
        ~~iii.~~**iv.** Check selected pressure scale on monitor, **if too large or too narrow of a scale is selected, the waveform will not be visible**.
        ~~iv.~~**v.** Recalibrate transducer.
        ~~v.~~**vi.** Compare cuff blood pressure (BP) to arterial reading.
        ~~vi.~~**vii.** Change stopcock and transducer.
        ~~vii.~~**viii.** Notify physician if interventions do not correct waveform **or if line is unable to be utilized for lab draw**.
~~3.~~**4.** ~~Daily~~ **Documentation**:
    a. Hourly invasive blood pressure per Standards of Care.
    b. Cuff BP once per shift and prn.
    c. Hourly site checks including: ~~location,~~ site status, extremity color, waveform assessment.

D. **BLOOD SAMPLING:**

1. **Utilizing Closed Needleless (CN) Micro-Draw Device**
    a. **Equipment:**
        i. **CN Micro-Draw device**
        ii. **Vented syringe or specimen collection syringes**

iii. Non-Sterile gloves
iv. Labels
v. CHG swabs

b. Identify correct neonate using two identifiers.
c. Verify lab orders and labels.
d. Perform hand hygiene and don non-sterile gloves.
e. Prepare rubber injection port using CHG for 30 seconds.

2. Open and inspect CN Micro-draw device. Make sure vent plug is in place on the extension lines with the blue and red clamps. The protective cover should be on the CN Micro-draw blunt tube.
3. Clamp both extension tubing clamps on the CN Micro-draw device.
4. Remove white vent plug from extension line with red clamp.
5. Pull plunger back on self-venting syringe to needed blood sample volume, then attach syringe to red clamp extension line.
6. Clamp the split-septum T-connector tubing using the attached slide clamp.
7. Remove the protective cover on the Hummi blunt tube. Fully insert CN Micro-draw blunt tube into the center of the split septum T-connector hub until resistance is met.
8. Unclamp the blue clamp and allow clearance blood to flow into the extension tube until it meets the white vent plug. Immediately close the blue clamp.
9. Unclamp the red clamp and allow the appropriate blood sample volume to fill the collection syringe.
10. Close red clamp after the blood sample is drawn. While holding the T-connector hub securely, remove the CN Micro-draw device and blood sample syringe slowly.
11. Remove sample syringe from the microdraw device and set aside for testing.
12. Unclamp the slide clamp from the T-connector tubing and resume normal arterial monitoring.

~~D.~~13. Dispose of the CN Micro-draw device in a sharps container.

~~1. Equipment:~~
~~a. Non-sterile Gloves~~
~~b. 2% chlorhexidine gluconate swabs~~
~~c. ABG syringe sampling kit/lab tubes~~
~~d. 22-25 gauge needle~~
~~e. 2x2 gauze~~
~~2. Procedure:~~
~~a. Perform hand hygiene.~~
~~b. Confirm patient identity using two-identifier system.~~
~~c. Don non-sterile gloves.~~
~~d. Place 2x2 gauze under t-connector port.~~
~~e. Clean diaphragm with 2% chlorhexidine gluconate swab for 30 seconds.~~ ~~Allow to dry for 30 seconds.~~
~~f. Clamp t-connector close to the hub with attached clamp.~~ ~~Keep infusion pump running.~~
~~g. Insert needle into t-connector port.~~
~~h. Allow three drops of blood to flow onto 2x2 gauze.~~
~~i. Fill lab tubes directly from the needle hub by allowing the blood to drip directly into the lab tube.~~
~~j. For ABG sample, adjust plunger on the ABG syringe to the 0.2ml mark then insert the syringe into the needle hub and allow the syringe to fill.~~
~~k. Withdraw the needle carefully and activate the safety mechanism.~~
~~l. Release clamp on the t-connector, allowing backpressure from pump to flush line.~~
~~m. Dispose of needle in the sharps container.~~
~~n. Remove gloves and perform hand hygiene.~~
~~o. Label labs with the appropriate patient information.~~

E. **CATHETER REMOVAL:**

1. Perform hand hygiene.
2. Confirm patient identity using two-identifier system.
3. Don non-sterile gloves.
4. Turn infusion pump off and clamp the T-connector.
5. Remove dressing and tape.
6. Pull catheter out, applying pressure with a sterile gauze pad over the site while removing the catheter and assess intactness of catheter.
7. Apply pressure over insertion site with sterile 2x2 gauze **for 1-3 minutes to achieve hemostasis.**
8. Discard used supplies in appropriate receptacles.
9. Remove gloves and perform hand hygiene.
10. Document the procedure **and the neonate's tolerance** in the patient's medical record.

F. **REFERENCE(S):**

1. Bailey, T. (2015). Common invasive procedures. In M.T. Verklan, M. Walden (Eds.), *Core curriculum for neonatal intensive care nursing* (5th ed., pp. 282-315). St. Louis: Saunders.
2. Ikuta, L.M. & Beauman, S.S. (Eds.). (2011). Policies, Procedures, and Competencies for Neonatal Nursing Care. National Association of Neonatal Nurses.
3. Infusion Nurses Society (INS). (2011). Standards of practice. Vascular access site preparation and device placement. *Journal of Infusion Nursing, 35*(Suppl. 1), S44-S45.
4. MacDonald, M. G., Ramasethu, J. & Rais-Bahrami, K. (Eds.). (2012). *Atlas of procedures in Neonatology, 5th ed.* Lippincott Williams & Wilkins.
5. O'Grady, N.P. and others. (2011). Guidelines for the prevention of intravascular catheter-related infections, 2011. Centers for Disease Control and Prevention. Retrieved April 27, 2015, from http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 01/99

SUBJECT: Automatic I.V. to Oral Conversion

POLICY NUMBER: 8390-6012

REVISION DATE(S): 03/00, 02/03, 06/05, 07/06, 01/12, 06/14

Department Approval:	**~~03/17~~03/18**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**~~05/17~~05/18**
Medical Executive Committee Approval:	**~~06/17~~06/18**
Professional Affairs Committee Approval:	**~~07/17~~07/18**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**

1. To provide a process for changing select parenteral medications to the oral or enteral route when medically appropriate in order to reduce cost, hospital length of stay, and associated risks with continued intravenous therapy while maintaining equivalent clinical outcomes

B. **POLICY:**

1. The clinical pharmacist will review patient profiles, current progress notes, pertinent labs, and discuss patient status with the patient's nurse or physician to determine eligibility for IV to PO conversion. If the patient meets approved criteria, the clinical pharmacist will transition the patient to oral therapy upon authority of the Pharmacy and Therapeutics (P&T) Committee
2. Such therapeutic conversions will be reviewed and revised at least annually
3. A complete list of approved IV to PO conversions shall be available on the Tri-City Medical Center intranet (see attachment)

C. **PROCEDURE:**

1. IV to PO conversion may be executed by pharmacists after prescribers have been advised of the policy set forth by the Pharmacy and Therapeutics Committee. Such medication conversions will be automatic and notification to each individual prescriber will be communicated via a ~~progress note entered in the patient's chart~~**comment placed in the replacement order and/or a progress note entered in the patient's medical record.**

~~1.~~**2.** Only medications with prior P&T approval may be automatically converted by pharmacists

~~2.~~**3.** Pharmacists will evaluate all adult patients for potential IV to PO conversion after receiving at least one dose of intravenous therapy and have been hospitalized for at least 24 hours

   a. Exception: Orders for IV levothyroxine will be held for up to 5 days **since the last known dose** in patients that were **confirmed to be** compliant with oral therapy prior to admission unless specifically ordered by physician not to hold IV levothyroxine, endocrinology is consulting on the patient, or patient has been diagnosed with myxedema coma. The pharmacist will discontinue the original IV levothyroxine order and enter a "Levothyroxine Consult" order as a placeholder. During the 5 day hold period, the patient may be converted to oral levothyroxine if eligible per policy. If ~~after~~ 5 days **have lapsed since the patient's last known oral dose and the** patient remains ineligible for oral conversion, IV levothyroxine will be initiated as per the original order

~~3.~~4. If the patient is being considered for an IV to PO conversion, the clinical pharmacist will examine the route of therapy and determine if it is clinically appropriate to perform a parental to oral therapy switch

~~4.~~5. If the patient meets the approved criteria and none of the exclusion criteria for transition to oral therapy, the clinical pharmacist will enter a new order via CPOE using the same physician name as the original order and will include the drug name, dose, route, and frequency. Any special instructions and "per Pharmacy IV to PO Protocol" will be entered in the order comments. The order shall be electronically signed by the pharmacist, "Per Pharmacy Protocol." The pharmacist shall discontinue the intravenous medication ordered by the physician to prevent duplication in therapy

~~5.~~6. The new order stop date will be changed by the pharmacist to reflect that of the original order

~~6.~~7. If a drug-food interaction exists that can alter absorption of the medication (i.e levofloxacin and iron, antacids, calcium, sucralfate), the pharmacist will change administration times of the drug to avoid such interaction

~~7.~~8. In the event the physician wishes to opt out of automatic IV to PO conversion, the physician shall write in the order comments of the IV order "No IV to PO conversion." The physician may also order an Rx Note stating "No IV to PO conversion" to cover all medications. Such instructions should also be documented in the latest progress note.

~~8.~~9. Any orders that are changed back to the IV form **by the physician following conversion by a pharmacist to oral therapy** will be referred for clinical review and discussion with the prescribing physician

~~9.~~10. Prior to writing an order to change the medication to the oral (or enteral) route, all of the following criteria must be verified:

a. Inclusion Criteria:
   i. Patient is improving clinically
   ii. Tolerating food or enteral feeding for at least 24 hours (may be NPO if cleared for, and tolerating other oral medications)
   iii. Able to adequately absorb oral medications via the oral, gastric tube, or nasogastric tube route
   iv. Has not received anti-emetics within the last 24 hours
   v. Patient adherence to oral therapy is anticipated
   vi. Does not display signs of shock; not on vasopressor blood pressure support
   vii. Taking other medications via the oral, gastric tube, or nasogastric tube route
   viii. Does not have any contraindications to oral or enteral medication administration
   ix. Additional requirements for antimicrobials:
      1) Blood cultures negative at 72 hours
      2) Afebrile for at least 24 hours (T <100.4F or 38C)
      3) Heart rate ≤ 90 BPM
      4) Systolic blood pressure ≥ 90 mmHg (without vasopressor drugs)
      5) RR ≤ 20 BPM
      6) Signs and symptoms of infection have improved or abated
         a) Improving or normalized WBC and differential counts
         b) Clinical improvement at site of infection
         c) Hemodynamically stable
         d) Patient is not septic
         ~~d)~~

c. Exclusion Criteria:
   i. Persistent nausea, vomiting and/or diarrhea
   ii. Difficulty swallowing, refuses oral medication, or is strict NPO for a procedure
   iii. Altered mental status or aspiration risk and no NG access
   iv. Experienced severe trauma within last 72 hours
   v. Patient with the following GI conditions:
      1) Known or suspected ileus with no active bowel sounds

2) Known or suspected malabsorption syndrome, motility disorder, short bowel syndrome, partial or total removal of the stomach
3) Known or suspected gastrointestinal obstruction
4) High nasogastric output (greater than 500ml/day) or requiring continuous GI suction
5) Continuous tube feedings that cannot be interrupted and patient requires a medication known to bind to enteral nutrition formulas (levothyroxine)
6) Active GI bleed
7) Receiving neuromuscular blocking agents

vi. Cystic Fibrosis exacerbation
vii. Patients with Grade III or IV mucositis
viii. Wernicke's encephalopathy (Utilizing high dose thiamine 500 mg IV q8h x 48 hours then 500 mg IV daily x 5 days. May switch to thiamine 100 mg po daily indefinitely once tx course complete)
ix. Hx of heavy ETOH use (Must receive 100 mg IV daily for at 3-5 days prior to thiamine interchange)
x. Myxedema coma or if endocrine consulting (for IV levothyroxine)
xi. Actively seizing or at high risk for recurrent seizures or if neurology consulting (for levetiracetam)
xii. Patient's condition is rapidly changing such that their ability to tolerate oral medication may be compromised within the next 24 hours
xiii. Any situation in which the patient is currently receiving other oral medication and/or food but the pharmacist or other healthcare provider questions the current suitability of this route
xiv. Additional requirements for antimicrobials

1) Patient has a serious or life threatening infection which include but not limited to: Meningitis, endocarditis, endovascular infections, inadequately drained abscess or empyema, necrotizing fasciitis, osteomyelitis, septic arthritis, bacteremia, legionella pneumonia, invasive candidiasis
2) Immunocompromised (i.e on concomitant immunosuppressive, recent chemotherapy, chronic steroid use, HIV infection)
3) WBC less than (<) 4 or greater than (>) 12 or ANC < 500
4) Temp ≥ 100.4F or 38C or Temp ≤ 98.6F or 36C
5) HR> 90 BPM or SBP< 90 mmHg
6) RR greater than (>) 20 BPM or PaCO2 greater than (>) 32 mmHg
7) Candidemia or bacteremia treated less than 7 days
8) Other infections which require extended intravenous therapy
9) Severe C.dif requiring IV metronidazole and oral vancomycin where switching to oral metronidazole offers no benefit

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

1. Automatic I.V. to Oral Conversion Medication Tables

Automatic I.V. to Oral Conversion Medication Tables

Table 1: GI drugs Eligible for IV to PO Conversion			
Dosing Suggestions			
Indication	**IV Regimen**	**PO Regimen**	**Enteral Feeding tubes**
SRMD Prophylaxis	Pantoprazole 40mg IV q24h Famotidine 20mg IV q12h	Pantoprazole 40mg PO AC-BFK Famotidine 20mg po BIDAC	~~Lansoprazole 30mg DHT/NG/OG/PEG q24h~~ Famotidine 20mg DHT/NG/OG/PEG q12h
***NSAID-induced ulcer prophylaxis**	Pantoprazole 40mg IV q24h Famotidine 20mg IV q12h	Pantoprazole 20mg PO AC-BFK Famotidine 20mg po BIDAC	~~Lansoprazole 15mg DHT/NG/OG/PEG daily~~ Famotidine 20mg DHT/NG/OG/PEG q12h
***Symptomatic GERD**	Pantoprazole 40mg IV q24h Famotidine 20mg IV q12h	Pantoprazole 20mg PO AC-BFK Famotidine 20mg po BIDAC	~~Lansoprazole 15mg DHT/NG/OG/PEG daily~~ Famotidine 20mg DHT/NG/OG/PEG q12h
***Erosive esophagitis**	Pantoprazole 40mg IV q24h Famotidine 20-40mg IV q12h	Pantoprazole 40mg PO AC-BFK Famotidine 20-40mg po BIDAC	~~Lansoprazole 30mg DHT/NG/OG/PEG daily~~ Famotidine 20-40mg DHT/NG/OG/PEG q12h
***Hypersecretory Disorders**	Pantoprazole 80mg IVP BID Famotidine 20mg IV q6h	Pantoprazole 40mg PO AC-BFK Famotidine 20mg po q6h	~~Lansoprazole 60mg DHT/NG/OG/PEG daily~~ Famotidine 20mg DHT/NG/OG/PEG q6h
***Active duodenal ulcer**	Pantoprazole 40mg IVP BID Famotidine 20mg IV q12h	Pantoprazole 20mg PO AC-BFK Famotidine 40mg po QHS or 20mg BIDAC	~~Lansoprazole 15mg DHT/NG/OG/PEG daily~~ Famotidine 40mg DHT/NG/OG/PEG q24h or 20mg q12h
***Active gastric ulcer**	Pantoprazole 40mg IVP BID Famotidine 20mg IV q12h	Pantoprazole 40mg PO AC-BFK Famotidine 40mg po QHS	~~Lansoprazole 30mg DHT/NG/OG/PEG daily~~ Famotidine 40mg DHT/NG/OG/PEG q24h

Table 2: Antimicrobials Eligible for IV to PO conversion		
IV Drug Regimen:		**Convert to:**
Drug	**IV Dose**	**Oral Conversion**
Azithromycin	250mg IV q24h 500mg IV q24h	250mg po q24h 500mg po q24h
Ciprofloxacin	400mg IV q24h 400mg IV q12h 400mg IV q8h	500mg po q24h or 250mg po q12h 500mg po q12h 750mg po q12h
Doxycycline	100mg IV q12h	100mg po q12h
Fluconazole	100mg-400mg IV q24h	100mg-400mg po q24h
Levofloxacin	250mg-750mg IV q24h-q48h	250mg-750mg po q24h-q48h
Linezolid	600mg IV q12h	600mg po q12h
Metronidazole	250mg IV q6h or q8h 500mg IV q6h or q8h	250mg po q6h-q8h 500mg po q6h-q8h
Sulfamethoxazole/trimethoprim (Bactrim or Septra)	5-10mg/kg/day TMP in divided doses 15-20mg/kg/day TMP in divided doses	5-10mg/kg/day TMP in divided doses 15-20mg/kg/day TMP in divided doses

Table 3: All Other Medications Eligible for IV To PO Conversion		
IV Drug Regimen:		**Convert to:**
Drug	**IV Dose**	**Oral/Enteral Feeding tube Conversion**
Acetaminophen	**1000 mg IV Q6H**	**1000 mg PO Q6H**
Levothyroxine	12.5mcg-100mcg IV daily	2 x IV dose (25mcg-200mcg po AC-BFK)
Levetiracetam	250-1500mg IV q12h-q24h	250-1500mg po q12h-q24h (same dose regimen)
Thiamine	100mg IV q24h	100mg po q24h (same dose regimen)
Folate	0.5-1mg IV q24h	0.5-1mg po q24h (same dose regimen)

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 03/00 **SUBJECT: Decreasing Medication Errors**

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

Department Approval:	**~~03/15~~02/18**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**~~06/05, 07/06, 07/09, 1/12, 07/15~~05/18**
Medical Executive Committee Approval:	**~~06/05, 07/06, 07/09, 1/12, 08/15~~06/18**
Professional Affairs Committee Approval:	**~~09/15~~07/18**
Board of Directors Approval:	**~~06/05, 07/06, 07/09, 1/12, 09/15~~**

A. **POLICY**:

1. It is the policy of Tri-City Healthcare District (TCHD) to take a proactive approach by focusing performance improvement activities toward reducing medication errors. Staff is reminded that errors can occur at any step of the process: prescribing, ordering, dispensing, administering or monitoring the effects of the medication.
2. The Institute for Safe Medication Practices (ISMP) has identified some common sources of errors:
   a. Unavailable patient information prior to dispensing or administering a drug (lab values, allergies, etc.)
   b. Unavailable drug information (written resources)
   c. Miscommunication of drug orders (similar names, use of zeros, inappropriate abbreviations, poor handwriting)
   d. Problems with labeling, packaging
   e. Drug Standardization, storage (stocking multiple concentrations of the same drug, look-alike containers)
   f. Drug device use and monitoring (lack of standardization in drug delivery devices, unsafe equipment)
   g. Environmental stress (distractions, noise during transcription or dispensing, long work hours)
   h. Limited staff education
   i. Limited patient education
3. The Institute of Safe Medication Practices also determined that a majority of medication errors resulting in death or serious injury were caused by "high alert medications":
   a. Insulin
   b. Opiates and narcotics
   c. Injectable potassium chloride (or phosphate) concentrate
   d. Intravenous heparin
   e. Sodium chloride solutions above 0.9%
4. TCHD has adopted the following strategies to decrease the incidence of medication errors:
   a. A unit dose system of medication distribution has been implemented.
   b. Information on ordered medications will be produced on the nursing units and provided, in writing, for the patient/family on discharge. The Pharmacist will be available to counsel patients on complex drug therapies.
   c. The Pharmacy and Therapeutics Committee has developed standardized practices for prescribing medications:
      i. All drug orders must be written in the metric system. Units must be spelled out.
      ii. Medication orders must include the name of the drug, dosage amount and form.
      iii. A leading zero (0) must always precede a decimal point for a dose less than one (1); a trailing zero (0) is never to be used after a decimal.

iv. The use of unapproved abbreviations (see Patient Care Services Policy: Use of Abbreviations) will be avoided.

d. Storage of medications will assist in distinguishing similar products from one another.

e. There will be special awareness with appropriate safeguard policies followed in the ordering, storage and administration of the identified "high-risk drugs".

f. Staff are encouraged to report medication errors which are then reviewed, trended, and reported to the Pharmacy and Therapeutics Committee.

g. Medication event reporting shall be done according to Administrative Policy Incident Report - Quality Review Report (QRR) RL Solutions 396.

h. The physician shall be notified of all medication errors upon discovery. If there was no harmful outcome from the error, the notification may take place during the next business day.

B. **RELATED DOCUMENTS:**

1. Patient Care Services Policy: Use of Abbreviations
2. Administrative Policy: Incident Report-Quality Review Report (QRR) RL Solutions 396

Tri-City Medical Center
Oceanside, California

PHARMACY ~~SERVICES POLICY~~

ISSUE DATE: 09/91

SUBJECT: Drug Samples

POLICY NUMBER: 8390-2009

REVISION DATE(S): 12/91, 01/97, 07/00, 02/03, 06/04, 04/05, 06/05, 07/06, 07/09, 10/10, 02/12, 01/14

Department Approval:	**04/18**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**~~12/91, 6/04, 01/97, 07/00, 02/03, 06/05, 07/06, 07/09, 2/12, 3/14~~05/18**
Medical Executive Committee Approval:	**~~12/91, 6/04, 01/97, 07/00, 02/03, 06/05, 07/06, 07/09, 2/12, 5/14~~06/18**
Professional Affairs Committee Approval:	**~~6/14~~07/18**
Board of Directors Approval:	**~~12/91, 6/04, 01/97, 07/00, 02/03, 06/05, 07/06, 07/09, 2/12, 6/14~~**

A. **DEFINITIONS:**

1. Drug Samples are prescription medications packaged as one or more dosage units by a manufacturer or distributer in accordance with Federal and State statues. Drug samples are provided by a pharmaceutical company to a licensed practitioner free of charge. A drug ~~of~~ sample is not intended to be sold and is intended to promote the eventual sale of the drug. A drug sample may be a packet, card, blister pack, bottle, container, or other single package that is provided to a patient in an unbroken or unopened condition. Drug samples include dose titration packages and starter kits.

B. **POLICY:**

1. The use of drug samples is not permitted for inpatients or outpatients within this hospital.

C. **EXCEPTION:**

1. The Behavioral Health Unit (BHU) may request samples be provided directly from the drug company representative to the pharmacy department pursuant to a written request from the prescribing practioner for certain non-formulary medications in the event that no other source of supply is available to the pharmacy. The pharmacy will store these samples in a locked area apart from other hospital stock, ~~monitor samples for expiration date~~**and ensure sample drugs are not expired** ——prior to dispensing to the BHU. These samples will be used for inpatient administration only and will not be dispensed for outpatient use.
2. Patient-Own-Med: Will be considered on a case by case basis in the event that no other source of supply is available to the pharmacy. Approval required by Clinical Manager.

D. **PROCEDURE:**

1. General use:
   a. Drug samples shall be provided only by licensed practioners in accordance with state laws and regulations
   b. A written request for drug samples shall be made on a form which contains the practitioner's name, address, and professional designation, the identity of the drug sample requested, the quantity of drug samples requested, the name of the manufacturer or distributor of the drug sample, the date of the request and signature of the practitioner making the request.

c. The pharmacy must keep copies of a practitioner's written request for drug samples for at least 3 years
d. Drug samples shall not be given for long-term use or maintenance therapy, unless they are part of a program that includes pharmacy dispensing and traditional safety checks that are provided by a pharmacist
e. The pharmacy is responsible for the procurement, distribution, and control of all drugs, including drug samples used in the institution

2. Prescribing, packaging, labeling, dispensing
   a. Drug samples must be dispensed in the original packaging and at a minimum will include the following:
      i. Drug name and drug strength
      ii. Lot number and expiration date
      iii. Only one dosage unit per blister, when blister packaging is used
      iv. Manufacturer-provided information as required by the FDA (i.e. medication guide)
   b. Multiple doses may be packaged in a manner that preserves labeling for each dose (i.e., the label of each dose will contain the drug's name, strength of medication, lot number, and expiration date)
   c. An order will be entered via CPOE and verified by the pharmacist as ~~NF-Drug Sample~~**TNF-MED "DRUG SAMPLE -** Name of Drug."
   d. An NDC number shall be assigned to each drug sample to facilitate electronic documentation and tracing of drug samples
   e. A BCMA label with the patient name and specific instructions for use will be affixed to the container dispensed
   f. Prior to dispensing of drug samples, the pharmacist shall check the expiration date and visually examine the product's integrity
3. Storage and handling
   a. Drug samples shall be safely stored and in accordance with the manufacturer's labeling.
   b. All expired, damaged, or deteriorated drug samples shall be immediately removed and disposed of properly
   c. Once appropriately labeled, the drug sample will be loaded for patient-specific use and stored in the BHU/inpatient unit Pyxis.
   d. Upon discontinuation of the drug or patient discharge, the pharmacy will be notified by nursing so that the drug sample can be unloaded from the Pyxis and returned to pharmacy or to the patient (if Patient Own Med).
4. Monitoring and record keeping
5. Patient-specific information (i.e. medical record) shall be readily available to the pharmacist at the time that sample medications are provided to patients for the purpose of checking for interactions/contraindications
6. Patients taking drug samples shall be monitored for therapeutic effect and adverse events.
7. Prescribers shall document in the patient's medical record drug samples given to patients as they would any other medication
8. Drug samples shall be included in any list of medications that is communicated to another provider or care setting.

E. REFERENCES:

1. Federal Food, Drug, and Cosmetic Act (FD&C Act). Prescription Drug Marketing Act of 1987. Section 5: Distribution of Drug Samples.
2. NCC MERP. Recommendations for Avoiding Medication Errors with Drug Samples. http://www.nccmerp.org/council/council2008-01.html
3. ASHP. Drug Distribution and Control: Distribution–*Technical Assistance Bulletins.* http://www.ashp.org/DocLibrary/BestPractices/DistribTABHosp.asp

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 01/90

SUBJECT: Emergency Medication Tray for Crash Cart

REVISION DATE: 05/94, 03/97, 10/99, 08/02/ 06/05, 07/06, 07/09, 01/12

Department Approval ~~Date(s)~~:	~~03/15,~~ 04/18
Medical Staff Department/Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval ~~Date(s)~~:	~~02/03, 06/05, 07/06, 7/09, 1/12, 03/15~~05/18
Medical Executive Committee Approval ~~Date(s)~~:	~~02/03, 06/05, 07/06, 7/09, 1/12, 04/15~~06/18
Professional Affairs Committee Approval ~~Date(s)~~:	~~05/15~~07/18
Board of Directors Approval ~~Date(s)~~:	~~02/03, 06/05, 07/06, 7/09, 1/12,~~ 05/15

A. **POLICY**:

1. This hospital maintains mobile supplies of emergency equipment and medications (crash carts) inpatient care areas of the hospital and at designated off-site clinics. The Code Blue Committee determines which medications will be stocked in these carts and the Pharmacy and Therapeutics Committee approves final recommendations. The Pharmacy Department is responsible for the integrity and security of medications contained in the crash carts.

B. **PROCEDURE**:

1. The emergency drug supply is stored in a clearly marked portable container. The contents of the container are listed and visible on or within the container and include the earliest expiration date of the drugs within.
2. The emergency medication tray will be filled by pharmacy personnel.
3. The emergency medication tray will be checked by a pharmacist or pharmacist intern.
4. The pharmacy personnel checking the emergency medication tray will verify contents, quantities, and expiration dates, then lock the tray with a lock that must be broken in order to gain access to the medications.
5. The first to expire medication, date of expiration, and lock number of the lock used to seal the tray will be included on a label which will be placed on the crash cart medication drawer.
6. Prior to placing the final lock on the crash cart, pharmacy personal will inspect IV solutions placed in the cart by Sterile Procedures Department personnel.
7. In an effort to confirm the integrity of the crash cart, when performing monthly area unit inspections, the pharmacy personnel performing the inspection will confirm the lock number on the crash cart matches the lock number recorded on the current crash cart checklist. If there is any question of integrity at that time the most appropriate person to address the matter will be notified.

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 12/13

SUBJECT: Employee Theft or Impairment

REVISION DATE:

Department Approval:	**04/18**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**~~11/13~~05/18**
Medical Executive Committee Approval:	**~~12/13~~06/18**
Professional Affairs Committee Approval	**07/18**
Board of Directors Approval:	**12/13**

A. **PURPOSE:**
1. To set the expectation for individuals employed with in the pharmacy department if suspected of chemical, mental or physical impairment, theft, or drug diversion.

B. **DEFINITIONS**:
1. Impairment: a symptom of reduced quality or strength
2. Theft: the wrongful taking and carrying away of the personal goods or property of another.
3. Drug Diversion: any criminal act or deviation that removes a prescription drug from its intended path from the manufacturer to the patient or return/waste.

C. **POLICY**:
1. If an employee is suspected of impairment, theft or drug diversion it shall be brought to the attention of the employee's direct supervisor and the Pharmacist in Charge (PIC) immediately.
    a. The supervisor or PIC will evaluate to determine the need for immediate intervention in compliance with existing hospital policies (Alcohol and Drug Testing Guidelines for Employees Policy 429, Coaching and counseling for Work Performance Policy# 8610-424, Locker Entry by Force, Security Department SDPPM #206)
        i. Immediate intervention can include drug or alcohol testing (in compliance with Health and Safety Policy 429)
        ii. If immediate intervention is not deemed necessary, a formal investigation will be launched.
            1) Based on the results of the investigation, further action taken may be up to and including termination.
            2) The seriousness of the violation, the position or responsibility held by the employee, and past record of employment are all things that will be considered in determining whether to suspend, transfer, terminate, or take other actions against the employee.
            3) The pharmacy shall report to the Board of Pharmacy within 14 days of the receipt or development thereof the following information with regard to any licensed individual employed with the pharmacy:
                a) Any admission by a licensed individual of chemical, mental, or physical impairment affecting his/her ability to practice.
                b) Any admission by a licensed individual of theft, diversion, or self-use of dangerous drugs.
                c) Any video or documentary evidence demonstrating chemical, mental, or physical impairment of a licensed individual to the extent it affects his/her ability to practice.

d) Any video or documentary evidence demonstrating theft, diversion, or self-use of dangerous drugs by a licensed individual.
e) Any termination based on chemical, mental, or physical impairment of a licensed individual to the extent it affects his/her ability to practice.
f) Any termination of a licensed individual based on theft, diversion, or self-use of dangerous drugs.

4) A copy of the report to the Board of Pharmacy will be kept in the pharmacy and readily retrievable for three (3) years.
5) The CEO of Tri-City Medical Center will be notified immediately if an employee is terminated for any of the above reasons.

2. According to the Drug Enforcement Agency (DEA), theft of a controlled substance from a pharmacy is a criminal act and a source of diversion that requires notification to DEA.
   a. A designated person within the pharmacy department must notify in writing the local DEA Diversion Field Office within one business day of discovery of a theft of controlled substance.
   b. The designated person must also complete a DEA Form 106 (Report of Theft or Loss of Controlled Substances) which can be found online at http://www.deadiversion.usdoj.gov/ under the Quick Links section.
   c. If, after initial notification to DEA, the investigation of the theft determines no such theft, a DEA Form 106 does not need to be filed. However, the registrant must notify DEA in writing of this fact in order to resolve the initial report and explain why no DEA Form 106 was filed regarding the incident.
   d. A copy of the DEA Form 106 shall be printed, kept in the pharmacy and readily retrievable for three (3) years.
3. The pharmacy may also choose to notify local law enforcement depending on the severity of the violation.
4. An employee who has knowledge of drug diversion by a fellow employee has an obligation to report such information to their supervisor or PIC. Failure to report will result in action up to and including termination of employment.

D. **RELATED DOCUMENTS:**
1. **Administrative Policy: Alcohol and Drug Testing Guidelines for Employees - 429**
2. **Administrative Policy: Coaching and counseling for Work Performance Policy - 424**
~~4.~~3. **Security Policy: Locker Entry by Force - 206**

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 05/94

SUBJECT: Floor Stock

REVISION DATE: 02/97, 08/00, 02/03, 06/05, 07/06, 01/12, 5/15

Department Approval:	**~~05/15,~~ 04/18**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**~~02/03, 06/05, 07/06, 07/09, 1/12, 05/15~~05/18**
Medical Executive Committee Approval:	**~~02/03, 06/05, 07/06, 07/09, 1/12, 06/15~~06/18**
Professional Affairs Committee Approval:	**~~07/15~~07/18**
Board of Directors Approval:	**~~02/03, 06/05, 07/06, 07/09, 1/12,~~ 07/15**

A. **POLICY:**

1. Responsibility for control of floor stock medications within this hospital rests with the Pharmacy Department. Policies and procedures are designed to ensure the safe and accurate dispensing of medications throughout the hospital.

B. **PROCEDURE**:

1. Floor Stock: Medications that are maintained outside of an Automated Dispensing Machine (ADM) in specific areas of the hospital. These medications are intended for use by physician/Allied Health Professionals with appropriate clinical privileges who are responsible for ordering, preparing and administering drugs.
   a. Medications contained in floor stock are stored in a secured, locked cabinet. Responsibility for security of the floor stock rests with the supervising licensed practitioner or nurse overseeing the unit in which the floor stock is stored.
   b. Medications contained in floor stock are stored under the conditions listed by the medication manufacturer to ensure stability.
   c. Medications designated as floor stock are requisitioned from the Pharmacy Department by the nurse or practitioner in quantities sufficient for anticipated needs.
   d. As with all other medications, all floor stock used to prepare medications (i.e diluent bags, diluent vials, etc) are accurately labeled with contents, expiration dates and appropriate warnings.
   e. Controlled substances designated as floor stock are requisitioned according to Pharmacy Policy Controlled Substances, stored in a securely locked, substantially constructed cabinet and inventoried weekly by two licensed personnel.
2. Inspection: All floor stock supplies within the hospital will be inspected monthly by the Pharmacy Department. A report of inspection will be maintained by the Pharmacy Department. Reports noting any discrepancies will be reviewed by the pharmacist in charge and shared with the supervising personnel of the unit involved.

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 12/11

POLICY: Formulary System

REVISION DATE: 02/12

Department Approval Date(s):	**~~03/15,~~ 03/18**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**~~01/12, 03/15~~ 05/18**
Medical Executive Committee Approval:	**~~02/12, 04/15~~ 06/18**
Professional Affairs Committee Approval:	**~~05/15~~ 07/18**
Board of Directors Approval:	**~~02/12,~~ 05/15**

A. **PURPOSE**:
1. To address the process for addition, removal, and restriction of pharmaceutical agents at Tri City Medical Center (TCMC).
2. The formulary system is operated under the auspices of the Pharmacy and Therapeutics (P&T) Committee to promote rational, cost-effective use of medications at Tri-City Medical Center.

B. **DEFINITIONS**:
1. Formulary System: An ongoing process through which a healthcare -organization establishes policies regarding the use of medications, therapies, and drug-related devices and identifies those that are most medically appropriate and cost-effective to best serve the health interests of a given patient population.
2. Formulary: a continually updated list of medications and related information, representing the clinical judgment of physicians, pharmacists, and other experts in the diagnosis, prophylaxis, or treatment of disease and promotion of health. A formulary includes, but is not limited to, a list of medications and medication-associated products or devices, medication-use policies, important ancillary drug information, decision-support tools, and organizational guidelines.

C. **ROLE OF THE PHARMACY AND THERAPEUTICS COMMITTEE:**
1. The P&T Committee is responsible for overseeing the effective and efficient operation of the formulary system. The Committee is responsible to the Medical Staff as a whole, and its policy recommendations are subject to approval by the Executive Committee as well as to the normal administrative approval process. The Committee assists in the formulation of broad professional policies relating to medications in the hospital, including their evaluation, selection, procurement, storage, distribution, administration, and use.
2. It is the responsibility of the P&T Committee to provide integrity to the formulary system by assuring current, consistent prescribing practices of medications designated as "formulary" medications and such medications are routinely stocked in the pharmacy, unless mechanisms for more rapid resupply or transfer is in place.

D. **FORMULARY DESIGNATION:**
1. Only those considered to be most cost-effective in patient care shall be designated as formulary medications.
2. The P&T Committee shall at minimum evaluate the following before designating a medication as formulary:
   a. Indications for use
   b. Effectiveness
   c. Drug interactions
   d. Potential for errors and abuse

e. Adverse drug events
f. Sentinel event advisories
g. Population(s) served (e.g., pediatrics, geriatrics)
h. Contraindications and Precautions
i. Costs compared to formulary alternatives

3. The organization shall have the appropriate capability to monitor patients' response to medications before the product will be added to the formulary, dispensed, or administered.
4. These medications are listed in the formulary; only formulary medications are routinely stocked and available from the pharmacy.
5. Only those medications that have been approved by the Food and Drug Administration (FDA) shall be considered for formulary addition. Therefore, investigational medications do not meet criteria for formulary addition.
6. The Department of Pharmacy is responsible for selecting, from available generic equivalents, those medications to be dispensed pursuant to a physicians order for a particular drug product. Generally, this choice is consistent with competitive bids awarded TCMC by group purchasing organizations.
7. Medications designated on the formulary shall be reviewed at least annually based on emerging safety and efficacy information, cost-effectiveness data, and inventory control standards.
   a. Pharmacy shall report the result of the annual review of the formulary to the P&T Committee
8. The Department of Pharmacy shall maintain an approved formulary list in Cerner

E. **ADDITION OF PHARMACEUTICAL AGENTS TO FORMULARY:**

1. It shall be the responsibility of the requesting practitioner (MD, DO, PharmD) to complete all paperwork necessary for addition of pharmaceutical agents to the TCMC formulary.
2. Pharmacy shall be responsible for determining acquisition costs, costs of therapy, and cost comparisons for therapeutically equivalent agents.
3. Pharmacy shall arrange for the requested pharmaceutical agent to be presented at the Pharmacy and Therapeutics committee in a timely fashion for review and approval to the formulary.
4. The requesting practitioner may provide written recommendations to the P&T committee or be present at the P&T committee when the pharmaceutical agent is being presented for review.
5. Requesting practitioners must disclose any and all "conflicts of interest" related to the pharmaceutical agent being requested to the Pharmacy and Therapeutics Committee.
6. Pharmacy shall notify all affected prescribers and/or departments once a medication is approved through P&T.

F. **REMOVAL OF AGENTS FROM THE FORMULARY:**

1. Pharmacy shall consult with all necessary practitioners with an expertise related to the pharmaceutical agent before requesting removal at the Pharmacy and Therapeutics Committee.
   a. Pharmacy shall document all communications with practitioners in this matter
2. Pharmacy shall notify all appropriate TCMC committees/departments of the proposal for removal of a medication prior to presentation at the Pharmacy and Therapeutics Committee.
3. Agents proposed by the Department of Pharmacy for removal from the formulary shall be presented at the Pharmacy and Therapeutics Committee.
4. The Department of Pharmacy shall present to the Pharmacy and Therapeutics committee evidenced based reasons for removal of agents from the formulary that include cost savings and pharmaceutical and therapeutically equivalent alternatives already on TCMC formulary.
5. Pharmacy shall notify all affected prescribers and/or departments once a medication is removed from the formulary.

G. **RESTRICTION OF FORMULARY AGENTS:**

1. The department of pharmacy will work with TCMC physicians to create criteria for use for pharmaceutical agents both formulary and non-formulary.
2. Formulary medications may be considered for restriction by the Pharmacy and Therapeutics Committee when they meet one or more of the following criteria:

a. The drug has limited therapeutic use that requires expertise in that area
b. Inappropriate use might result in excessive or unnecessary expenditures
c. The medication is a high risk agent with potential problems due to adverse effects or toxicity
d. Other reasons as deemed appropriate by the Pharmacy and Therapeutics Committee

3. Formulary medications may be restricted to use, either by a medical service (e.g., oncology), prescribing criteria (e.g., specific indications), or patient care area (e.g., Intensive Care Unit).
4. A current list of restricted medications will be maintained on the Department of Pharmacy website **(Formulary Keeper)**.
5. Physicians requesting the use of a medication outside its established restriction shall fill out the Pharmacotherapy Utilization form (See Appendix 1).
6. Pharmacy service shall create a method to administer restricted agents outside their restriction when necessary. This may involve one or more of the following:
   a. Case by case review of each request within the pharmacy, and if necessary input a Pharmacy and Therapeutics Committee chairperson.
   b. Obtaining a consult from an authorized prescriber.
   c. Moving a patient to the needed area for proper treatment.
7. Pharmacy shall notify all affected prescribers, TCMC departments and/or committees of the proposal to restrict a pharmaceutical agent prior to presentation at the Pharmacy and Therapeutics committee.

H. **FORMULARY STATUS OF NEW MEDICATIONS:**

1. New medications approved by the FDA, but not yet considered for formulary addition by the Pharmacy and Therapeutics Committee shall be considered non-formulary until the P~~+~~&~~+~~T Committee has reviewed these medications. Prior to the P~~+~~&T Committee deliberation, use of the medications shall conform to the non-formulary medication use process.

I. **OBTAINING NON-FORMULARY MEDICATIONS:**

1. When a non-formulary medication is prescribed, a pharmacist shall contact and inform the prescribing physician that the medication is non-formulary and not stocked in the pharmacy. The pharmacist shall inform the physician of other formulary alternatives available.
2. If the physician determines that the non-formulary medication is needed, approval must be obtained from the Clinical Pharmacy Manager. For tracking purposes, the physician or pharmacist must fill out the Pharmacotherapy Utilization form documenting why the medication is needed (See Appendix1). The medication will then be obtained by pharmacy for a specific patient.
3. Non-formulary medications are normally obtained within 24 hours, but may take longer depending on when the order is received and product availability. The P&T Committee may deem some products not to be ordered, dispensed, or stocked, even on a non-formulary request basis.

J. **MONITORING OF NON-FORMULARY MEDICATION PRESCRIBING:**

1. The Clinical Pharmacy Manager shall compile and analyze data regarding non-formulary medication use as appropriate and report findings to the P&T Committee.
2. The Committee shall determine appropriate action necessary to maintain the integrity of the formulary system. This may include:
   a. Reconsidering a medication formulary addition
   b. Undertaking educational efforts to reduce inappropriate prescribing
   c. Imposing prescribing restriction

K. **FORMS/RELATED DOCUMENTS:**

1. Pharmacotherapy Utilization Form

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 01/72

SUBJECT: Hours of Operation and Authorized Access to the Pharmacy

REVISION DATE: 01/75, 01/80, 01/90, 01/00, 06/05, 07/06, 07/09, 01/12

Department Approval Date(s):	**~~03/15,~~ 02/18**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**~~06/05, 07/06, 07/09, 1/12, 03/15~~05/18**
Medical Executive Committee Approval:	**~~06/05, 07/06, 07/09, 1/12, 04/15~~06/18**
Professional Affairs Committee Approval Date(s):	**~~05/15~~07/18**
Board of Directors Approval:	**~~06/05, 07/06, 07/09, 1/12,~~ 05/15**

A. **POLICY**:

1. As approved by the medical staff committees and Tri-City Medical Center administration, the Pharmacy hours of operation will be seven (7) days per week, 24 hours per day.
2. Access to the Pharmacy is limited to the Pharmacy staff.
   a. Medical staff, nursing staff, administrative, environmental services and other personnel are authorized admission only in conjunction with their duties and under supervision of Pharmacy staff.

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 05/94

SUBJECT: Labeling Standards

REVISION DATE: 10/96, 02/97, 08/00, 02/03, 06/05, 03/06, 4/09, 07/09, 01/12

Department Approval:	~~06/15,~~ 02/18
Medical Staff Department/Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	~~02/03, 06/05, 03/06, 07/09, 1/12, 07/15~~05/18
Medical Executive Committee Approval:	~~02/03, 06/05, 03/06, 07/09, 1/12, 08/15~~06/18
Professional Affairs Committee Approval:	~~09/15~~07/18
Board of Directors Approval:	~~02/03, 06/05, 03/06, 07/09, 1/12,~~ 09/15

A. **POLICY**:

1. All medications shall be clearly labeled in a consistent and legible manner, in compliance with state and federal requirements, professional standards, and regulations.
2. There shall be a standard method for appropriately and safely labeling medications dispensed to both inpatients and outpatients.
3. Any medication or medication container (i.e. syringe, bag, bottle, tube, jar) that is prepared but not immediately administered must be labeled in accordance with this policy.
   a. Note: The Joint Commission defines immediately administered as; "An immediately administered medication is one that is prepared or obtained, taken directly to a patient, and administered to that patient by an authorized staff member, without any break in process."
4. When preparing individualized medications for multiple patients or when the person preparing a medication is not the person administering the medication, the label must also include the patient's name and the patient's location
5. For labeling of medications dispensed to a sterile field see Patient Care Services Policy Labeling Medications/Solutions On and Off a Sterile Field

B. **PROCEDURE:**

1. Labels prepared by the pharmacy are typed or printed from a computer.
2. To the extent feasible, labels are affixed directly to the immediate container and not to an overwrap such as a box, foil wrap, or plastic bag. In cases where the physical characteristics of the immediate container of the medication do not permit full labeling, a partial label containing, at a minimum, the patient name and location may be placed on the container and the complete labeling applied to an appropriate outer container.
3. All medications dispensed from the pharmacy, including compounded IV admixtures and parenteral nutrition, contain, at a minimum, the following information on the label:
   a. The patient's name and location
   b. The proprietary and/or nonproprietary name of the medication
   c. Medication strength or concentration
   d. Dose
   e. Dosage form, including any pertinent statements bearing on special characteristics of the dosage form (i.e. sustained release, enteric coated, sublingual, chewable, solution, elixir, suspension, etc)
   f. Bar-code
   g. Manufacturer or distributor (if not evident from a proprietary name or from pharmacy prepackaging records
   h. Expiration date or beyond use date

i. Expiration time, when it occurs in less than 24 hours
j. Date prepared and ingredients including diluents on all compounded IV admixtures and parenteral nutrition
k. Quantity dispensed
l. Infusion rate, if IV and if applicable
m. Directions for use and any applicable storage, handling, or cautionary statements (e.g., refrigerate, shake well, not to be chewed, "Caution: Chemotherapy", "Not to be given IV, For Irrigation Only")

4. Medication bar-codes are scanned and verified to assure they read and are linked in the computer system(s) to the right medication, right strength and right dosage form
5. Medications that are mislabeled (i.e., labels are illegible, incomplete, incorrect, etc.) are segregated from the active inventory and are not used
6. Source or bulk containers prepared for use during compounding will be labeled pursuant to Pharmacy Policy Sterile Product Preparation
7. Chemotherapy will be labeled pursuant to Pharmacy Policy Chemotherapy Prescribing, Processing, and Preparation
8. Prescriptions intended for use outside of the hospital shall be labeled to ensure complete understanding and compliance by the patient/family and shall include at a minimum:
   a. Patient's name
   b. Prescriber's name
   c. Date the prescription is issued
   d. Prescription number or other means of identifying the prescription
   e. Generic drug name and manufacturer's name (manufacturer's name not required if Brand name is used)
   f. Strength of the drug
   g. Directions for use
   ~~g.~~**h. Physical description of the dispensed medication including its color, shape, and any identification code that appears on the tablets or capsules (unless exempted per Board of Pharmacy)**
   ~~h.~~**i.** The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription
   ~~i.~~**j.** Quantity of the drug dispensed
   ~~j.~~**k.** Expiration date of the drug dispensed
   ~~k.~~**l.** Name and address of the pharmacy

C. **RELATED DOCUMENTS:**
1. Patient Care Services Policy Labeling Medications/Solutions On and Off a Sterile Field
2. Pharmacy Policy Sterile Product Preparation
3. Pharmacy Policy Chemotherapy Prescribing, Processing, and Preparation

D. **REFERENCES:**
1. The Joint Commission Standards MM.05.01.09; MM.03.01.01 EP:7 (2017)
2. Centers for Medicare and Medicaid Services (CMS) 482.25(b)
3. California Code of Regulations, Title 16, Section 4076 and 4128
4. American Society of Hospital Pharmacists. ASHP technical assistance bulletin on single unit and unit dose packages of drugs. Am J Hosp Pharm.1985; 42:378–9.

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 06/05

SUBJECT: Medication Dispensing/Distribution

REVISION DATE: 06/05, 03/06, 07/09, 01/12

Department Approval:	**~~06/15,~~ 04/18**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**~~06/05, 03/06, 07/09, 1/12, 07/15~~05/18**
Medical Executive Committee Approval:	**~~06/05, 03/06, 07/09, 1/12, 08/15~~06/18**
Professional Affairs Committee Approval:	**~~09/15~~07/18**
Board of Directors Approval:	**~~06/05, 03/06, 07/09, 1/12,~~ 09/15**

A. **PURPOSE**:
1. To define the policies used to ensure the safe dispensing and distribution of medications that are in accordance with law and regulation, licensure, and professional standards of practice.

B. **POLICY**:
1. The Pharmacy Department is responsible for the control and distribution of all medications.
2. Medications in patient care areas are available in the most ready to administer forms commercially available or, when possible, in unit-doses that have been repackaged by the pharmacy or a licensed repackager.
3. The Pharmacy makes every attempt to utilize a consistent dose packaging system; however, if a different system is required for use, the Pharmacy staff will provide education about the use of the dose packaging system to the appropriate medication administration staff and patients. This includes dose packaging systems for controlled substances.
4. In response to a new medication order, the Pharmacist shall review the order for appropriateness prior to dispensing or releasing the medication for administration to the patient pursuant to Pharmacy Policy Pharmacist Order Verification and Patient Care Services Policy Medication Administration.
5. If the medication is not in the Automated Dispensing Machine (ADM), the Pharmacy Technician or Pharmacist Intern shall prepare the medication for delivery in accordance with Pharmacy Policies: Medication Preparation, Technician Checking Technician Program, and Automated Dispensing Machine.
6. Only a licensed pharmacist or authorized Pharmacy Department personnel under the direct supervision of a licensed pharmacist shall package medications or make labeling changes in accordance to Pharmacy Policy Labeling Standards.
7. Medications will be dispensed and distributed to patient care areas in a timely manner and in accordance with Pharmacy Policies: Automated Dispensing Machine, Controlled Substances, Floor Stock, and Delivery of Medications Ordered as STAT and at Specified Time Intervals.
8. When delivering medication to nursing units, pharmacy staff shall check return bins to retrieve any discontinued or unused medications that should be returned to the pharmacy.
9. Unused unit-of-use packaging doses may be returned to inventory for reuse and credited to the patient if the package is intact (security and integrity maintained) and within the expiration period.
10. Unusable medications will be removed from storage areas of the hospital pursuant to Pharmacy Policy Unusable Medications.

C. **REFERENCE LIST**:
1. The Joint Commission Standards MM. 03.01.01~~-EP 10~~, MM.05.01.01, MM.05.01.11, MM.05.01.19 (2017~~5~~)

~~JULY 2013~~SEPTEMBER 2017

TRI-CITY MEDICAL CENTER
MEDICATION ERROR REDUCTION PLAN
~~2013 REVISION~~

~~APPROVED: OCTOBER 2013~~

TRI-CITY MEDICAL CENTER'S MEDICATION ERROR REDUCTION PLAN

2013 REVISION

1.0 Purpose

The purpose of Tri-City Medical Center's Medication Error Reduction Plan (the Plan) is to eliminate or substantially reduce medication-related errors and increase patient safety within Tri-City Medical Center (TCMC); thus adhering to our Mission Statement: "To advance the health and wellness of those we serve."

This document also contains a description of the scope of services, oversight and management, strategy and objectives, delivery methodology, plan for orientation, training and education of staff, expected outcomes and monitoring.

The Plan will be reviewed annually in consideration of the changing needs of patients, staff, quality management and performance improvement, and risk management processes.

The purpose of the Plan includes:

- Creating & embracing a non-punitive culture for identifying and reporting medication errors;
- A "systems" approach to understanding and eliminating medication errors through multidisciplinary involvement;
- Organization-wide quality management and performance improvement processes to identify and analyze medication errors and near-misses;
- System changes to minimize the likelihood of future medication errors and near misses;
- Multidisciplinary involvement: Pharmacy and Therapeutics (P&T) Committee, Patient Safety Committee, ~~**Quality Assurance/Performance Improvement Committee**~~ **Professional Practice Shared Decision Making Council** and Medical Executive Committee involvement to direct and monitor the medication safety effort. The establishment of a multidisciplinary Medication Safety Committee will report to the P&T Committee to oversee the coordination of the Plan.

2.0 Scope

The Plan applies to all patients receiving care within the facility or under the licensure of the facility, including both inpatients and outpatients. The Plan pertains to all areas within TCMC in which medications are received, processed, stored, ordered, distributed, administered, or monitored.

3.0 Fundamentals

3.1 Definitions

Common terms and standards for which medication safety will be identified and assessed include the following:

Adverse Drug Event (ADE)

Any injuries resulting from medication use, including physical harm, mental harm, or loss of function.

Adverse Event

Any undesirable experience associated with the use of a medical product in a patient.

Adverse Drug Reaction (ADR)

Any response to a drug which is noxious and unintended, and which occurs at doses normally used in man for prophylaxis, diagnosis, or therapy of disease, or for the modification of physiological function.

Medication

A medication is any substance, other than a food or device, which may be used on or administered to patients as an aid in the diagnosis, treatment or prevention of diseases or other abnormal condition. For purposes of this document the Joint Commission definition of medications will be utilized.

Medication Error

Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional or patient. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.

Near Miss

An event, situation, or error that took place but was captured before reaching the patient.

Root Cause Analysis (RCA)

A process for identifying the basic or causal factor(s) that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event.

Sentinel Event

An event that has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition or the risk thereof.

3.2 Developmental Considerations

The following fundamental components were considered in the development of TCMC's Medication Error Reduction Plan:

1. Create, communicate, and demonstrate a leadership-driven culture of medication safety.
2. Maintain an organization-wide medication safety program.
3. Encourage reporting with a non-punitive reporting process that minimizes individual blame or retribution for involvement in a medication error.
4. Maintain simple, consistent reporting procedures for both actual and potential medication errors in all TCMC care areas.
5. Use internal and external sources to identify and acknowledge risks to medication safety issues that contribute to medication errors.
6. Assess, measure and implement risk reduction processes designed to improve the safety of medication use.
7. Recommend indicators that monitor medication safety and identify areas for improvement.
8. Facilitate multidisciplinary teams and committees to address identified medication safety issues.
9. Through preventative measures, reduce the risk of medication errors and sentinel events.
10. Promote education of staff, vendors, providers, patients' families, and volunteers.
11. ~~Strive to achieve and maintain a minimum of 90% compliance with National Patient Safety Goals (NPSGs).~~
12. Incorporate improvements consistent with organization-wide and departmental goals.

4.0 Objectives

1. Improve error detection, reporting and analysis of data and use of information to improve medication safety.
   - Evaluate on-line reporting and enhance activities reporting.
   - Enhance awareness of on-line reporting tools and methodology for capturing data and tracking medication incidents. Orient and educate staff on processes for reporting medication events. Re-orient staff on a regular basis.
   - Create methods to enhance error detection by capturing medication errors and near misses through computer surveillance and trigger events, Medication Administration Records (MAR) reconciliation, pharmacy interventions and competency assessment processes. Use the data to identify additional opportunities to improve medication processes.

2. Emphasize a non-punitive reporting process that encourages staff to report potential or actual medication safety risks to patients, and all other persons in the organization environment.
    - Widely communicate the commitment to medication use safety in specific terms and with concrete examples in staff newsletters and educational programs.
    - Develop methods to obtain frontline staff feedback about medication/patient safety issues.
    - Disseminate the ISMP Medication Safety Alert to all nurse managers, nurse educators and pharmacists.
    - Establish a blame-free environment for responding to errors. Involve staff in Root Cause Analysis to assist in evaluation of systems and procedures that may contribute to errors.
3. Evaluate where technology can help reduce the risk of medication errors.
    - Utilize systems such as Cerner Order Alerts, Cerner Discern Alerts, Multum Alerts, **barcode scanning,** Pyxis Clinical Data Categories where needed to reduce the risk of medication errors.
    - Turn Data into Information: Collect sufficient data, analyze the data to identify areas needing improvement and implement appropriate strategies for medication error reduction.
4. Reduce the risk of errors with high-alert medications prescribed and administered to high-risk patient populations or at vulnerable periods of transfer through the health care system.
    - Evaluate medication management processes for high-risk patients and patients receiving high-alert medications (e.g. pediatric and chemotherapy) through quality management results to include the following indicators:
        - Establish maximum safe doses for high-alert medications and enter them into the pharmacy computer system to electronically alert staff to potentially toxic doses.
        - Evaluate the storage and use of high-alert medications in the hospital and initiate safe practice recommendations as published in the literature.
        - Where appropriate, establish standard order sets for the use of high-alert medications.
        - Standardize IV infusions concentrations.
        - Establish a consistent process for a cognitive, independent double check of all high-alert medications.
    - Implement key best practices as compiled by nationally recognized organizations such as ISMP, Joint Commission Sentinel Event Alerts and California Institute for Health Systems Performance. (Appendix B)
5. Focus on indicators that are related to improve medication use safety.
6. Ensure continuous compliance with safety strategies recognized by professional and accreditation standards.
    - Measure compliance with standards through quality management and Joint Commission Medication Management standards assessments.

5.0 Organization and Philosophy

An overall culture for safety ~~and adverse event reporting policy~~ is ingrained in the organization's mission and values statement and supported by the organization's philosophy of error management and accountability through Just Culture. The safety events are communicated through the actions & functions of the Patient Safety Committee, ~~TJC Steering Committee~~**Regulatory Commitee**, qQuality Committees, and Executive Council.

- Leadership at TCMC has created a compelling vision that has motivated and communicated urgency for change.
- Leadership has created an environment of psychological safety that has fostered an open reporting of failures, active questioning, and frequent sharing of insights and concerns.
- Leadership has empowered the staff to identify, analyze, and remove hazards that threaten patient safety.

~~**Comprehensive Unit-Based Safety Program:** CUSP is a safety culture program that is designed to educate and improve awareness about patient safety and quality of care. TCMC is working with risk management & the safety officer to roll out this program throughout the facility. The beginning stages are education. This process will be augmented by the Studer initiative.~~

SUCCESS: Implemented by Risk Management, SUCCESS defines TCMC's service standards. Also, the Patient Safety Committee annually provides an opportunity for employees to evaluate the facility for a culture of safety.

Staff: The frontline staff is responsible for observing policies, procedures, practices, and objectives of the Medication Error Reduction Plan. Staff is educated and encouraged to report adverse outcomes/events, near-miss events and opportunities for improvement regularly via the organizational process for reporting (RL Solutions, compliance "hot line", through their managers and directors).

Patient Safety Committee: The Patient Safety Committee provides input to the Medication Safety Committee and integrates MERP activities with the facility's regulatory compliance efforts.

Chief Nursing Executive (CNE): The CNO is responsible for quality patient care in a safe and caring environment, which includes the safe administration of medications.

Director of Pharmacy (DOP): The DOP oversees the procurement, storage, distribution, and clinical monitoring of medications.

The Medication Safety Committee: The Medication Safety Committee (MSC) is a collaborative forum, chaired by the Medication Safety Officer, **or designee,** in which Pharmacy, Quality, Risk and Nursing address medication safety issues. MSC is responsible for the Annual Safety Plan's implementation, monitoring, revisions, and improvements, and shall report progress at least quarterly to the P&T Committee, which shall provide advice and direction. ~~Bi-a~~Annual reports shall be given to the Professional Advisory Council and the ~~Quality Outcomes Committee~~ **Quality Assurance/Performance Improvement Committee** to apprise the Medical Staff and Administration of the Plan's progress. (The Committee's responsibilities are further defined in Appendix C)

Patients and Families: Patients and their families are empowered to voice their concerns regarding medication safety. The patient is encouraged to observe the chain of command, and escalate up the organizational hierarchy if the patient's concerns are not addressed to his satisfaction by the immediate caregiver or the caregiver's supervisor.

6.0 PROCESSES OF THE PLAN

6.1 Plan Development

The Medication Safety Committee (MSC) is responsible for development of the Medication Error Reduction Plan. The MSC is also responsible for recommending the Plan's approval through the Pharmacy and Therapeutics Committee, Medical Executive Committee and the Board of Directors.

Membership of the MSC includes:

- Chief Nursing Executive **or designee**
- Director of Pharmacy
- Director of Risk Management **or designee**
- Educators
- IT
- Medication Safety Officer **or designee**
- Patient Safety Officer
- Physician
- PI/Quality
- Staff Nurses

6.2 Plan Implementation and Assessment

The Medication Safety Committee (the Committee) will provide primary oversight of Tri-City Medical Center's Medication Error Reduction Plan (MERP). The Committee's role will guide and

direct others within TCMC towards the provision of the safe medication use, the reduction of medication errors and the improvement of medication management processes.

~~Hospital and medical staff leadership, m~~Medical staff, ~~and~~ hospital staff, **and leadership** will work collaboratively across interdepartmental boundaries, as needed to address medication safety issues and to assess the effectiveness of the MERP.

1. Implementations of best practices are monitored and adjustments to enhance effectiveness may be made by the Medication Safety Committee, with quarterly reporting to P&T at a minimum.
2. ~~GAP a~~Analysis of the plan is performed and priorities are established annually.
3. Perform technology upgrade feasibility review when needed.

6.3 Improvement Strategies

Current literature is reviewed on an ongoing basis for the development and ongoing review and revision of the Medication Error Reduction Plan's improvement strategies. The literature includes publications from the Institute for Safe Medication Practices (ISMP), American Society of Health-System Pharmacists (ASHP), the Joint Commission and other publications/organizations as appropriate.

Medication use systems and procedures have been identified to include current and future improvement strategies. (See Medication Error Reduction Accomplishments Grid)

6.4 Implementation Strategies

1. Improvement strategies are evaluated regularly and resultant implementation strategies are identified. Strategies will include technology and non-technology approaches.
2. Review the effectiveness of existing plans, and make adjustments to enhance effectiveness.
3. Implement Best Practices Plan of Action
4. ~~Respond rapidly to potential errors of, and errors caused by the Pyxis workflow~~

6.5 Education and Awareness

The following methodology will assist to increase the identification and reporting of medication errors and reducing their incidence.

- Current systems will be reviewed to identify current "best practice" as well as where best practices are needed and do not exist.
- Expected outcomes and measures of success will be identified for identification/reporting of medication errors and for identified process changes for error reduction.
- Education will include several methods including Nursing Orientation~~, Nursing Skills Day~~ and annual competency reviews for pharmacy, ~~and~~ nursing staff **and Respiratory Care Practitioners**.
- The medical staff will be apprised of MERP progress via committee presentations.

6.6 Monitoring

Data from three sources: Employee reporting, concurrent chart audits and computerized surveillance will be monitored by a team comprised of MSC members & ~~additional nurse management~~ **nursing**.

6.7 Reporting

1. Findings and recommendations from MSC are first reported to the P&T Committee, which through its representative will report to the Medical Staff QA/PI committee and then on to the Medical Executive Committee.
2. MSC will also present its findings to the Patient Safety Committee and the **Quality Assurance/Performance Improvement Committee**~~Quality Outcomes Committee~~, ~~which are comprised of leadership from the facility's functional departments.~~

~~3.~~2. MSC will utilize various methods including employee newsletter articles & Power Minutes to inform employees of MERP's progress.

6.8 Annual Review

Tri-City Medical Center's Medication Error Reduction Plan will be reviewed annually and modified as needed to focus efforts to reduce medication related errors. The analysis will consist of both concurrent and retrospective review of patterns and trends of clinical care, weakness and deficiencies, and focus on system related opportunities for improvement. ~~Individual performance issues will not be addressed during an annual review and will be corrected within a timely manner upon identification.~~

The annual assessment of the effectiveness of the implementation will include, but not be limited to, a comprehensive review of prescribing, prescription order communication, labeling, packaging, nomenclature, compounding, dispensing, distribution, administration, patient and staff education, monitoring tools and overall medication use.

The annual review of the Plan will occur within the Medication Safety Committee and will be shared with the Pharmacy and Therapeutics Committee, the ~~Quality Outcome Committee~~**Quality Assurance/Performance Improvement Committee**, the Medical Executive Committee and the Board of Directors.

7.0 REFERENCES

Health & Safety Code 1339.63

CMS Conditions of Participation

The Joint Commission

8.0 APPROVALS

Chief Nursing Executive: **09/13, 10/17**

Director of Pharmacy: 09/13, **11/17**

Pharmacy & Therapeutics Committee: 09/13

~~QA/PI Committee: 10/13~~

Medical Executive Committee: 10/13

Board of Directors:10/13

9.0 ATTACHMENTS

Appendix A: Computer Surveillance Methodology

Appendix B: Medication Use Process Best Practices

Appendix C: Medication Safety Committee

Appendix D: Technology Implementation Strategies

10.0 HISTORY

Original Plan: 2001

Revision: 7/2013

Revision: 10/2017

Appendix A: Computer Surveillance Methodology

Rescue Medications and Trigger Drugs

Rescue medications and trigger drugs are agents which, when used, may indicate adverse medication events. Using the reporting functions of Pyxis and the Cerner Pharmacy System, utilizations of the following medications are monitored.

Medication	Possible Adverse Medication Event
Dextrose 50%	Hypoglycemic agent overdose
Diphenhydramine (Benadryl)	Drug allergy
Epinephrine	Anaphylaxis
Flumazenil (Romazicon)	Benzodiazepine overdose
Glucagon	Hypoglycemic agent overdose
Glucose	Hypoglycemic agent overdose
Mephyton (Oral Vit K)	Warfarin Overdose
Hydrocortisone Sodium Succinate (Solu-Cortef)	Anaphylaxis, severe drug allergy
Naloxone (Narcan)	Opiate overdose
Phytonadione (Vit K)	Warfarin overdose
Protamine	Heparin overdose

They are then investigated by the clinical pharmacist to confirm adverse events, then trended and evaluated for opportunities for improvement. These events are reported to, and recommendations **made** (if any) ~~made monthly~~ to the Medication Safety Committee and ~~quarterly to the~~ P&T Committee.

Override Reports

A "profiled" Pyxis Medstation is one in which only those medications that have been reviewed and entered by the pharmacist are authorized for removal. Overrides are removals from a profiled Pyxis prior to pharmacist review or order entry. Each override must be accompanied by a physician's order. Unacceptable reasons for overrides may indicate unauthorized administration. ~~All o~~Overrides are reviewed by the clinical pharmacist to confirm there is a physician's order.

Discrepancies

Pyxis discrepancies may indicate diversion or unintended over dose, and must be resolved by the end of the shift. Resolved **controlled substance** discrepancies are reviewed daily by the controlled substance technician and reported immediately to the nurse manager if discrepancies remain unresolved or invalid

resolution resulted in controlled substances unaccounted for. An investigation by a unit manager will be conducted and if it remains un-resolved will be documented in the med error reporting system, the ~~Medication Safety Officer~~ **Pharmacy Director, or designee** will be notified and an audit may be conducted on staff involved.

Audits

Medication safety also encompasses identifying controlled substances diverters and keeping them away from patient care. Manual audits are performed regularly towards this goal.

An automated Pyxis data management system is used for diversion analysis. Audits are also performed on an as requested basis should the need arise.

Medication Integrity

Medication refrigerator temperatures are monitored using AwarePoint. ~~There are some~~**In the event a refrigerator is not** ~~exceptions to~~ monitor~~ed~~~~ing by AwarePoint~~ **by AwarePoint,** ~~and in~~ those ~~cases the~~ refrigerators ~~are~~ **will be** monitored manually. Deviations beyond acceptable limits are reported to the Director of Pharmacy or designee, who will initiate action for adjustments or repairs, and assess the viability of the affected products.

In the event of a recalled medication, ~~O~~once identified, ~~Pyxis access to recalled meds can be blocked.~~ **recalled medications will be removed from supply according to the Medication Recall policy. The information will be tracked through the recall system in use throughout TCMC.** ~~The recalled medications are readily traced, thereby facilitating removal of affected products. All departments throughout TCMC are using a recall system and tracking from ECRI Institute.~~

Appendix B: Medication Use Process Best Practices

The following medication use practices have been shown to be effective in reducing medication-related errors.

Medication Use Process	***Best Practice Examples***
Prescribing	▪ Minimize and eliminate symbols and abbreviations ▪ Use of CPOE-Computerized prescriber order entry system ▪ Automatic allergy checking ▪ Automatic duplication alerts of high risk meds ▪ Abnormal laboratory value alerts; e.g., creatinine ▪ Potential antidote orders ▪ Alerts on automatic stop orders ▪ Use of CPOE Power Plans and preprinted medication order forms ▪ Do not use trailing zeros; e.g., 20.0 mg ▪ Always use a zero before a decimal point; e.g., 0.5 mg ▪ Make current drug information readily available ▪ Make laboratory information readily available ▪ Minimize verbal - telephone orders ▪ Develop and implement dosing protocols ▪ Require all physician orders to be complete ▪ including changes in level of care; e.g., Critical Care unit to Medical/Surgery Unit ▪ Use of Power Plans
Prescription Order Communication	▪ Minimize verbal – telephone orders ▪ Authenticate and verify verbal order by prescriber as soon as possible ▪ Use of CPOE Power Plans and preprinted medication order forms ▪ Simplify and streamline the communications of orders ▪ Clarify all irregular or ambiguous orders ▪ Reduce or eliminate transcription
Product Labeling, Packaging, & Nomenclature	▪ Print trade & generic names on the label ▪ Ensure all medications are labeled; e.g., procedure medications not prepared in pharmacy, anesthesia medications, first dose of intravenous solutions prepared by nursing staff, etc. ▪ Use of appropriate warning labels ▪ Attach specific dose instructions if multiple dose vials must be dispensed ▪ Highlight critical parts of the label; e.g., drug concentration, unusual dose, look alike and sound alike names, etc. ▪ Distinctive labeling for similar or sound alike names

	▪ Use metric system not apothecary or English units
Compounding	▪ Maintain a pharmacy based intravenous admixture system ▪ Use USP grade ingredients for compounding ▪ Quality control measures –personnel competency and end product sampling ▪ Follow standards of practice for all type of compounding; e.g., ASHP guidelines
Dispensing	▪ Utilize computer software with clinical screening ▪ Do not stock concentrated, hypertonic electrolyte solutions on nursing units ▪ Computerized Pharmacy system ▪ Automatic drug-drug interaction alerts ▪ Minimum and maximum dose alerts ▪ Automatic allergy checking ▪ Automatic duplication alerts ▪ Automatic stop alerts ▪ Automatic alerts for critical laboratory values; e.g., creatinine ▪ Automatic alerts for clinical contraindication ▪ Unit dose all medications ▪ Pharmacist reviews and verifies orders before drug is dispensed or administered ▪ Identify and restrict the availability of high risk medications; e.g., Concentrated Potassium, Neuromuscular blocking agents, Concentrated Opiate Solutions, Look alike, sound alike drugs ▪ Standardize concentrations of drugs; e.g., Heparin, Potassium chloride ▪ Double check system for built in redundancy for high risk, problem prone medications; e.g., chemotherapy ▪ Dispense drugs in ready to administer dosage form ▪ Bar coding bedside technology ▪ Automatic drug delivery systems
Distribution	▪ Maintain a unit-dose distribution system ▪ Remove excess medication floor stock ▪ Identify and restrict the availability of high risk medications ▪ Restrict use of drugs to formulary drugs unless clinical circumstances mandate an exception ▪ Remove discontinued drugs (from the nursing unit)
Administration	▪ Periodic & continual staff re-education ▪ Patient education ▪ RN double check for all high alert medications (before medication is administered) ▪ Include generic and trade names of medication on eMAR

	▪ Standardized administration times ▪ Ensure proper administration times for medications; e.g., 1 hour before meals prints a correct time on the MAR ▪ No medication is unlabeled ▪ All syringes are labeled ▪ Bar coding bedside technology ▪ Electronic charting or medication administration record (MAR) ▪ Ensure the five rights of administration ▪ Use distinctive administrative sets to reduce the risks of medication and nutritional products from being administered by the incorrect route
Education	▪ Develop special procedures for high risk drugs with special guidelines ▪ Complete, current, and accessible drug information for all staff ▪ Provide in-services for professional staff ▪ Administer competency exams for pharmacists ▪ Develop and provide nursing with dosing charts ▪ Make drug and Formulary information available on line ▪ Provide education/references for new drugs. ▪ Patient, caregiver education, and or family education on the proper use of medication and possible adverse events ▪ Alerts on look alike sound alike and High Risk Drugs
Monitoring	▪ Pharmacist available 24 hours a day ▪ Pharmacist based monitoring with problematic or high risk patients and medications ▪ Healthcare professionals' access to laboratory information ▪ Computer tracking of medication related errors for trending and analysis ▪ Direct observation of medication administration ▪ Use of trigger drugs to identify medication error related events; e.g., naloxone, flumazenil, protamine etc. ▪ Encourage the reporting of errors by focusing on process and systems problems. Individual blame and involvement should be minimized ▪ Use of protocols for drugs with a narrow therapeutic index
Use	▪ Medication use evaluations- including medications with frequent interventions and/or "near misses" ▪ Assign clear responsibilities for investigation and review ▪ Perform root cause analysis and if applicable, assign a severity grade

Appendix C: Medication Safety Committee

The Medication Safety Committee was established to further the goal of being a leader in medication safety by ensuring safe practices in the medication use process (selection and procurement, storage, ordering and transcribing, administration, and monitoring) for all areas of care throughout Tri-City Medical Center.

Role

The role and function of the Medication Safety Committee (the Committee) should be purposefully structured to achieve the goal of a "culture of safety" with primary oversight of TCMC's Medication Error Reduction Plan (MERP). The Committee's role will guide and direct others within TCMC towards process improvements that support the reduction of adverse drug events and other factors that contribute to unintended adverse patient outcomes.

The Committee provides leadership for safety assessments, coordinates the activities of the MERP, educates other practitioners on the system-based causes for medication errors, consults with TCMC's Patient Safety Committee and hospital management, and communicates literature-based ideas regarding effective patient safety strategies to others.

Scope

1. Oversees the review and refinement of TCMC's Medication Error Reduction Plan and sets goals on an annual basis.
2. Oversees the management and use of medication incident information. Supports and encourages error reporting through a non-punitive error reporting system.
3. Reviews internal error reports and medication use safety issues. Prepares reports and analyses setting forth progress and adverse trends with appropriate recommendations or conclusions.
4. Collaborates on the development of policy and procedures and medication use safety standards.
5. Evaluate significant events.
6. Develops a mechanism for internal communication of medication safety related information.
7. Designs and implements educational presentations that facilitate the understanding and implementation of medication use safety within TCMC.
8. Serves as a resource on issues of medication use safety. Serves as an expert resource on medication safety standards and process improvement strategies.
9. Identifies, develops, coordinates and drives medication safety initiatives. Ensure consistent practices across all areas where medications are received, processed, stored, ordered, distributed, administered, or monitored.

Work Performed

1. Collaborates on development of tools for effective training, implementation and monitoring of medication safety initiatives.
2. Develops medication use safety policies and incorporates fail-safe procedures and safety surveillance systems.
3. Assures systems are in place to conduct and review root-cause analysis and trends for reported medication errors and preventable adverse drug events.
4. Review trended data on medication errors and ADEs regularly.
5. Facilitates implementation and monitoring of system changes to help prevent similar events in the future.

Appendix D: Technology Implementation Strategies

The following table summarizes the technology currently or in progress, and the medication-related error event they are used to reduce. Noted in brackets is the anticipated year of implementation.

Technology	Error Reduction Goal
Pyxis Automated Dispensing Cabinet **(upgraded Oct 2012)**	**Dispensing** **-BioID for improved security** **-Cubie drawer use to isolate individual meds** **-Pharmacist reviews and verifies orders before drug is dispensed** **-Restricts the availability of high risk medications** **-Dispense drugs in ready to administer form** **Distribution** **-Remove excess medication floor stock** **Education** **-implemented clinical data alerts regarding high risk meds, LASA, and other pertinent warnings.** **-Lexi-Comp reference on Pyxis**
Computer Physician Order Entry (CPOE) (2004)	**Prescription Order Communication** **-CPOE in Emergency Department**
Cerner Clinical Laboratory Reporting System (2004)	**Prescribing** **-making laboratory information readily available**
Cerner Pharmacy System (2004, latest version update 2014, 2017)	**Prescription Order Communication** **- medication reconciliation** **Dispensing** **-utilizing computer software with clinical screening.** **Product Labeling** **- printing generic names on the label.** **Packaging and Nomenclature** **- Tall-Man lettering on labels** **Administration** **-Electronic MAR** **-Generic and Ordered As names on MAR** **-Patient education material**
Integrated Medication Process (2004-2013)	**Ordering** **-CPOE with clinical decision support alerts (allergy information, lab related alerts etc)** **-Power Plans with complete order sentences** **Administration** **-Updated MARs** **-Patient education material** **-RN double check for all high alert medications** **-Ensures proper administration times** **Monitoring** **-targeted monitoring or patients and medications** **-use of trigger drugs to identify medication error related events**
Talyst Carousel (2007, hardware upgrade 2016, software upgrade 2017)	**Distribution** **-improve accuracy of medication receiving and distribution through the hospital**

Smart Pump – Alaris (2007)	**Administration** **-reduce risk of IV administration errors** **-implementation of guard rails**
Point of Care Bar Coding (2007-2011)	**Administration** **-improve accuracy with 5 rights with use of bedside scanning**
MicroMedex with web based access (2008)	**Education** **-improves access to medication information**
Clean Room completion including EZ797 web based automated system for compliance and monitoring, Critical Point Education training (2008)	**Compounding** **-improve sterility of compounded products** **-797 compliance**
RL Solutions Electronic Reporting System (2010)	**Monitoring** **– tracking of medication related errors for trending and analysis** **Use** **- assigning clear responsibilities for investigation and review.**
ECRI Electronic Recall Notification (2013) **National Recall Alert System Implemented (2015)**	**Distribution** **– removing discontinued or recalled drugs from ~~nursing unit.~~ supply.**
MedKeeper -IV checking/tracking as well as delivery tracking (2014)	**Compounding** **-797 compliance** **Dispensing** **-tracking of deliveries for accuracy and timeliness**
MacroHelix 340B management software (2014 approved) (2017 implemented)	**Monitoring** **-New monitoring system for 340B compliance**
Vigilanz EIR platform that combines real-time clinical intelligence with actionable business intelligence and predictive analytics (2017~~5~~)	**Monitoring** **-utilize real time clinical intelligence** **Prescribing** **-can prescribe based on real time intelligence**

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 01/75

SUBJECT: Medications Ordered STAT and at Specified Time Intervals

POLICY NUMBER: 8390-3107

REVISION DATE: 06/05, 03/06, 03/08, 04/08, 07/08, 01/12

Department Approval ~~Date(s)~~:	~~03/15,~~ 04/18
Medical Staff Department/Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	~~06/05, 03/06, 03/08, 07/09, 1/12, 03/15~~05/18
Medical Executive Committee Approval:	~~06/05, 03/06, 03/08, 07/09, 1/12, 4/15~~06/18
Professional Affairs Committee Approval ~~Date(s)~~:	~~05/15~~07/18
Board of Directors Approval:	~~06/05, 03/06, 03/08, 07/09, 1/12,~~ 05/15

A. **POLICY**:

1. STAT medications from the Pharmacy will be delivered to the requesting area within 30 minutes or less from time of receipt of STAT order in the Pharmacy Department.

B. **PROCEDURE**:

1. The Pharmacy Department will be notified of STAT medications via a CPOE order entered as STAT ~~by the ordering prescriber~~ or via telephone/verbal communication **from the ordering prescriber** ~~immediately~~ followed by a scanned telephone/verbal or electronic medication order.
2. If the medication is not available via Pyxis Medstation, the medication will be delivered to the appropriate patient care area, directly to the primary nurse.
3. Medications ordered at specified time intervals shall be adjusted to standard hours as per "Medication Administration Times" policy as soon as possible, unless ~~attending physician~~**ordering prescriber** specified otherwise.
4. For non-formulary orders, back ordered medication and/or out of stock STAT medication orders, the pharmacist will contact the primary RN and the prescriber to explain the delay and offer potential alternatives.

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 02/03

SUBJECT: Patients' Use of Herbals and Natural Remedies

REVISION DATE: 02/03, 06/05, 03/06, 07/09, 01/12

Department Approval:	**~~03/15~~02/18**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**~~02/03, 06/05, 03/06, 07/09, 1/12, 03/15~~05/18**
Medical Executive Committee Approval:	**~~02/03, 06/05, 03/06, 07/09, 1/12, 04/15~~06/18**
Professional Affairs Committee Approval:	**~~05/15~~07/18**
Board of Directors Approval:	**~~02/03, 06/05, 03/06, 07/09, 1/12,~~ 05/15**

A. **POLICY**:

1. Due to clinically significant drug-drug interactions and unproven efficacy, continuation of herbals and natural remedies are not recommended during hospital admission.
2. The admitting nurse shall encourage the patient to send all medications home with a responsible family member or patient representative. .
3. If the medication(s) cannot be sent home, they shall be stored in the Pharmacy Department until discharge.
4. If the "natural" remedy is prescribed by the physician and the patient wishes to continue taking the substance while in the hospital, the medication shall be ordered via CPOE as a "Patient Own Med."
5. The medication shall be identified, labeled, and dispensed in accordance to California State Law and Patient Care Services Policy Medications Brought in by the Patient.
6. As with other medications brought from home, herbals are returned to the patient upon discharge.

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

1. Patient Care Services Policy Medications Brought in by the Patient

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 01/80

POLICY: Pharmacy and Therapeutics Committee

REVISION DATE: 01/94, 01/97, 09/00, 02/03, 06/05, 07/06, 07/09, 01/12

Department Approval:	**04/18**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**~~2/03, 06/05, 07/06, 07/09, 1/12, 1/1405/18~~**
Medical Executive Committee Approval:	**~~2/03, 06/05, 07/06, 07/09, 1/12, 3/1406/18~~**
Professional Affairs Committee Approval:	**~~4/14~~07/18**
Board of Directors Approval:	**~~2/03, 06/05, 07/06, 07/09, 1/12, 04/14~~**

A. **POLICY**:

1. The Pharmacy and Therapeutics Committee exists as part of the hospital medical staff and is responsible for managing the formulary system. P&T committee members are appointed by medical staff to serve in an evaluative, educational, and advisory capacity to the medical staff and organizational administration in all matters pertaining to the use of medications (including investigational medications). The P&T committee is responsible for overseeing policies and procedures related to all aspects of medication use within an institution. The P&T committee is responsible to the medical staff as a whole, and its recommendations are subject to approval by the organized medical staff as well as the administrative approval process.
2. Other responsibilities of the P&T committee include medication- use evaluation (MUE), adverse-drug-event monitoring and reporting, medication-error prevention, and development of clinical care plans and guidelines.

B. **ORGANIZATION:** As defined in Section 10.18-1 of the Medical Staff Bylaws.

C. **FUNCTIONS AND SCOPE**: As defined in Section 10.18-2 of the Medical Staff Bylaws.

D. **CONFLICT OF INTEREST**

1. To assure decisions made by the Pharmacy and Therapeutics Committee are of the highest ethical quality and not influenced by any associations with outside sources with respect to an alternate agenda the following is required:
   a. Pharmacy and Therapeutics Committee members in order to serve are required to complete and sign a Conflict of Interest Disclosure Statement. See Attachment 1: Conflict of Interest Disclosure Form below.
   b. Anyone who provides information or recommendations to the committee related to medication use is required to sign a Conflict of Interest Disclosure Statement.
   c. Any practitioner submitting a request for formulary revision is required to provide a Conflict of Interest Disclosure Statement. This statement may be included within the Formulary Revision Request Form document. See Attachment 2. Formulary Request Form.
   d. Conflict of Interest Disclosure Statement forms are submitted to the Pharmacy and Therapeutics Committee Chairperson or the Director of Pharmacy and are reviewed by the committee. Any actual or potential conflicts identified will attempt to be resolved. In the absence of resolution, the matter shall be in accordance with the Medical Staff Conflict of Interest Policy. Conflict of Interest Disclosure Statements are retained on file by the Director of Pharmacy Services.
   e. Any member of the hospital committee who perceives a conflict of interest for himself/herself is required to take the following action:

i. Declare the conflict of interest prior to discussions or debate
ii. Refrain from voting on an issue in which the conflict of interest exists
iii. Refrain from influencing other members' votes for an issue in which a conflict of interest exists

f. Any member that perceives or suspects another member of a potential conflict of interest is required to request tabling the discussion until the suspicions and conflicts are resolved.

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 10/07

SUBJECT: Technician Checking Technician Program

REVISION DATE: 10/07, 07/09, ~~11/09~~01/12

Department Approval:	**~~05/15~~04/18**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**~~10/07, 07/09, 1/12, 05/15~~05/18**
Medical Executive Committee Approval:	**~~10/07, 07/09, 1/12, 6/15~~06/18**
Professional Affairs Committee Approval:	**~~07/15~~07/18**
Board of Directors Approval:	**~~10/07, 07/09, 1/12,~~ 07/15**

A. **POLICY**:

1. A general acute care hospital, as defined in Health and Safety code 1250(a), that has an ongoing clinical pharmacy program may allow pharmacy technicians to check the work of other pharmacy technicians in connection with the filling of floor and ward stock and unit dose distribution systems for patients admitted to the hospital whose orders have previously been reviewed and approved by a licensed pharmacist.
2. Only inpatient hospital pharmacies as defined in 4029(a) that maintain a clinical pharmacy services program as described in 4052 may have a technician checking technician program as described. The pharmacy shall have on file a description of the clinical pharmacy program prior to initiating a technician checking technician program. The overall operation of the program shall be the responsibility of the pharmacist-in-charge.
3. This section shall only apply to acute care inpatient hospital pharmacy settings.
4. Hospital pharmacies that have a technician checking technician program shall deploy pharmacists to the inpatient care setting to provide clinical services.
~~4.~~5. **The Technician Check Technician (TCT) program shall include only refills to the Automated Dispensing Machines (ADM).**

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

~~1. To ensure quality patient care and reduce medication errors, programs that use pharmacy technicians to check the work of other pharmacy technicians must include the following components:~~

~~2.~~6. Compounded~~,~~ **and** repackaged ~~or non-scanned~~ products must ~~have been previously~~ **be** checked by a pharmacist ~~and then may be used by the technician to fill unit dose distribution systems, and floor and ward stock.~~**prior to the medication being used under the TCT for refill into the ADM.**

~~3.~~7. The pharmacist(s) on duty will be responsible for answering any questions or handling any issues a technician may have with regards to ~~tech check tech~~**TCT** program.

8. Every technician will have their work checked by another technician when **refilling any** ~~non-compounded or non-repackaged~~ medication for distribution to ~~Automated Dispensing Cabinets or for distribution to other medication storage areas.~~**an ADM.**

~~4.~~9. **Quality Assurance audits will be conducted at random and unannounced times. If more than one mistake is found during the audit, education will be given and the audit will be repeated at a random time within the next 30 days. If more than one error is found on the repeat audit, the technician will undergo further training and shall not be permitted to act as a Technician Checker until 3 consecutive audits result in no more than a single error.**

~~5.~~10. All technicians will be given a written test (Pharmacy Tech Competency Test) on an annual, ongoing basis. **A supervisor will re-educate as needed when 100% score is not achieved on the annual written test.**

6. ~~A Competency review form will be signed by the technician and qualified evaluator upon completion of the written test.~~

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.**

Department Review	Department of Anesthesiology	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Blood Utilization Review Committee	Professional Affairs Committee	Board of Directors
03/18	n/a	03/18	n/a	**05/18**	**07/18**	**07/18**	11/96; 06/00; 03/03; 01/06; 10/09; 09/12

Tri-City Medical Center
Oceanside, California

WOMEN'~~S~~ AND ~~CHILDREN'S~~ NEWBORN SERVICES ~~POLICY MANUAL~~(WNS)

ISSUE DATE: 2/03

SUBJECT: HEARING SCREENING PROGRAM: NEWBORN AND INFANTS

POLICY NUMBER: 6385-100

REVISION DATE: 6/03, 2/07, 2/08, 5/09, 7/09, 04/09, 6/11, 10/13, 6/13

Department Approval:	**02/18**
Department of OB/GYN Approval:	**n/a**
Perinatal Collaborative Practice Approval:	**n/a**
Department of Pediatrics Approval	**~~12/13~~05/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval	**~~05/14~~06/18**
Professional Affairs Committee Approval:	**~~06/14~~07/18**
Board of Directors Approval:	**06/14**

A. **PURPOSE:**

1. To identify infants with possible hearing loss, Tri-City Medical Center (TCMC) will provide **N~~n~~ewborn H~~h~~earing S~~s~~creening P~~p~~rogram services (NHSP~~NHPS~~)** in accordance with:
   a. California Children's Services (CCS) ~~Newborn Hearing Screening Program (~~NHSP~~)~~.
   b. Health & Safety Code 123975.
   c. Article 6.5 (commencing with Section 124115) of Chapter 3, Part 2 of Division 106 of the Health & Safety Code.
2. All newborns and infants who are admitted to **Women's and N~~n~~ewborn S~~s~~ervices (WNS)** at Tri-City Medical Center (TCMC) will have a hearing screen done prior to discharge unless a newborn hearing screening waiver is signed by the parent or guardian. Parents of infants admitted to the Neonatal Intensive Care Unit (NICU) may only waive NHS for religious reasons.
3. Newborn Hearing Screening will be available, as needed via pager 24 hours a day/ seven days a week/365 days a year.
4. NHS may be provided by a contract agency.
5. The Department of **Health Care ~~Medical~~** Services (**DHCS~~DMS~~**) and **NHSP ~~NHPS~~** or its designee will be notified
   a. Of any changes in the use of a contract agency.
   b. Of any other changes to the program, including but not limited to the director.
   c. The hearing screen coordinator will inform the South Eastern Hearing Coordination Center regarding change in the program director.

B. **STAFF AND PROGRAM:**

1. The director for the hearing screen program will be the director of **WNS** ~~maternal child health services~~ or the designee, who is a registered nurse employed by Tri-City Medical Center. The director is responsible for the following:
   a. Oversight for the operation and management of the program.
   b. Coordination of all services related to the program.
   c. Staff training and supervision of the individuals performing the screening.
      i. Staff will be selected in accordance with state and regulatory standards.
      ii. Records of staff annual competency validation and training will be maintained in ~~Maternal Health Services~~ **WNS** at Tri-City Medical Center.
   d. Providing weekly, monthly, and annual reports regarding the number of infants screened and the number of infants who pass or do not pass the exam.
   e. Staff, parent, & physician education.

f. Ensure follow-up for infants requiring referral.
g. Ensure participation in hearing coordination center semi-annual meetings.

2. The medical director of the Neonatal Intensive Care Unit (who is a CCS paneled Neonatologist) provides medical direction and oversight of the program in collaboration with the director.
3. A CCS-paneled consulting audiologist is available to:
   a. Review and approve, in collaboration with the medical director, the hearing screening program for newborns and infants at TCMC.
   b. Provide ongoing assessment and evaluation of the program at least annually.
   c. Inspect and approve newborn hearing screen equipment.
   d. Review and sign (per an addendum) all policies and procedures.
4. The Hearing Screen Coordinator:
   a. Is accountable to the director/designated RN.
   b. Is responsible for the daily operations of the program.
   c. Is the data manager.
   d. Provides screener training and maintains documentation of training at TCMC.
   e. Ensures staff is available to perform testing 24 hours a day, 7 days per week, 365 days per year.
   f. Monitors and orders supplies.
   g. Provides data reports to the director and **Infant Data Management Services (IDMS)**/designee, monthly, quarterly, and annually as required by the **DHCS/NHSP**~~DMS~~.
   h. Maintains hearing screening logs, checks, reconciles/updates DMS birth log for both the newborn and NICU units.
5. The hearing screen technicians will:
   a. Maintain screening log with patient information, correct and legible.
   b. Have had documented training and competency validation in the use of the hearing screening equipment and rationale for the program.
   c. Provide hearing screening for all screen eligible newborns and infants at Tri-City Medical Center.
   d. Contact all families of newborns and infants discharged prior to screening and schedule an appointment within four weeks following discharge (if not completed by the coordinator).
   e. Complete all associated paperwork and refer to RN to provide educational materials to parents or provide educational information to parents.
   f. Note the following in the patient record:
      i. Test type
      ii. Results
      iii. Date
      iv. The Primary Care Provider (PCP) shall obtain written hearing screen results in the infant's medical record.
      v. Technician's signature.
   g. Inform RN or physician of any questions parents may have.
   h. Document all required information on IDMS website **or fax when the website system is down**.

C. **STAFF COMPETENCY VALIDATION**:

1. The hearing screen coordinator and technician will have documented training and competency validation in:
   a. The use of the hearing screening equipment.
   b. Rationale for the program.
2. Competency shall meet criteria as established by the NHSP and will be conducted annually.
3. Training will include watching a video, taking an exam, observing a hearing screen and doing a return demonstration successfully in the presence of the instructor.
4. Additionally, the coordinator will document periodic random checking of technicians performing the test.

a. Employee's annual competency shall be documented in the employee file and maintained by Tri-City Medical Center.

5. Education:
   a. Participation in semi-annual meetings with Hearing Coordination Center.
      i. Hearing screening coordinator or designee will attend one semi-annual meeting.
      ii. Hearing screening technicians may attend semi-annual meeting.

D. **EQUIPMENT:**

1. Tri-City Medical Center's newborn hearing screening program is performed using FDA-approved evoked potential testing, (screening automated auditory brainstem response (AABR) that detects a mild (30-40 dB) hearing loss in infants and newborns
2. Use of screening equipment shall be in accordance with the manufacturer's operating literature and stated norms.
3. The equipment performs a probe calibration in each ear prior to each AABR test.
4. The Coordinator/Technician will validate calibration prior to each screening. If self-calibration is not complete, testing will not be performed.
5. TCMC biomedical department will do an initial and annual calibration on all equipment (preventative equipment maintenance) used for the screening.
6. Records regarding validation of preventative equipment maintenance will be maintained in the biomedical department.
7. The director will be notified of completion of the annual validation.
8. The manufacturer of the equipment will also do testing once per year. Tri-City Medical Center's biomedical department will coordinate this equipment calibration and maintain the equipment records.
9. In the event of primary equipment failure, the hearing screen coordinator will arrange back up equipment from the manufacturer. If the backup/loaner equipment is not available within 24-hours the HCC will be notified of the equipment failure.
10. The equipment will be stored in the maternal child health services unit when not in use.

E. **SUPPLIES:**

1. The **IDMS**~~Department of Medical Services~~ or its designee will approve all brochures and equivalent materials.
2. The Hearing Screen Coordinator is responsible for maintaining supplies and for ensuring that all disposables are not reused.

F. **MEDICAL AND NURSING STAFF EDUCATION:**

1. Physician information will be disseminated by the NICU Medical Director to the medical staff by committee meetings and written correspondence.
2. **Women's and Newborn Services** (WN~~C~~S) clinical and medical staff providing care for pregnant women and infants shall be in-serviced **at a minimum of** annually~~ or as requested~~, regarding the newborn hearing screen program.
3. The program director/ designee will maintain minutes of all educational offerings in the **WNS**~~maternal child health~~ department **to be provided annually as a minimum.**

G. **PATIENT EDUCATION:**

1. The hearing screen program is reviewed during maternity tours and during the admission process.
2. Informational literature specific to the program is placed in admission packets.
3. RN will review "ages and stages" with parents prior to discharge.
4. The hearing screen technician shall inform each parent of the opportunity to have a hearing screen, the methodology of administration of the exam.
5. Following the exam the hearing screen technician may provide scripted information to parents if their infant successfully passes the hearing screen. The hearing screen technician will notify the RN of any waiver or refer and the registered nurse will discuss these with infant's parents.

Written material will also be provided. The Department of Health Services or it's designee will approve all brochures and equivalent materials.

6. Participation in semi-annual meetings with Hearing Coordination Center.
   a. Hearing screening coordinator or designee will attend one semi-annual meeting.
   b. Hearing screening technicians may attend semi-annual meeting

H. **NEWBORN HEARING SCREENING:**

1. Identification of Infants:
   a. Hearing screen staff will review the daily census to identify new infants who have not been screened.
   b. For the infant in NICU, the neonatologist will order the hearing screening when the infant is medically stable and/or age appropriate.
   c. Infants transferred out of NICU **to another facility** will receive a hearing screen prior to transfer, if medically stable.
   d. Any transfers **to other facilities** must be entered into DMS website within 24 hours **or faxed when the website system is down** .
2. Consent:
   a. The information packets given to parents on the postpartum and NICU contain information about the hearing screening process and is given to the parent/guardian by the registered nurse.
   b. Consent for the hearing test is achieved through the signing of Conditions of Admission followed by Admission Orders for Newborn Nursery.
   c. Waiver form for refusing screening will be obtained from the parent or guardian of the infant.
   d. The waiver needs to be signed by the parent or guardian and then witnessed by RN and screening technician.
   e. If the parent/guardian refuses testing, the registered nurse should further educate the family, and if screening is still refused, the waiver shall be signed.
   ~~e.~~**f.** **The waiver form will be documented as part of the infant's medical records.**
3. Performing the screen:
   a. Maternal-child health services:
      i. Newborn hearing screening(s) will take place **at the mothers bedside if conditions allow or** in the newborn hearing screening room.
   b. Neonatal intensive care unit:
      i. Newborn screening(s) will be performed in a quiet environment **and as close to discharge as possible.**
   c. A log of all screens performed will be maintained for the newborn nursery and in NICU.
   d. Infants with unilateral atresia and/or microtia shall have test done on the developed ear, then shall be referred to Children's Audiology Clinic for a diagnostic evaluation.
4. Notification of results:
   a. A registered nurse will notify, document and educate the parents of hearing screen results. The ages and stages will be reviewed with parents by RN and documented. The hearing screen technician may provide scripted information to parents if their infant successfully passes the hearing screen. The registered nurse will be notified by the hearing screen technician of any waiver or refer. The registered nurse will notify the infant's parents of the date, time, location, contact number and the importance for follow-up screening. Appropriate **NHSP**~~DMS~~ brochures (pass, refer, waive, or refer to diagnostic) will be given to parent.
   b. The registered nurse will forward any questions they cannot answer to the physician.
   c. All hearing screen result printouts will be maintained in the medical record.
   d. The newborn's primary care provider will be informed of screening waivers, missed tests, **passes** or refers by mail.
   e. Notification of pass, refer, or waiver of hearing tests is included in the newborn record.
   f. The hearing screen technician will write the date, time, and location of the follow-up screen appointments (if needed). Notification will be sent to the primary care provider

from the coordinator within one week of any infants that REFER, including any required follow-up.

g. Infants who do not pass the hearing screen in each ear **shall**~~may~~ be retested in both ears prior to discharge~~, if time allows~~.
   i. **The discharge RN will ensure the rescreen is completed prior to discharge. The need for the rescreen will be handed off in report to ensure it is done prior to discharge.**

h. Infants with unilateral or bilateral atresia, and/or microtia shall be:
   i. Referred to Diagnostic services as soon as possible.
   ii. Assisted in completing the CCS application form.
   iii. Referred to Early start (fax# 1-916-445-4550) utilizing the early start referral form– atresia infants only.

i. If the infant refers, an appointment will be made with an outpatient provider, (i.e. TCMC) to take place within two weeks of discharge.

j. The hearing screen technician will schedule the referral appointment prior to the infant's discharge. The appointment will be within two weeks of discharge if possible and no later than four weeks after discharge. Parents will be given written information regarding appointment date/time/location/contact number. Document parent's receipt of appointment information in the medical record.

k. The following will be obtained on all infants with a "refer" result:
   i. Primary contact information – verification of parent/legal guardian address and phone number).
   ii. Secondary contact information – obtain name/address/phone number for an additional person not living with the family if possible.
   iii. The parent/legal guardian shall be provided with a contact number for the newborn hearing screen program, and shall be instructed to inform the hearing screen coordinator/technician for:
      1) Changes in contact phone number and/or address
      2) The need to reschedule appointment

l. The primary care provider will be notified of the re-screening provider and appointment time. Information will be documented in the medical record for missed screens.

m. Scheduling a hearing screen for infants who are missed is done by the hearing screen coordinator/ technician by at least three good faith attempts via the following and recorded in the medical records:
   i. Telephone call
   ii. Registered letter written to the family of missed event
   iii. Letter to the Primary Care Physician about the missed event **and follow up information.**

n. Outpatient Provider (i.e. TCMC) or Type C CDC Provider will be notified of inpatient results and special needs (i.e. monolingual).

I. **NEONATAL INTENSIVE CARE UNIT:**

1. All infants admitted or transferred into the NICU shall have an Automated Auditory Brainstem Response (AABR) hearing screen **when the infant's medical condition warrants and ~~on the day of discharge~~as close to discharge as possible.**~~.~~
2. **Infants transferred from ~~newborn nursery~~mother baby unit to the NICU shall be screened in the NICU prior to discharge- whether or not they have been previously screened.**
~~2.~~3. **If the infant does not pass the initial screening in each ear,**~~T~~ the infant shall be re-screened **in both ears ~~on the day of~~**prior to discharge. ~~if the infant does not pass the initial screening in each ear.~~
4. **Validity of hearing screening results is limited to 7 days. The infant needs to be re-screened prior to discharge if hospitalization continues greater than 7 days after the most recent screen.**

~~3.~~5. Any infants six months corrected age or older at time of discharge shall be scheduled for a **C Communicative Disorders Center** (C CDC) diagnostic evaluation at a type ~~C Communicative Disorders Center (~~C CDC~~)~~.

~~4. The hearing screen shall be performed when the infant's medical condition warrants on the day of discharge.~~

~~5. Validity of hearing screening results is limited to 7 days. The infant needs to be re-screened on the day of prior to discharge if hospitalization continues greater than 7 days after the most recent screen.~~

~~6.1. Infants transferred from newborn nursery to the NICU shall be screened in the NICU prior to discharge whether or not they have been previously screened.~~

~~7.~~6. Infants transferred from the NICU to another facility will receive a hearing screen prior to transfer, if medically stable. If the infant/newborn is transferred before being medically stable (screenable), newborn hearing screening shall be included in the plan of care on the transfer record.

~~8.~~7. Infants transferred back to **TCMC** NICU from another the facility will have the hearing screen ~~prior to on the day of~~**as close to discharge as possible**~~. discharge.~~

~~9.~~8. If a NICU infant refers, the hearing screen coordinator or technician will:

~~10.~~9. Schedule an appointment with an outpatient provider (i.e. TCMC) within 2-4 weeks of discharge or:

a. According to the Neonatologist orders: schedule an outpatient re-screen, or schedule a diagnostic evaluation with a CCS-approved Type C Communication Disorders Center.
b. Schedule the appointment as soon as possible after discharge.
c. The follow up appointment date, time, and location shall be documented in the patient's medical record and IDMS website.
d. For infants with orders to follow up with A CCS-approved Type **C CDC** ~~C Communication Disorders Center~~ or equivalent facility approved by the infant's insurance, assist families in completing a CCS application, complete request for services, and a copy of screen results shall be documented in the medical record, sent to the C CDC audiologist and sent to the appropriate CCS office. **Family will be provided with written information regarding the referral or an appointment date/time/location if obtained.**

J. **REPORTING AND DATA MANAGEMENT**:

1. The hospital, as a certified inpatient and outpatient infant hearing screening provider shall report to the ~~Department of Medical Services (~~IDMS~~)~~ or its designee, data on all infants receiving neonatal services in a format and frequency specified by IDMS.
2. The hearing screen coordinator shall:
   a. Oversee program for accuracy, including results for infants receiving newborn hearing screening services in the Mother/Baby Unit and the NICU.
   ~~b. The screening log(s) shall contain the following information for every infant:~~
      ~~i. Infant name~~
      ~~ii. Date of birth~~
      ~~iii. Medical record number~~
      ~~iv. Date of screening~~
      ~~v. Screening results~~
      ~~vi. Follow up appointment (if applicable)~~
   ~~c.~~**b.** All infants screened will be compared to all admissions to the unit. Validation of hearing screening ~~log~~ will be compared to TCMC deliver**ies**~~y log~~ for completeness and accuracy of data.
   ~~d.~~**c.** Review, reconcile and update DMS~~-Birth Log~~. Verification that infant reporting that are entered into DMS for the following infants:
      i. Infants who pass screening
      ~~i.~~**ii.** Infants who did not pass screening.
      ~~ii.~~**iii.** Infants who did not receive screening.
      ~~iii.~~**iv.** Parents who waived screening

~~iv.~~**v.** Infants transferred to another facility.
~~v.~~**vi.** Expired infants.
~~vi.~~**vii.** Infants with Atresia and/or microtia, Bilateral or Unilateral
~~vii.~~**viii.** Screening not medically indicated (NMI) determined by a physician.

~~e.~~**d.** Transmitting a monthly report to the **South Eastern Hearing Coordination Center** (SECHCC) in the DHCS approved format that includes the following **(for both WNS and NICU acuity)** no later than the 10th day after the ending month:
~~i.~~ ~~A copy of the NICU screening logs shall be submitted for the reporting month.~~
~~ii.~~**i.** The total number of infants who left the NICU during the reporting month.
~~iii.~~**ii.** The total number of live births during the reporting month.
~~iv.~~**iii.** The total number of infants screened.
~~v.~~**iv.** The total number of infants who pass the inpatient screen.
~~vi.~~**v.** The total number of infants who refer.
~~vii.~~**vi.** The total number of infants who expire.
~~viii.~~**vii.** The total number of waives.
~~ix.~~**viii.** The total number of NMI.
~~x.~~**ix.** The total number of missed.

~~f.~~**e.** Data uploads and archival storage
i. Will be managed by medical records Hearing screening results and data will be entered by technician.~~.~~
ii. Hearing screening backup and archived data will be stored in appropriate manner as determined by Tri-City Healthcare District policy and the director of medical records.

~~g.~~**f.** Data purge
i. Data will purged annually from the Screening device (in accordance with the manufacturer's instructions).

K. **QUALITY ASSURANCE:**
1. The hearing screen program director/designee, medical director, and hearing screen program coordinator will meet at least semi-annually.
2. Director/designee, medical director, or hearing screen program coordinator will participate in semi-annual meetings with the Hearing Coordination Center.
3. Nursing, hearing screen technicians and medical staff will have newborn hearing education at least once per year.
4. The coordinator will provide quality assurance, with reports submitted to the director.
5. The coordinator and director will monitor quarterly screening rates, with target goals being:
   a. A minimum of 98% of newborns born in the hospital are provided hearing screening prior to discharge.
   b. 100% of NICU infants receive a hearing screen prior to discharge.
   c. Expected refer rate **less than or equal to~~=<~~5% and greater than and equal to 1%.**
   d. Corrective measures if targets are not achieved, as evaluated by the director, include the following:
      i. Checking equipment/recalibration.
      ii. Observing screeners by the Coordinator.
      iii. Checking compliance with policies and procedures.

L. **REFERENCES:**
1. American Academy of Pediatrics/ACOG. (2012~~07~~). Guidelines for Perinatal Care, 7~~6~~th Edition.
2. California Children's Services Standards Chapter 335, statutes of 2006
3. California Health and Safety Code, Section 123975
4. Joint Committee on Infant Hearing (2007). Year 2007 Position Statement; Principles and Guidelines for Early Detection and Intervention Programs.
5. Department of Health Care Services (2008) AB 2651 amended Section 124116.5.
6. California Children's Services Manual of Procedures, Chapter 3 – Provider Standards, Infant Hearing Screening Services, 3.42.1. Revision **September 2016**~~April 2009.~~

Tri-City Medical Center	Women's ~~and Children's~~ Newborn Services Neonatal Intensive Care Unit (NICU)
PROCEDURE:	**NEWBORN HEARING SCREENING: INPATIENT AND OUTPATIENT HEARING SCREENING OF NEWBORN AND INFANTS USING BIOLOGIC EQUIPMENT**
Purpose:	To establish a process to offer and provide newborn hearing screenings to all newborns during their birth admission or infants admitted to the Neonatal Intensive Care Unit
Supportive Data:	Hearing problems are typically not detected until a child normally learns speech, at two or three years of age. Detecting hearing problems at birth may help prevent the occurrence of developmental and social problems later in childhood if the hearing problems are not detected in a timely fashion. Newborn and infant hearing loss is estimated to occur in 2 to 3 per 1,000 births. Fifty percent of infants with hearing loss are normal, full-term babies. Infants can be fitted with hearing aids as early as one month of age.
Equipment:	Biologic Abaer Screening Unit Disposable ear tips Electrodes for **Automated Auditory Brainstem Response** (AABR) testing

A. **PRE-PROCEDURE:**

1. Select an infant appropriate for screening. Infants should be at least 12 hours old.
   a. The hearing screener will review the postpartum census daily to identify infants to be screened.
   b. Infants who are preparing for discharge from the Neonatal Intensive Care Unit (NICU) will be identified in interdisciplinary rounds. The names of NICU identified infants will be forwarded by the NICU charge nurse to the hearing screener to be scheduled for a hearing screen when medically stable and prior to discharge.

B. **DEFINITIONS:**

1. **AABR** = Automated auditory brainstem response.

C. **PROCEDURE:**

1. Plug electrical cord of machine into dedicated outlet.
2. Turn system on properly.
3. Log onto the system.
4. Enter patient information on the SCREENING HOME screen for the patient about to be screened, including type of screen being performed.
   a. Enter all required newborn patient information.
   b. Note risk factors that may be important to have on the test report.
5. Place disposable ear tip on ear probe and insert in infant's ear. This is required for (AABR) screening. Ear muffins may be used for the AABR test.
   a. Proper insertion and fitting of the ear probe is required for the acquisition of valid data.
   b. Guidelines for placing the ear probe:
      i. Check that the disposable tip is completely onto the probe.
      ii. The disposable tip should be inserted snugly, but not completely into the ear canal.
      iii. The end of the disposable ear tip should not be kinked or pressed against the ear canal wall.
      iv. If the disposable tip is too small for the ear canal, select a larger size to ensure a snug fit.
   c. Conducting an AABR:
      i. Apply electrodes and plug electrodes into electrode yoke:
         1) Ear muffins:

~~Review/Revision Date~~Department Review	Department of OB/GYN	Perinatal Collaborative	Department of Pediatrics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
7/03, 10/06, 6/07, 5/08; 6/09, 6/11, 02/18	n/a	n/a	12/13, 05/18	n/a	05/13, 05/14, 06/18	06/13, 06/14, 07/18	06/13, 06/14

a) Blue (nape of neck)
b) White (forehead)
c) Red (shoulder)

ii. Ear probes:
1) Blue (behind left ear)
2) White (forehead)
3) Red (behind right ear)

6. Press "accept" button and identify which ear is to be screened.
   a. The screening will begin when all protocols are in place
   b. Click PAUSE to temporarily pause screening. Click PAUSE again to resume screening.
   c. Click STOP to discontinue screening if necessary
      i. The operator will have the option to print patient reports or letters
7. Repeat steps 4 through 6 on the other ear.
8. If the screening needs to be repeated, follow steps 4 through 6.

D. **POST-PROCEDURE**

1. Remove ear probe from infant. Discard disposable tip and place probe in designated location .
2. Print hearing screening results.
   a. Make additional copies of the hearing screening results and give to:
      i. Infant's health care provider – to be mailed out monthly.
      ii. Infant's parents
3. Chart placement of results.
   a. Inpatients:
      i. Place hearing screening results in infant's hospital chart.
   b. Outpatients:
      i. Place results of screening in the medical record's out box.
4. Turn system off properly.
   a. Select EXIT in the top right hand corner of the Abaer program screen.
   b. Select START in the lower left hand corner of the Windows main desktop.
   c. Select SHUT DOWN from the start menu.
   d. Select SHUT DOWN, click OK and wait until the Windows message indicates that it is safe to turn the system off.
   e. Turn the power off via the power mains (refer to the operator manual).
5. If the infant receives a PASS:
   a. The RN shall inform the parents that the infant passed the screening.
   b. The hearing screener may inform the parents that the infant passed the screening using scripted language.
6. If the infant receives a REFER:
   a. The hearing screener should re-screen the infant.
      i. This should be done within several hours of the original screening.
   b. If the infant still received a REFER, the infant will be scheduled to return to Tri-City Medical Center or a certified California Newborn Hearing Screening Outpatient Provider within four weeks of discharge for an outpatient newborn hearing screening.

E. **PARENTAL/CAREGIVER NOTIFICATION OF RESULTS:**

1. Notification of results
   a. A registered nurse will notify the parents of hearing screen results. The hearing screen technician may provide scripted information to parents if their infant successfully passes the hearing screen. The hearing screen technician will notify the registered nurse of any waiver or refer and the registered nurse will notify the infant's parents of the date, time, and location or follow-up screen and the need for follow-up. Written material will also be provided. All brochures and equivalent materials will be approved by the department of health care services or its designee.

F. **DOCUMENTATION, TRI-CITY MEDICAL CENTER: ALL HEARING SCREENING RESULTS WILL BE MAINTAINED IN THE MEDICAL RECORD:**

1. Consent/waiver for declination of hearing screening in the infant's chart.
   a. If the parent(s) decline the screening, they are to be given the waiver of newborn hearing screening brochure, and sign the verification that they have waived the hearing screening.
2. Printed hearing screening results are distributed as follows:
   a. Infant's chart
   b. Infant's parents
   c. Infant's health care provider
3. Infants who PASS
   a. The parents are given a hearing screening pass brochure with the following information entered by the hearing screener:
      i. Infant's name
      ii. Date of screening
      iii. Type of screening (ABR) circled
4. Infants who REFER
   a. Well babies:
      i. The parents are given a hearing screening refer brochure with the following information entered by the hearing screener:
         1) Infant's name
         2) Appointment date and time
         3) Appointment location
         4) Appointment contact phone number
   b. NICU babies:
      i. The parents are given a hearing screening refer brochure or diagnostic hearing evaluation referral brochure (if determined by physician) with the following information entered by the hearing screener:
         1) Infant's name
         2) Appointment date and time
         3) Appointment location
         4) Appointment contact number
5. Scheduling of infants who refer:
   a. The hearing screen coordinator/technician will schedule outpatient refer appointments prior to the infant's discharge or provide follow-up information.

G. **DOCUMENTATION REQUIREMENTS, STATE OF CALIFORNIA**

1. Completion of the DMS Data Entry **(or fax when the website system is down)** is required for the following circumstances:
   a. Passed results
   b. Refer results
   c. Transferred in house (e.g. NICU) or intra-facility transfers (e.g. infant is transferred to Children's Hospital)
   d. Discharged missed
   e. Waived
   f. Expired or not medically indicated (NMI) for screening per physician determination.

~~2. Refer to the infant reporting from guideline and infant record information from guideline.~~

H. **REFERENCES:**

~~1. California Newborn Hearing Screening Program (2008). *Program summary.* Retrieved from http://www.dhs.ca.gov/pcfh/cms/nhsp/summary.htm.~~

1. California Children's Services Manual of Procedures, Chapter 3 – Provider Standards, Infant Hearing Screening Services, 3.42.1. **September 2016**~~Revision April 2009~~.
2. **California Children's Services Standards Chapter 335, statues of 2006**

Tri-City Medical Center	~~Distribution:~~ Women~~'s~~ and ~~Children's~~ **Newborn** Services~~,~~ **Neonatal Intensive Care Unit** (NICU)
PROCEDURE:	**NEWBORN HEARING SCREENING: SCHEDULING OUTPATIENT HEARING SCREENING**
Purpose:	To establish a mechanism to provide outpatient newborn hearing screening to NICU, well babies and new patients requiring an initial screening, or for repeat screening after two (2) hearing screen refers. If the infant still has a REFER condition after inpatient re-screening, the infant is scheduled for an outpatient appointment.
Supportive Data:	Hearing problems are typically not detected until a child normally learns speech, at two or three years of age. Detecting hearing problems at birth may help prevent the occurrence of developmental and social problems later in childhood if the hearing problems are not detected in a timely fashion. Newborn and infant hearing loss is estimated to occur in 2-3 per 1000 births. Fifty percent of infants with hearing loss are normal, full-term babies. Infants can be fitted with hearing aids as early as one month of age.
Equipment:	~~1.~~ Biologic Abear ~~2.~~ Disposable ear tips ~~3.~~ Electrodes for AABR testing **REFER TO NEWBORN HEARING SCREENING: INPATIENT HEARING SCREENING PROCEDURE**

A. **PROCEDURE:**

1. For Well Born Nursery & NICU
   a. The hearing screener will notify the registered nurse of any waiver or refer. The RN will forward any questions s/he cannot answer to the physician. Written material will also be provided to the parents.
      i. All brochures and equivalent materials will be approved by the department of health services or its designee.
2. The outpatient appointment will be scheduled prior to infant's discharge from the hospital.
3. Notify the infant's **P**~~p~~rimary **C**~~c~~are **P**~~p~~ractitioner (PCP) of rescreen outpatient appointment.
4. After the RN and the hearing screener have spoken with the parents:
   a. The hearing screener shall complete the referral form:
      i. Location of the outpatient screening
      ii. Date and time of outpatient screening
      iii. Name of hearing screening contact person
      iv. Hearing screening refer brochure
   b. The copies of the form will be distributed:
      i. Original for infant's chart
      ii. Yellow copy for parents
      iii. Pink copy for infant's physician
      iv. Goldenrod copy for hearing screener's records
5. The outpatient screening appointment must be scheduled within **1 to 2** weeks of discharge.
6. Information will be given to new parent about registering for **an** initial outpatient screen.
7. Initial outpatient screen will be made following written order from PCP. Confirm appointment with Tri-City Medical Center patient registration (non-TCMC patients).
8. The outpatient screening will be conducted in the designated hearing screening location.

B. **IN THE EVENT THE OUTPATIENT SCREEN IS STILL A REFER:**

1. Notify the infant's ~~primary care practitioner (~~PCP~~)~~, and schedule the infant for an out-patient audiologic diagnostic evaluation:
   a. Type C communication disorder center
   b. Level 3 speech and hearing facility

Department Review/~~Revision Date~~	Department of OB/GYN	Perinatal Collaborative Practice	Department of Pediatrics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors ~~Approval~~
7/03, 6/09, 6/11, 10/13, 02/18	n/a	n/a	6/09, 6/11, 12/13, 05/18	n/a	06/18	06/14, 07/18	7/03, 6/09, 06/13, 06/14

c. Equivalent under the family's insurance plan

2. A California Children's Services (CSS) application ~~(attachment A)~~ and request for services ~~(attachment B)~~ is then completed.
3. FAX the completed CCS program application, completed CCS request for service form, and the hearing screening results to the appropriate county program and the audiologist (attachment C).
   a. The referral shall be documented in the infant's medical record, and DMS website **or fax when the website system is down**.
4. When a complete audiologic work-up is ordered, and after the registered nurse and the hearing screener have spoken with the parents:
   a. The hearing screener shall complete the referral form
      i. Location of complete diagnostic hearing evaluation
         1) Including directions to the location
      ii. Date and time of complete audiologic work up
      iii. Name of audiology contact person
      iv. Diagnostic hearing evaluation referral brochure
   b. The hearing screener will give this information to the hearing screening coordinator.
      i. The hearing technician will notify the infant's PCP of the referral for a complete diagnostic evaluation.
5. Any special needs will be addressed by the Registered Nurse **and communicated to the follow-up provider**.
   a. Notification of Refer and outpatient provider of appointment
   b. Need for translating services
6. Confirmation of appointment will be done by the hearing screening technician by telephone and the following will be faxed to the diagnostic provider:
   a. Copy of diagnostic referral appointment letter
   b. Baby's Facesheet
   c. Mother of Baby's Facesheet
   d. CCS application and request for services.
   e. Printout of results

C. **REFERENCES:**

1. Department of Health Services, Children's Medical Services Branch (2008). *California Newborn Hearing Screening Program Provider Manual.* Sacramento: Author.
2. California Children's Services Manual of Procedures, Chapter 3 – Provider Standards, Infant Hearing Screening Services, 3.42.1. Revision **September 2016**~~April 2009~~.
3. California Children's Services Manual of Procedures, Chapter 3 – Provider Standards, Infant Hearing Screening Services, 3.42.2. Revision-**May 2011**~~July 2008~~.

Tri-City Medical Center	~~Distribution:~~ Women~~'s And Children's~~ **and Newborn** Services
PROCEDURE:	**NEWBORN HEARING SCREENING: STATE OF CALIFORNIA REPORTING**
Purpose:	To outline the procedure required for transmitting Newborn Hearing Screening Program information to the designated State of California Hearing Coordination Center
Supportive Data:	Section 124119 California Health and Safety Code
Equipment:	~~1.~~ ~~WBN~~ Newborn Hearing Screening Monthly and Weekly Report ~~2.~~ **Neonatal Intensive Care Unit** (NICU) Newborn Hearing Screening Monthly and Weekly Report ~~3.~~ Infant Reporting Form (IRF) ~~4.~~ Infant Record Information Form (IRIF) ~~5.~~ Outpatient ~~Screening and~~ Reporting Form (OSRF)

A. **PROCEDURE:**

1. ~~Wbn~~ Newborn Hearing Screening Monthly And Weekly Report
   a. ~~WBN~~ Newborn Hearing Screening data is reported daily to the Department of **Health Care**~~Medical~~ Services (**DHCM**S) website according to the baby's birth date **or fax when the website system is down.**
      ~~i. For example, the baby is born on 1/31, screened and discharged 2/2, report the baby's admission and screening results with the JANUARY statistics (the month of birth).~~
      ~~ii.~~**i.** Include all supportive documentation:
         1) Any transfers ~~within 24 hours~~ must be entered within 24 hours of transfer, noting the receiving hospital:
         2) Any outpatient screens:
            a) Completed Infant Outpatient **Reporting**~~Screening and Referral~~ Form (OSRF)
         3) Outpatient Diagnostic Refers, Atresia or Microtia:
            a) CCS Request for Service Form
            b) CCS Application for Eligibility Form
   b. Weekly Reporting
      i. Check the live births entered into the **Infant Data Management Services** (IDMS) **(or faxed when the website system was down)** from the previous week, compare with the labor and delivery log, and ensure entry of all required demographics of live births into the IDMS **(or faxed when the website system was down).**
   c. Monthly Reporting
      i. Check the IDMS birth log **(or the faxes if the website system was down)** for the previous month, and ensure matching of live birth count obtained from TCMC Birth Log and the number of infants entered into the IDMS **(or faxed when the website system was down).** Reconcile/update if necessary.
      ii. The completed ~~WBN~~ Newborn Hearing Screening Monthly Report is to be faxed to the designated Hearing Coordination Center no later than the 10th day of the month following the reporting month.
2. NICU Newborn Hearing Screening Monthly And Weekly Report/Fax Transmittal
   a. NICU Newborn Hearing Screening data is reported daily **(or faxed when the website system is down)** to the ~~Department of Medical Services (~~IDMS~~)~~ website, baby's information is entered after screening but prior to discharge.
      ~~i. For example, baby is born on 12/15, admitted to NICU, screened 12/30 and discharge 1/3, report the baby's discharge and screening results with the JANUARY statistics (the month of discharge).~~

Review/Revision Date	Department of OB/GYN	Perinatal Collaborative Practice	Department of Pediatrics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
7/03, 10/06, 05/08 6/09, 7/09, 6/11, 02/14, 02/18	n/a	n/a	8/07, 6/09, 12/13, 05/18	n/a	06/18	06/13, 06/14, 07/18	9/07, 6/09, 6/13, 06/14

~~ii.~~**i.** Include all supportive documentation:
1) Any transfers ~~within 24 hours~~ must be entered within 24 hours of transfer, noting the receiving hospital:
2) Any outpatient screens:
a) Completed Infant Outpatient **Reporting**~~Screening and Referral~~ Form (OSRF)
3) Outpatient Diagnostic Referrals, Atresia or Microtia:
a) CCS Request for Service Form
b) CCS Application for Eligibility Form

b. Weekly Reporting
i. Check the live births entered into the IDMS **(or faxed when the website system is down)** from the previous week, compare with the labor and delivery log, and ensure entry of all required demographics of live births into the IDMS **(or faxed when the website system is down)**

c. Monthly Reporting
i. Check the IDMS birth log **(or faxed when the website system is down)** for the previous month, and ensure matching of live birth count obtained from TCMC Birth Log and the number of infants entered into the IDMS **(or faxed when the website system is down)**. Reconcile/update if necessary.
~~ii. NICU Newborn Hearing Screening data is reported after the baby's discharge date (e.g., baby is born on 12/15, admitted to NICU, screened 12/30 and discharged 1/3 report the baby's discharge and screening results with the JANUARY statistics, the month of discharge).~~
~~iii.~~**ii.** The completed NICU Newborn Hearing Screening Monthly Report is to be faxed to the designated Hearing Coordination Center no later than the 10th day of the month following the reporting month.
~~iv.~~**iii.** ~~Newborn Hearing Screening patient log sheets must be included in fax.~~

3. Faxing of these documents will be done according to Tri-City Hospital District Administrative Policy, *Faxing of Protected Health Information.*

B. **REFERENCES**

1. Department of Health Services. **September 2016**~~(04/09)~~. California Children's Services Manual of Procedures. Sacramento: Author.
2. Department of Health Services. (04/09) NHSP Reporting Requirements Reminder. Sacramento: Luis Rico, Acting Chief
3. Tri-City Hospital District Administrative Policy, *Faxing of Protected Health Information.*

AUDIT COMPLIANCE AND ETHICS COMMITTEE
July 26, 2018

Administrative Policies & Procedures	Policy #	Reason	Recommendations
1. Ethics in Provision of Services	262	3 year review, practice change	
2. Identity Theft (Red Flag Rules)	596	3 year review, practice change	

Tri-City Health Care District
Oceanside, California

Administrative Policy ~~Manual~~

ISSUE DATE: 7/97 **SUBJECT: ETHICS IN PROVISION OF SERVICES**

REVISION DATE: 4/00; 5/02; 12/02, 12/03, 6/09, 05/12 **POLICY NUMBER: 8610-262**

Department Approval:	**03/18**
Administrative Policies & Procedures Committee Approval:	**~~09/15~~04/18**
Organizational Compliance Committee Approval Date(s)	**04/18**
Medical Executive Committee Approval Date(s):	**05/18**
Audit, Ethics and Compliance Committee Approval:	**10/15**
Board of Directors Approval:	**10/15**

A. **PURPOSE:**

1. Tri-City Healthcare District (TCHD) recognizes its responsibility to create a workplace culture based on ethical principles and to use those principles as a guide in determining how best to serve the needs of its patients and the community it serves. TCHD relies on its mission, values and philosophy statement, strategic plan, Code of Conduct, Compliance Plan and other guiding documents to provide a consistent, ethical framework for its business services and patient care operations.

B. **DEFINITIONS:**

Ethical Tenet	Right	Responsibility
Beneficence Accountability	To respectful care	Advocacy
Autonomy	To Self-determination (To Privacy/Confidentiality)	Informed consent
Veracity Patient teaching	To truthful information	Informed consent
Justice	To Equal consideration for treatment	Collaboration to meet needs alternative choices
Fidelity	To deliver the care that is indicated/ordered	Competency/ Credentialing/ Appropriate services

C. **POLICY:**

1. It is the basic responsibility of employees, medical staff and others to work cooperatively. To provide optimum patient care, proper functioning of the healthcare team, and efficient management of business. Employees will conduct themselves utilizing the tenets included in the TCHD Mission and Value statements and Code of Conduct in the performance of their duties and their interactions with others. It is also the expectation that employees will fully demonstrate and model the Professional Code of Ethics established by their professional organization or licensing body.
2. Supply contracts are approved or rejected based on best-value practices and the potential for **actual or the appearance of** conflicts of interest.
3. TCHD is committed to truth in advertising.
4. Patients with emergencies are treated without regard for ability to pay. The rights of all patients are valued without regard to race, color, creed/religion, sex, and national origin/ancestry.
5. Services are provided in a considerate and respectful manner, with regard to privacy and age specific needs allowing for expressions of personal values and beliefs as long as these do not jeopardize the safety or well-being of others. **Patient information will be accessed or disclosed only as permitted by law.**

6. Billing practices **and policies** have been developed so that customers are billed only for those services and care provided; bills include dates of service and itemized charges. Billing is based on **accurate, timely and complete records that** ~~appropriate~~ **meet** regulatory and other accepted standards.
7. Media policies and procedures have been established to ensure that patient rights and privacy are protected. At no time will any member of news media be allowed to obtain any type of information (verbal or written), without prior authorization from the Director of Marketing and Communications**, or designee. Employees should never give the impression that they are speaking on behalf of TCHD in any communication that may become public if they are not authorized to do so.**
8. The hospital's code of ethical business and professional behavior protects the integrity of clinical decision making, regardless of how the hospital compensates or shares financial risk with its leaders, managers, clinical staffs and licensed independent practitioners.

D. REFERENCES:

1. Administrative Policy Manual: Accounting of Disclosures of Protected Health Information (PHI) #8610-528
2. Administrative Policy Manual: Advance Health Care Directive #8610-354
3. Administrative Policy Manual: Patient Complaints & Grievances #8610-318
4. Administrative Policy Manual: Use and Disclosure of Protected Health Information: Records #8610-515
~~4.~~**5. Administrative Policy Manual: EMTALA: Emergency Medical Screening #8610-506**
~~5.~~**6. TCHD** Code of Conduct
~~6.~~**7.** Patient Care Services Policy Manual: Patient Rights & Responsibilities #8610-302
~~7.~~**8.** Physician Referral Service Protocol
~~8.~~**9.** Code of Ethics on the TCMC Intranet

Tri-City Health Care District
Oceanside, California

Administrative Policy ~~Manual~~
Compliance

ISSUE DATE: 12/08 **SUBJECT:** Identity Theft (Red Flag Rules)

REVISION DATE(S): **POLICY NUMBER:** 8610~~-531~~596

Department Approval:	01/18
Administrative Policies & Procedures Committee Approval:	~~10/08~~01/18
~~Operations Team Committee Approval:~~	~~10/08~~
Medical Executive Committee Approval:	02/18
Organizational Compliance Committee Approval:	04/18
Audit, Compliance and Ethics Committee Approval:	
~~Professional Affairs Committee Approval:~~	~~11/08~~
Board of Directors Approval:	12/08

A. **PURPOSE:**

1. **To develop an Identity Theft Prevention Program that protects patients by reducing the risk of identity theft by establishing requirements for identifying, investigating and responding to identity theft red flags.**~~To protect our patients, reduce risk from identity fraud, and minimize potential damage from fraudulent activities. TCMC is subject to 16 CFR 68.12 "Identify Theft Rules" which requires the hospital to establish an Identify Theft Prevention Program.~~

B. **POLICY:**

1. **Tri-City Healthcare District (TCHD) is subject to Identity Theft Rules, 16 C.F.R. §~~section~~ 681, which requires ~~Tri-City Medical Center (TCMC~~HD~~)~~ to establish an Identity Theft Prevention Program (ITPP).**~~Tri-City Medical Center is committed to the prevention of identity theft by strictly adhering to the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules.~~ **TCHD maintains and administers an ITPP to detect, prevent and mitigate identity theft in connection with new or existing patient accounts.**

~~B.~~2. **TC~~MC~~HD collects registration and billing information to create patient accounts and/or bill for the provision of healthcare services. Patient accounts are a specific subset of covered accounts.** ~~Tri-City Medical Center~~**TC~~MC~~HD** will address the issues of identity theft including:

   a. Identifying potential red flags that signal identity theft.
   b. Training appropriate staff to recognize and mitigate red flags.
   c. Notifying individuals and local law enforcement if personal information may have been compromised.
   d. Review red flag process routinely to protect against any changes in risk.

C. **DEFINITIONS:**

1. Red Flag: **A pattern, practice, or specific activity that indicates the possible existence of identity theft.** Warning signs of identity theft include but not limited to address discrepancy, name discrepancy, suspicious documents, conflicting personal information, and notice from patients or law enforcement.

~~2.~~D. **PROCEDURE:**

1. ~~1.~~ Verify identification of patient.
   a. Patient's identity should be verified with government issued photo identification **(ID).** ~~**Acceptable If the patient refuses or is unable to provide a photo ID**~~

i. **Acceptable** government documentation **includes**:
1) Passport
2) Driver's license or equivalent
3) Military ID
4) Permanent resident card.

b. Upon initial registration, adult patients should be asked to show documentation of identity that includes address information, with the following exceptions:

i. If the patient requests emergency evaluation or treatment, TC~~M~~GHD will not delay a medical screening examination in order to obtain documents verifying identity.

ii. TC~~M~~GHD staff may use professional judgment to waive the production of photo ID if a delay in care could put the patient's health and safety at risk.

~~A.~~**c. When reviewing a patient's ID, TC~~M~~GHD should do the following:~~S~~**

~~B.~~**i.** Scrutinize to verify that it has not been altered or forged.

~~C.~~**ii.** Verify that the picture and physical description on the identification provided matches the appearance of the patient.

~~3.~~**iii.** Verify that the information on the identification is consistent with the information in the patient Medical Record.

~~D.~~**d. If a patient refuses or is unable to provide a photo ID, TC~~M~~GHD staff should document that photo ID was "not provided". In addition, the TC~~M~~GHD staff member should ask the patient for two (2) forms of non-photo ID, one of which has been issued by a state or federal agency (i.e., ~~Social Security~~Medicare ID card or number,~~and~~ utility bill or company or school ID). When the patient is under 18 or if the patient is unable due to their condition to produce ID, the responsible party's ID shall be requested**

~~1.~~**2.** Red Flags

a. Everyone shall be alert to potential red flags.

b. Below are examples of red flags to look for:

~~E.~~**i.** -Complaints or concerns from a patient relating to:
1) Received a bill for someone else.
2) Received a bill for services that were not received.
3) Received information from Insurance Company for services that were not received.
4) Collection notice for services never received.

~~F.~~**ii.** -The photograph on the identification does not resemble the patient.

~~G.~~**iii.** Identifying information given by the patient is not consistent with the patients' medical record.

~~H.~~**iv.** Social Security Number Red Flags:
~~i.~~**1)** ~~1)~~The social security number has not been issued.
~~I.~~**2)** The social security number is listed in Administration's Death Master File
~~J.~~**3)** The social security number is invalid.
~~K.~~**4)** The following numbers are always invalid:
a) The first three digits are in the 800, 900, or 000 are in the 700 range above 772 or are 666.
b) The fourth and fifth digits are 00.
c) The last four digits are 0000.
~~b.~~**d)** ~~E.~~ The identifying information furnished by the patient including the Social Security Number are the same as another patient.

~~c.~~**v.** ~~F.~~ Other Red Flags:
1) The address given by the patient does not exist or is a post office box.
2) The phone number given is invalid, or is associated with a business, disconnected etc.

~~ii.~~**3)** ~~3)~~ The patient fails to provide identifying information after repeated tries.

~~L.~~4) The information provided by the patient differs from the informant in the medical record or is different on clinical examination.
~~M.~~5) The patient's signature does not match the signature in the medical record.
~~N.~~6) Notification from patient stating they are a victim of identity theft.
~~O.~~7) The entity received notice of address discrepancy from a consumer reporting agency.
8) Discrepancies in information provided by patient in the medical record.

~~P.~~3. **Investigations:**
- a. **TCHD shall investigate concerns involving potential identity theft associated with patient accounts.**
- ~~1.~~b. **If it is determined that a patient is a victim of identity theft, the following actions shall be taken:**
  - ~~a.~~i. **Promptly isolate and correct any inaccuracy in the patient's designated record set.~~;~~**
  - ~~b.~~ii. **Notify the patient in writing or by phone.~~;~~**
  - ~~c.~~iii. **Instruct billing areas to cease collection; if the account has been referred to a collection agency, instruct the collection agency to cease collection activity.~~;~~**
  - ~~d.~~iv. **Cooperate with any law enforcement investigation.~~;~~**
  - ~~e.~~v. **Ascertain whether an insurance company, government program, patient or other payeer has made payment on the account, notify the payeer of the incident and arrange for a refund of the amount paid.~~;~~**
  - ~~f.~~vi. **If an adverse report was made to a consumer reporting agency, notify the agency of the incident and explain that the account was not the responsibility of the patient~~; and~~.**
  - vii. **Notify all other TCHD departments as necessary to resolve and/or restore the accuracy of account information.**

4. **Remediation:**
- a. **When identity theft is confirmed, any documents identified as not belonging to the patient shall be segregated and any information relating to the identity theft shall be removed, marked in error or suppressed (as applicable to whether paper documents or electronic systems are affected).**

5. **Address Discrepancy**
- a. **When TC~~M~~CHD receives a notice of address discrepancy from a consumer reporting agency, TC~~M~~CHD shall verify that the report relates to a patient about whom the information is requested.**

~~2.~~6. **~~TCHD~~Administrative Policy: 8610-395~~,~~ Fraud Recognition ~~and~~ Response, details all measures taken by TCHD when identity theft has been identified.**

E. **RELATED DOCUMENT(S):**
- ~~3.~~1. **Administrative Policy: 395 Fraud Recognition Response**
- 2. **Patient Care Services Procedure: Medical Record, Making Corrections to Documentation**

~~Q.~~F. **REFERENCE(S):**
1. ~~16 CFR 68.12 "~~Identify Theft Rules~~"~~, **CFR Title 16 Div. § 681.**
2. Federal Register Vol. 72, No. 217~~,~~ ~~November 9,~~ (2007).
3. **Federal Trade Commission (2008). New 'red flag' requirements for financial institutions and creditors will help fight identity theft.** FTC Business Alert~~, June 2008~~.
- ~~3.~~4. **Identity Theft Rules: Interim Final Rule and Request for Comment - Amendment of the Definition of "Creditor" in the Original Red Flags Rule, CFR Title 16 § 681 (2012).**
- 5. **Red Flag Program Clarification Act of 2010, 15 U.S.C. 1681m(e)(4), Pub. L. 111-319, 124 Stat. 3457 (2010).**

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS

June 28, 2018 – 1:30 o'clock p.m.
Assembly Room 1 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at Tri-City Medical Center, 4002 Vista Way, Oceanside, California at 1:30 p.m. on June 28, 2018.

The following Directors constituting a quorum of the Board of Directors were present:

Director James Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Colin Coffey, Board Counsel (via teleconference)
Steven Dietlin, Chief Executive Officer
Susan Bond, General Counsel
Scott Livingstone, Chief Operations Officer
Dr. Gene Ma, Past Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 1:30 p.m. in Assembly Room 1 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Kellett to approve the agenda as amended. Director Nygaard seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the June 28, 2018 Regular Board of Directors Meeting Agenda.

   There were no public comments.

4. Oral Announcement of Items to be discussed during Closed Session

   Chairman Dagostino made an oral announcement of the items listed on the June 28, 2018 Regular Board of Directors Meeting Agenda to be discussed during Closed

Session which included two matters of Existing Litigation, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; Approval of Closed Session minutes and Conference with Legal Counsel regarding four (4) matters of Potential Litigation.

5. Motion to go into Closed Session

It was moved by Director Kellett and seconded by Director Mitchell to go into Closed Session. The motion passed unanimously (7-0).

6. The Board adjourned to Closed Session at 1:35 p.m.

8. At 3:30 p.m. in Assembly Rooms 1, 2 and 3, Chairman Dagostino announced that the Board was back in Open Session.

The following Board members were present:

Director James Dagostino, DPT, PT
Director Leigh Anne Grass
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Absent was Director Cyril F. Kellett, M.D.

Also present were:

Colin Coffey, Board Counsel (via teleconference)
Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Ray Rivas, Chief Financial Officer
Carlos Cruz, Chief Compliance Officer
Susan Bond, General Counsel
Dr. Gene Ma, Past Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Chairman Dagostino reported no action was taken in closed session.

10. Director Mitchell led the Pledge of Allegiance.

11. Chairman Dagostino read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 24. Chairman Dagostino requested that speakers adhere to the three minute time allotment. He also requested that speakers that have questions address them to Administration at a later time.

12. Educational Session:

a) Presentation of Cardiovascular Awards –
Eva England, Cardiovascular Service Line Director and
Jennifer Sabotka, Executive Director of the San Diego Division of AHA

Ms. Eva England, Cardiovascular Service Line Director reported once again Tri-City has won four additional awards from the American Heart Association. Ms. England acknowledged the staff and physicians who were instrumental in achieving these awards. Ms. England welcomed Ms. Jennifer Sabotka, Executive Director of the San Diego Division of the American Heart Association.

Ms. Sabotka presented the 2018 Get with the Guidelines Achievement Awards which included:

1) Mission Lifeline and STEMI Silver Award
2) Mission Lifeline's STEMI Gold Award
3) Get with the Guidelines Heart Failure Gold Plus Target Heart Failure Honor Roll Award
4) Get with the Guidelines Stroke Gold Plus Target Stroke Elite Honor Roll Award.

Ms. Sabotka stated each of these awards were earned through commitment and success in implementing high standards of cardiac and stroke care by ensuring that Tri-City's Heart Attack Heart Failure and Acute Stroke patients receive treatment that meets nationally accepted, evidence-based standards and recommendations. Ms. Sabotka recognized the champions for these programs including CEO Steve Dietlin, Cardiovascular Service Line Director Eva England, Dr. Jack Schim, Carol Reeling, Dr. Cary Mells, Dr. Donald Ponec, Heidi Benson, Dr. Laura Desadier, Dr. Karim El-Sherief, Lydia Serrin, Heather Tardy, the Cath Lab staff and the ER staff. Ms. Sabotka stated Tri-City Medical Center will also be recognized in the hospital edition of the *U.S. News & World Report* as well as at the American Heart Association scientific sessions in Chicago this November and the International Stroke Conference in Honolulu in February. Ms. Sabotka expressed her appreciation for Tri-City's commitment to improving the lives of Americans with stroke and heart disease.

No action taken.

13. Report from TCHD Auxiliary – Jeff Marks – First Vice President

In Ms. Mary Gleisberg's absence, Mr. Jeff Marks, TCHD Auxiliary First Vice President provided an update on the activities of the Auxiliary as follows:

- The Auxiliary Awards and Installation of Officers was held on June 23rd and attended by members of the Board as well as members of Administration. Awards were given for those volunteers with 500 to 14,500 hours. Judy Howard Jones in the Escort Service was recognized for her 34 years of service.
- The Auxiliary provided a check to the hospital for $80,000 which will be used towards the 3D Mammography.
- Auxilians have worked 62,463 hours so far this year equating to a little over $1 million in net savings in labor costs to the Medical Center.

Lastly, Mr. Marks commented on a personal experience in the Emergency Department recently and the wonderful staff assisting those patients and their families in a time of great need.

Chairman Dagostino stated the Auxilians are not just volunteers they are important team members and he expressed his appreciation for all the services the Auxiliary provides.

No action taken.

14. Report from Chief Executive Officer CEO

Mr. Steve Dietlin stated he had the opportunity to attend the Annual Auxiliary Awards Luncheon last Saturday and is continually amazed by their organization that is run by truly caring and compassionate community members. Mr. Dietlin stated there are over 400 active volunteers participating in 28 hospital departments. Mr. Dietlin stated in addition to the tremendous number of hours the Auxilians have committed, they also have a Junior Scholarship program that has invested over $1 million dollars in scholarships to date. Mr. Dietlin expressed his appreciation to the Auxilians who demonstrate true commitment to this community and create an experience for the patient that is unmatched each and every day.

Mr. Dietlin stated that over the past months we have been regularly discussing the challenging healthcare regulatory and reimbursement environment locally and nationally along with the expectations that this challenging environment will continue. Patients are continually transitioning from inpatient to an outpatient setting. Aging facility challenges and increased regulatory standards, compressed reimbursement and upward pressure on operating costs have led many hospitals to close or transition their services. We have continually stressed the need to remain proactive and flexible while maintaining the highest standards in order to preserve a positive future for healthcare delivery in this community. Mr. Dietlin stated earlier this week discussion was held with the Board regarding updated federal regulatory standards that require substantial environment of care structural modifications for mental health patients in an aged hospital settings. He explained that performing required structural modifications at Tri-City is estimated to take over one year to complete along with a cost of over $3 million. Mr. Dietlin stated a one-year timeframe is not appropriate to reach updated environment of care standards. Therefore it was Administration's recommendation to suspend inpatient Behavioral Health Unit and Crisis Stabilization Unit operations in an expedited and orderly manner while maintaining the highest patient safety possible over a period not to exceed 60 days. The Chief of the Medical Staff, Dr. Victor Souza, along with the former Chief of Staff, Dr. Gene Ma who is here with us today expressed their support for this recommendation and the Board of Directors publicly voted unanimously to take this action. Mr. Dietlin stated this was a difficult but necessary action. He expressed his appreciation to the Board and the Medical Staff for having the courage to collaborate regarding the difficult decisions that must be made in a challenging healthcare regulatory and reimbursement environment. Mr. Dietlin stated Tri-City continues to operate an intensive outpatient Mental Health Services program and have recently expanded our hours of operation and will continue to expand hours of operation based on community need. He explained that transitioning to expanded outpatient care preserves services to the greatest number of patients at the highest quality of care at this time. Mr. Dietlin stated we are committed to working with our public and private partners and we are reaching out to our local county, state and federal officials and representatives as well as HASDIC, CHA, NAMI and other community leader advocates for regulatory and reimbursement reform and identification and implementation of long-term comprehensive sustainable community solutions.

Mr. Dietlin reported earlier today we held our annual public meeting to discuss and seek approval of the 2019 fiscal year budget. The fiscal 2019 budget approved by the Board of Directors today takes into account the continued shift from inpatient to

outpatient as well as reimbursement compression and the outward pressure and operating costs we discussed. It also takes into consideration continued efforts to move forward with campus redevelopment and projects modest growth and world class healthcare services provided to the community. Mr. Dietlin stressed that we must continue to focus on the highest quality, value and needs of this community while remaining fiscally responsible in order to ensure Tri-City Healthcare District is able to serve this community for many years to come.

Mr. Dietlin stated the American Heart Association awards that were presented earlier today are awards based on actual objective clinical data. He extended his congratulations to the entire Cardiovascular Team.

Mr. Dietlin concluded his report by reading a letter from a Tri-City patient that he received this week.

No action taken.

15. Report from Chief Financial Officer

Mr. Ray Rivas reported on the YTD Financials as follows (Dollars in Thousands):

- Net Operating Revenue – $330,775
- Operating Expense – $$343,298
- EROE - ($7,380)
- EBITDA – $$6,885

Other Key Indicators for the YTD driving those results included the following:

- Average Daily Census – 175
- Adjusted Patient Days – 104,535
- Surgery Cases – 5,936
- Deliveries – 2,065
- ED visits – 56,130

Mr. Rivas also reported on the current month financials as follows (Dollars in Thousands):

- Operating Revenue - $31,014
- Operating Expense - $31,897
- EBITDA - $900
- EROE – ($408)

Mr. Rivas reported on current month Key Indicators as follows:

- Average Daily Census – 162
- Adjusted Patient Days – 9,330
- Surgery Cases – 571
- Deliveries – 163
- ED Visits – 4,845

Mr. Rivas reported on the following indicators for FY18 Average:

- Net Patient Accounts Receivable - $45.4

- Days in Net Accounts Receivable - 48.3

Mr. Rivas commented that Average Length of Stay is up a bit at 4.5 days but is still a fairly good number for us.

Chairman Dagostino commented that although the financials show a lot of "red ink", the budget that was approved today is addressing those issues. Mr. Rivas agreed it is going to take some major overhaul but is confident in the budget presented.

No action taken.

16. Report from Chief Governmental & External Affairs Officer

Ms. Aaron Byzak, Chief Government External Affairs Officer introduced himself to the public and reported he joined the team approximately two months ago and he is in charge of Marketing, Communications, Community Engagement and Government Affairs. He explained that we are focusing not only on the Service Lines that help prop up the bottom line of this organization but also focus on community health needs. He explained the community needs is data driven and comes from the Community Health Needs Assessment that is produced by the Hospital Association.

Mr. Byzak stated for the past two months we have been considering strategies of how to focus our outreach efforts, our engagement efforts, communications and also advocacy around the issues that are a primary or priority health concern for the community. He stated very high on that list is Behavioral Health. The decision that was made earlier this week related to Behavioral Health puts additional emphasis on the need for that. He stated we will be reaching out and are open to holding forums to discuss Behavioral Health with a variety of stakeholders. Mr. Byzak explained that we want to work with public and private partners across the board to identify comprehensive sustainable approaches to deal with the issues that we are facing. Mr. Byzak stated the public is free to reach out to him and he will also be reaching out proactively to have these discussions.

Chairman Dagostino stated Mr. Byzak typifies what we are all trying to do here which is to have an open serious communication on a very difficult subject. Chairman Dagostino commented that Behavioral Health is a community problem and Tri-City is willing to be part of the discussion.

No action taken.

17. New Business

a) Consideration to approve Resolution No. 793, A Resolution of the Board of Directors of Tri-City Healthcare District Establishing the Appropriations Limit for TCHD for the Fiscal Year Commencing July 1, 2018 and ending June 30, 2019, in Accordance with Article XIIB of the Constitution of the State of California, Code of the State of California.

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors approve Resolution No. 793, A Resolution of the Board of Directors of Tri-City Healthcare District Establishing the Appropriations Limit for TCHD for the Fiscal Year Commencing July 1, 2018 and ending June 30, 2019, in Accordance with Article XIIB of the

Constitution of the State of California, Code of the State of California. Director Nygaard seconded the motion.

Mr. Rivas explained this is a resolution that is a statutory requirement that sets an appropriation limit for the District. He further explained it is a calculation that sets the maximum amount the District could collect in tax revenue and is based on cost of living and population statistics. Special Districts have an apportionment of the 1% property tax that is collected and the resolution reflects the maximum Tri-City could receive.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Kellett**

b) Consideration to approve amended Bylaws to reflect change in committee structure and reference to District Zones for election purposes.

Chairman Dagostino explained we recently implemented zone based elections and our Bylaws have been amended to reflect that change. In addition an amendment has been made to reflect the change in the committee structure.

It was moved by Director Grass that the Tri-City Healthcare District Board of Directors approve the amended Bylaws as presented. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Kellett**

18. Old Business

a) Update and action on Board Committee Structure Recommendation

Chairman Dagostino reported the Board has decided to streamline their processes by eliminating some Board committees and turning some of the duties of those committees over to the Board in total. Chairman Dagostino invited the Chair of the Ad Hoc Committee to explain recommendations related to the PAC committee which was also described in the Board Agenda packet. Based on these recommendations, Director Grass proposed that the Professional Affairs Committee meet on a quarterly, bi-annually or monthly basis as deemed necessary and appropriate. The operating unit, performance improvement and risk management oversight and responsibilities will also be reported to the Board on an as needed basis. Chairman Dagostino explained these are changes to the internal structure to help the Board operate more efficiently and provider greater

transparency. These changes described also eliminate redundancy and cut down on administration's time.

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors approve the recommendations of the Ad Hoc Committee including the amended PAC Charter. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Kellett**

Director Reno questioned how each and every Board member will serve on a committee.

Chairman Dagostino stated in this reorganization of the committee structure there is one Board member (Director Reno) who is not currently serving on a committee. He questioned if Director Reno would be willing to serve on the PAC committee. Director Mitchell stated she is willing to step down from the committee and allow Director Reno to take her seat. Director Reno agreed to serve on the PAC committee. Director Grass stated the committee will meet next month as scheduled and then go to a quarterly schedule.

1) Consideration to Establish Special Quarterly Board Meetings

Chairman Dagostino explained that due to the reorganization of the committee structure, items that were formerly heard in committee will be brought forward to the Board as a whole in the form of special meetings. He proposed Special Quarterly Board meetings be scheduled to provide oversight in the following areas: 1) Pension Plan; 2) Business Development; and 3) Quality issues which might include patient safety, risk, etc.

It was moved by Director Reno that the Tri-City Healthcare Board of Directors schedule Special Quarterly Board Meetings to discuss the Pension Plan, Business Development and Quality

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Kellett**

19. Chief of Staff

a. Consideration of June Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on June 25, 2018.

It was moved by Director Mitchell that the Tri-City Healthcare Board of Directors approve the June Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on June 25, 2018. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Mitchell, Reno, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Kellett**

20. Consideration of Consent Calendar

It was moved by Director Mitchell to approve the Consent Calendar. Director Reno seconded the motion.

It was moved by Director Reno to pull item 19. B. 11) Approval of an agreement with North Coast Pathology Medical Group for Clinical & Anatomic Pathology Laboratory services for a term of 24 months, beginning July 1, 2018 through June 30, 2020 at $57,917 a month for an annual cost of $695,000 and a total cost for the term of $1,390,000. Director Schallock seconded the motion.

The vote on the main motion, minus the item pulled was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Kellett**

21. Discussion of items pulled from Consent Agenda

Director Reno, who pulled the North Coast Pathology Medical Group Agreement questioned if there is a write-up for this item and requested clarification as to whether the $694,000 is for the full group. Mr. Scott Livingstone, COO referred Director Reno to the write-up on page 64 in the agenda packet. He also confirmed the amount is for the full Pathology group. Mr. Livingstone explained an independent Fair Market Evaluation was conducted and the amount requested is within fair market value. Chairman Dagostino stated Pathology is a service that is required under Title 22.

It was moved by Director Schallock to approve an agreement with North Coast Pathology Medical Group for Clinical & Anatomic Pathology Laboratory services for a term of 24 months, beginning July 1, 2018 through June 30, 2020 at $57,917 a month for an annual cost of $695,000 and a total cost for the term of $1,390,000. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Kellett**

22. Reports - None

24. Comments by Members of the Public

Chairman Dagostino recognized the following individuals who spoke in support of retaining Behavioral Health Inpatient and Crisis Stabilization Services: Rachel Engh, Mali Woods, Esther Sanchez, Nique Pichette, Larry Kovnit, Laura White, Katherine Smith, Sara Gurling, Regina Glenn, Sheila Kadah, Veronica Glaser, Bob Brooks, Liz Kruidenier, Donna Rencsak, Diane Bagby, Michael Bagby and Eric Revere.

Chairman Dagostino recognized Dr. Cary Mells who commented on the struggles the Emergency Department physicians are experiencing in their ability to care for the Behavioral Health patients and the fact that those struggles have impacted their ability to care for the community in other ways. He sympathized with the audience and stated this was a very difficult decision.

Chairman Dagostino recognized Jessica Godfrey who commented on Director Reno's lawsuit against the district.

Chairman Dagostino recognized Cathy Cronce who proposed the Board adopt a Resolution on the Vital Role of Collective Bargaining in Providing Safe Patient Care and Vital Pubic Service to the Community.

25. Additional Comments by Chief Executive Officer

Mr. Dietlin thanked the public for exercising their right to speak and be heard.

26. Board Communications

Reports from Board Members

Director Schallock stated he appreciates all the community's input.

Director Schallock reported effective June 30th the Redevelopment Committee that he has served on for the past six years has been dissolved and the county is now providing oversight related to redevelopment. Director Nygaard stated she is an alternative on the LAFCO's Redevelopment Committee and will attend those meetings and provide a report to Board.

Lastly, Director Schallock wished everyone a safe and happy 4th of July.

Director Reno thanked everyone for coming to today's meeting and acknowledged their concerns and emotional status. She stated it has been difficult for her as a Director to make the decision to suspend inpatient Behavioral Health Services and the Crisis Stabilization Unit however in light of the current financials Tri-City has

chosen to suspend those services and expand Outpatient Behavioral Health Services.

Director Nygaard had no comments

Director Grass thanked the community members who attended today's meeting and voiced their opinions. She also expressed her appreciation to the nurses and the employees from the BHU and CSU. Director Grass stated it certainly was not a decision that was taken lightly and the Board is open to hearing solutions.

Director Grass clarified that she was asked to speak at DEMCO but was out of town. However the last time that she spoke at DEMCO the reception was much like a "whipping post" for things that she had no idea had occurred in years past on the Board. The moderator did not intercede and she stated it was quite degrading. Director Grass stated if she is in town and available she would consider speaking at DEMCO but she does not want to be asked questions that she has no accountability for.

Director Mitchell thanked everyone for attending today's meeting and voicing their opinions. She stated this was a difficult decision and there is no easy answer.

With regard to DEMCO, Director Mitchell stated she had not received an invitation to DEMCO.

26. Report from Chairperson

Chairman Dagostino reiterated previous comments from his colleagues related to mental health. He stated he takes no offense in the comments made today and believes in their advocacy. Chairman Dagostino acknowledged that the county will be concerned with the Board's decision and he welcomes the opportunity to sit down with our colleagues, other hospitals and the county to come up with a solution.

31. There being no further business Chairman Dagostino adjourned the meeting at 5:40 p.m.

_____
James J. Dagostino, DPT, PT
Chairman

ATTEST:

_____
Leigh Anne Grass, Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

June 28, 2018 – 10:00 o'clock a.m.
Assembly Rooms 2&3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 10:00 a.m. on June 28, 2017.

The following Directors constituting a quorum of the Board of Directors were present:

Director Jim Dagostino, DPT, PT
Director Cyril F. Kellett, M.D.
Director Laura Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Absent was Director Leigh Anne Grass

Also present were:

Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Ray Rivas, Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
Aaron Byzak, Chief of Governmental & External Affairs Officer
Carlos Cruz, Chief Compliance Officer
Susan Bond, General Counsel
Dr. Gene Ma, Past Chief of Staff
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 11:00 a.m. in Assembly Rooms 2&3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Reno led the Pledge of Allegiance.

2. Approval of agenda.

   It was moved by Director Kellett to approve the agenda as presented. Director Reno seconded the motion. The motion passed (6-0-1) with Director Grass absent.

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the Board Agenda. There were no public comments.

4. Oral Announcement of Items to be discussed during Closed Session

   Chairman Dagostino made an oral announcement of items listed on the June 28, 2018 Special Board of Directors Meeting Agenda to be discussed during Closed Session

which included one Report Involving Trade Secret with a disclosure date of June 28, 2018 and one matter of Potential Litigation.

5. Motion to go into Closed Session

It was moved by Director Mitchell and seconded by Director Schallock to go into Closed Session. The motion passed (6-0-1) with Director Grass absent.

Chairman Dagostino adjourned the meeting to Closed Session at 11:10 a.m.

6. The Board returned to Open Session at 12:18 p.m. with all Board members present with the attendance as previously noted.

7. Report from Chairperson on any action taken in Closed Session.

Chairman Dagostino reported no action had been taken in closed session.

8. Open Session

a) Board of Directors Public Workshop for the purposes of review, discussion and possible action on the Operating and Capital Budgets for Fiscal Year 2019.

Mr. Ray Rivas, CFO stated we are requesting approval for a budget for FY2019. The budget is projecting an EROE profit of approximately $5 million which is a significant turnaround from our projected loss this year. Mr. Rivas explained that we are accomplishing this through significant expense reductions including salaries, wages, benefits and supplies. In addition, we are showing some increased revenue through increased surgeries as well as an increase in Medicare revenue.

Chairman Dagostino questioned if Administration believes this is a realistic progression of where we think we are going to go. Mr. Rivas commented that the expense reductions are real, the growth budgets are very conservative and he believes it is very doable.

It was moved by Director Reno that the Tri-City Healthcare District Board of Directors approve the Operating and Capital Budgets for Fiscal Year 2019 as presented. Director Kellett seconded the motion

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Grass**

9. There being no further business, Chairman Dagostino adjourned the meeting at 12:20 p.m.

_____
James J. Dagostino
Chairman

ATTEST:

_____
Leigh Anne Grass
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

June 26, 2018 – 6:00 o'clock p.m.
Assembly Rooms 2&3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 6:00 p.m. on June 26, 2018.

The following Directors constituting a quorum of the Board of Directors were present:

Director James J. Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Steve Dietlin, Chief Executive Officer
Sharon Schultz, Chief Nurse Executive
Scott Livingstone, Chief Operations Officer
Carlos Cruz, Chief Compliance Officer
Ray Rivas, Chief Financial Officer
Susan Bond, General Counsel
Dr. Gene Ma, Past Chief of Staff
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 6:00 p.m. in Assembly Rooms 2&3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Kellett led the Pledge of Allegiance.

2. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the Board Agenda. There were no public comments.

3. Approval of agenda.

   It was moved by Director Kellett to approve the agenda as presented. Director Nygaard seconded the motion. The motion passed unanimously (7-0).

4. Oral Announcement of Items to be discussed during Closed Session

   Chairman Dagostino made an oral announcement of the item listed on the June 26, 2018 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter of Potential Litigation.

5. Motion to go into Closed Session

It was moved by Director Mitchell and seconded by Director Kellett to go into Closed Session at 6:04 p.m. The motion passed unanimously (7-0).

8. Open Session

The Board returned to Open Session at 6:15 p.m. with all Board members present with the attendance as previously noted.

9. Report from Chairperson on any action taken in Closed Session.

Chairman Dagostino reported no action was taken in closed session.

10. New Business

a) Consideration of suspension of certain Mental Health Services

It was moved by Director Kellett that the Tri-City Healthcare District Board of Directors authorize and instruct Tri-City Healthcare District Administration to take all necessary actions to suspend the Inpatient Behavioral Health Unit and Crisis Stabilization Unit operations in an expedited and orderly manner. The suspension of operations is to be completed in no longer than 60 days. Director Schallock seconded the motion.

Mr. Steve Dietlin, CEO read the following statement into the record:

"Over the past months we have been regularly discussing the challenging healthcare and regulatory and reimbursement environment locally and nationally, along with the expectations that this challenging environment will continue. Patients are continually transitioning from an inpatient to outpatient setting. Aging facility challenges, increased regulatory standards, compressed reimbursement and upward pressure on operating costs have led many hospitals to close or transition services. We have continually stressed the need to remain proactive and flexible while maintaining the highest standards in order to preserve a positive future for healthcare delivery in this community. Updated federal regulatory standards require substantial environment of care structure modifications for mental health patients in aged hospital settings. Performing required structural modifications at Tri-City is estimated to take over one year to complete, along with a cost of over $3 million. A one-year timeframe is not appropriate to reach environment of care standards. Therefore, Administration's recommendation is to suspend inpatient Behavioral Health Unit and Crisis Stabilization Unit operations in an expedited and orderly manner while maintaining the highest patient safety possible over a period not to exceed 60 days. Tri-City continues to operate an intensive outpatient Behavioral Health Services program. We have recently expanded our hours of operation and will continue to expand hours of operation based on the community's needs. Transitioning to an Outpatient Services preserves to the greatest number of patients at the highest quality of care. Tri-City remains committed to working with our public and private partners to identify long term sustainable solutions to properly address the needs for this community and remain committed to our mission to enhance the health and wellness of the community we serve. Our operational decisions must be in alignment with this long term mission."

On behalf of Dr. Souza and the Medical Staff, Dr. Gene Ma read the following statement into the record that was composed by Dr. Souza:

"We the Medical Staff feel compelled to provide the best care to all patients with compassion and respect. Our desire is to offer our patients services from all specialties at Tri-City Medical Center with the full understanding that we cannot be everything to everyone. We have to be absolutely sure that if a line of service has to be suspended, that all possible and feasible options were considered in order to keep that service viable. We are confident that the Administration, under the direction of Mr. Dietlin has done their due diligence in that regard. We in the Medical Staff will support their decision in order to keep our Organization afloat and to continue with our mission to advance the health and wellness of our community in the best way possible. In regards to psychiatry, we see the continuation and enhancement of the outpatient program as the most viable option to meet our institution's mission and vision."

Dr. Ma commented on a similar challenge that occurred several years ago when the Board was faced with the very difficult decision of suspending Pediatric care. He stated that was a tormenting decision and he knows this Board is facing that same battle today. Although many of the physicians have struggled with that decision, he firmly believes that the organization did the right thing for this community at that time 15 years ago. He stated those patients are getting a phenomenal level of care that cannot be delivered in every hospital. However that does not mean that Tri-City is not a critical component of that network of care. The focus is to deliver great outpatient care and send the specialty care to where it really belongs. Dr. Ma stated he believes Tri-City is now taking the evolution in psychiatry which has very similar challenges as Pediatrics did to evolve to address the outpatient aspects which is where healthcare is going as the number's would suggest and also addressing the preemptive aspect of preventative care which is so critical in psychiatry. Dr Ma stated he realized that these are tough decisions however on behalf of the Medical Staff he believes that the large majority of physicians that are aware of these issues and have had these discussions in the past do support these tough decisions that the Board is being faced with at this point in time.

On behalf of the Board, Chairman Dagostino expressed his appreciation to both Mr. Dietlin and Dr. Ma for their support.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

11. Comments by Members of the Public

There were no comments from members of the public.

12. There being no further business, Chairman Dagostino adjourned the meeting at 6:25 p.m.

James J. Dagostino
Chairman

ATTEST:

Leigh Anne Grass
Secretary

ACHD
ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

July 1, 2018

Mr. Steven Dietlin
Chief Executive Officer
Tri-City Healthcare District
4002 Vista Way
Oceanside, CA 92056

Re: ACHD Membership Renewal Invoice

Dear Mr. Dietlin,

Thank you for being a loyal Member of the Association of California Healthcare Districts (ACHD). Enclosed you will find your Membership renewal invoice and a brochure detailing the numerous benefits of Membership with ACHD. The Association remains committed to providing quality education and advocacy while also being strong fiscal stewards for our members.

ACHD represents the diverse needs of Healthcare Districts throughout the state in many ways: enhancing public awareness about the role of Healthcare Districts; training and educating our Members; and representing our Members in front of the Legislature, Governor, and State Agencies. We firmly believe that "Members Drive Change" and that our collaboration and strength enable Healthcare Districts to continue to deliver the best possible health and well-being services to their communities.

Again, thank you for your membership in the Association of California Healthcare Districts. Your continued involvement is important and very much appreciated. And as a reminder, please submit your payment no later than July 30, 2018, to avoid a lapse in your membership.

Sincerely,

Kenneth B Cohen

Kenneth B. Cohen
Chief Executive Officer, ACHD

Cc: James Dagostino, Chair, Tri-City Healthcare District

ACHD
ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

Invoice

Invoice No.	**18004809**
Date	07/01/2018
Terms	30 Days

Tri-City Healthcare District
Attn: Accounts Payable
4002 Vista Way
Oceanside, CA 92056

Qty.	Description	Rate	Amount
1	Member Dues Covering 7/1/18 - 6/30/19	25,750.00	25,750.00
		Total	**$25,750.00**

Association of California Healthcare Districts
by check:
1215 K Street, Suite 2005
Sacramento, CA 95814

y wire:
Wells Fargo Bank
Account #: 4121-229975
ABA/Routing #: 121000248

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases

Month Ending June 30, 2018

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Lease Term Ending	Services & Location
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.48	(a)	44,164.55	07/01/17	06/30/27	**OSNC - Carlsbad** 6121 Paseo Del Norte, Suite 200 Carlsbad, CA 92011
American Health & Retirement DBA: Vista Medical Plaza 140 Lomas Santa Fe Dr., Ste 103 Solona Beach, CA 92075 V#82904	Approx 1,558	$2.47	(a)	5,029.28	01/27/17	05/31/20	**PCP Clinic - Venus** 2067 W. Vista Way, Ste 160 Vista, CA 92083
Camelot Investments, LLC 5800 Armada Dr., #200 Carlsbad, CA 92008 V#15608	Approx 3,563	$1.86	(a)	10,766.67	04/01/16	01/31/20	**PCP Clinic - Radiance** 3998 Vista Way, Ste. C Oceanside, CA 92056
Cardiff Investments LLC 2729 Ocean St Carlsbad, CA 92008 **V#83204**	10,218	$2.50	(a)	30,480.05	07/01/17	06/30/22	**OSNC - Oceanside** 3905 Waring Road Oceanside, CA 92056
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	$2.70	(a)	20,540.00	02/01/15	01/31/20	**PCP Clinic - Vista** 1926 Via Centre Drive, Ste A Vista, CA
CreekView Orthopaedic Bldg, LLC 1958 Via Centre Drive Vista, Ca 92081 **V#83025**	Approx 4,995	$2.50	(a)	15,184.80	07/01/17	06/30/22	**OSNC - Vista** 1958 Via Centre Drive Vista, Ca 92081
Elfin Investments, LLC Clancy Medical Group 20136 Elfin Creek Trail Escondido, CA 92029 V#82575	3,140	$2.56	(a)	9,642.26	12/01/15	12/31/20	**PCP Clinic - Clancy** 2375 Melrose Dr. Vista Vista, CA 92081
Investors Property Mgmt. Group c/o Levitt Family Trust 2181 El Camino Real, Ste. 206 Oceanside, Ca 92054 V#81028	5,214	$1.86	(a)	10,458.44	09/01/17	08/31/19	**OP Physical Therapy** **OP OT & OP Speech Therapy** 2124 E. El Camino Real, Ste.100 Oceanside, Ca 92054
Melrose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 V#43849	7,247	$1.35	(a)	10,101.01	07/01/16	06/30/21	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	4,760	$4.12	(a)	26,047.00	10/01/12	10/01/22	**Chemotherapy/Infusion Oncology Center** 3617 Vista Way, Bldg 5 Oceanside, Ca 92056
Ridgeway/Bradford CA LP DBA: Vista Town Center PO Box 19068 Irvine, CA 92663 V#81503	3,307	$1.10	(a)	5,135.39	10/28/13	10/31/18	**Vacant Building** 510 Hacienda Drive Suite 108-A Vista, CA 92081
Total				**$ 187,549.45**			

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending June 2018

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6010	2ND ANNUAL PATIENT EXPERIENCE	60818	120.00	81883	MEREBETH RICHINS
6185	ONS/ONCC CHEMOTHERAPHY BIOTHERAPY	52518	279.00	43324	GEMMA RODRIGUEZ
7290	CAHSAH ANNUAL CONFERENCE	52118	278.78	82008	MONICA TRUDEAU
7290	CAHSAH ANNUAL CONFERENCE	52118	730.47	82655	CYNTHIA BOATRIGHT
7790	UCSD MINDFULNESS BASED STRESS REDUCTION	62518	570.00	10897	PAULA BALLWEBER
8340	SERVSAFE FOOD & BEVERGE CERTIFICATION	61818	1,927.73	79501	CHRISTINE CARLTON
8440	WASTE MGMT MANIFESTO CERTIFICATION	225036	1,290.00	82652	EVS STAFF
8480	ONSITE EDUCATION & TRAVEL	101351353	1,690.13	16215	INFORMATION TECH STAFF
8615	CHA LOBBY ACTION DAY-340B PROGRAM	60718	191.96	77438	AARON J BYZAK
8620	340 B LEGISLATION - TRAVEL	60518	369.73	81515	JAMES DAGOSTINO
8620	AHA ANNUAL MTG/CA CONGRESSIONAL ACTION PLAN - TRAVEL	51018	2,152.40	81515	JAMES DAGOSTINO
8631	PHILAMTHROPY COUNCIL MTG	53018	110.00	79486	GLEN NEWHART
8720	CMS CONDITION OF PARTICIPATION	51118	108.34	59683	SHARON SCHULTZ
8723	CHA CM COMMITTEE MEETING	52318	250.92	77502	LISA STROUD
8740	COOL TOPICS IN NEONTOLOGY	60118	125.00	79414	CHRISTINA MARKS-TAFOYA
8740	COOL TOPICS IN NEONTOLOGY	60118	200.00	62892	AIMEE HARDT
8740	ADVANCED FETAL MONITORING	60118	200.00	80156	CHRYSTALLE BECHTOLD
8740	NICU CERTIFICATION REVIEW	60118	200.00	81919	NATALIE MURRAY
8740	LVN-RN PROGRAM	60118	607.33	79537	MISA LE
8740	RN-BSN PROGRAM	60118	2,500.00	19980	DAISY MONTES
8740	RN-BSN PROGRAM	52418	2,500.00	77804	DEBBIE ENGELHART
8740	ADN-BSN PROGRAM	60118	2,500.00	82065	CHRISTIN SANTA MARIA
8740	RN-BSN PROGRAM	60118	2,500.00	83269	ANAYELI SOTO MAYA
8740	MSN PROGRAM	60118	5,000.00	78932	DARLENE FINK
8758	CMS CONDITION OF PARTICIPATION	51118	108.34	59683	SHARON SCHULTZ

**This report shows reimbursements to employees and Board members in the Education & Travel expense category in excess of $100.00.
**Detailed backup is available from the Finance department upon request.

CLINICAL CONTRACT EVALUATION REPOR TO THE BOARD OF DIRECTORS

Annually, clinical contracts at Tri-City Healthcare District, (TCHD) are evaluated by contract owners within TCHD. The 2017 clinical contracts have been evaluated for performance. Remaining clinical contracts are undergoing further review.

The Board of Directors has been updated.

Susan M. Bond, General Counsel
Date: July 26, 2018