TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
September 27, 2018 – 2:30 o'clock p.m.
Classroom 6 - Eugene L. Geil Pavilion
Open Session – Assembly Rooms 1, 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	**1 Hour**	
	a. Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d) 2 (2 Matters)		
	b. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	c. Approval of prior Closed Session Minutes		
7	Motion to go into Open Session		
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

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
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	Special Recognition – Dr. Rica Brown and the Emergency Department Team	10 min.	Chair
13	Educational Presentation – a) Medical Integration at the Tri-City Wellness Center – Susan Webster, Manager	5 min.	Chair
14	Report from TCHD Foundation – Glen Newhart, Chief Development Officer	10 min.	Standard
15	Report from TCHD Auxiliary – Connie Jones	10 min.	C. Jones
16	Report from Chief Executive Officer	10 min.	Standard
17	Report from Chief Financial Officer	10 min.	Standard
18	New Business a) Consideration to accept the FY2018 Financial Statement Audit and Single Audit	15 min.	Moss Adams
	b) Consideration to amend Board Policy 14-006 – Board of Director Meeting Minutes	10 min.	Chair
	c) Consideration of Board Committee Community Member Recognition	10 min.	Director Grass
	d) Consideration of former Board Committee Community Member's future service on Board Committees	10 min.	Director Grass
19	Old Business – None		
20	Chief of Staff a. Consideration of August Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on September 27, 2018.	5 min.	Standard
21	Consideration of Consent Calendar **Administrative & 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.***	5 min.	Standard

	Agenda Item	Time Allotted	Requestor
	(3) Requested items to be pulled require a second.		
	(1) Administrative Committee		
	a) Policies & Procedures:		
	1) **Patient Care Services Policies & Procedures:** a) Hazardous Drugs Procedure b) HIV Identification Screening Prevention of Perinatal Transmission Standardized Procedure c) IV Solution, Storage & Warming of Procedure d) Medication Reconciliation Policy e) Nitrazine Test on Vaginal Fluid Procedure f) Nutritional Screening Care & Assessment for Infants, Pediatrics & Adolescents Policy g) Potential Food and Drug Interactions, Patient Education Policy h) Sharps Disposal, Procedural Areas Policy i) Sharps Injuries Prevention Policy j) Urine Chemistry Using a Urine Dipstick Measuring Procedure k) Urine Dipstick Analysis Using Siemens Clintek Status Procedure		
	2) **Administrative** a) Workplace Violence Policy – 463		
	3) **Food & Nutrition** a) Diet Manual Policy		
	4) **Infection Control** a) Aerosol Transmissible Diseases and Tuberculosis Control Plan IC 11 Policy b) Cleaning and Disinfection – IC-9 Policy c) Philosophy – IC 1 Policy		
	5) **Medical Staff** a) Audit Criteria for Blood UR 8710-540 Policy		
	6) **Surgical Services** a) Local Anesthesia in OR Policy b) Surgical Supply Stocking, Rotation and Outdate Policy		
	7) **Formulary Requests** a) Gadoversetamide (Optimark) conversion to Gadobutrol (Gadavist) b) Nitroglycerine 0.4mg Spray		
	(2) Board Committees		
	A. Community Healthcare Alliance Committee Director Nygaard, Committee Chair *(No meeting held in September, 2018)*		CHAC Comm.

	Agenda Item	Time Allotted	Requestor
	B. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 0 *(Committee minutes included in Board Agenda packets for informational purposes)* 1) Approval of an agreement with Dr. Kabra, Cardiovascular Health Institute – Quality Committee member for a term of nine months, beginning October 1, 2018 through June 30, 2019, not to exceed two hours per month at an hourly rate of $210, for an annual cost of $3,780 and a total cost for the term of $3,780. 2) Approval of a Change Order to Dick Miller, Inc. for $96,634 for additional traffic control costs due to unforeseen storm drain relocation and delays and the additional project budget of $64,000 to cover the Change Order costs. 3) Approval of an agreement with Dr. Richard Smith, Chair of Antibiotic Stewardship for a term of 24 months, beginning October 1, 2018 through September 30, 2020, at an hourly rate of $175, not to exceed 300 hours per year, for the annual rate not to exceed $52,500 and a term cost of $105,000. 4) Approval of an agreement with Dr. Geehan D'Souza as the Medical Director for Plastic Surgery Consultative and Procedural Services for a term of 12 months beginning October 1, 2018 through September 30, 2019, for a total cost for the term of $45,360. 5) Approval of an agreement with the Neurology Center to provide comprehensive coverge/directorship for ARU, Stroke, Neurology, Epilepsy, ARU (mid-level) for a term of 12 months beginning October 1, 2018 through September 30,, 2019, for a total cost for the term of $561,130. 6) Approval of an agreement with Drs. Tina Dhillion-Ashley and Marlene Pountney-Levesque to the currently existing ED On-Call Coverage Panel for OB/GYN for a term of 21 months, beginning October 1, 2018 through June 30, 2020.		FO&P Comm.
	C. Professional Affairs Committee Director Grass, Committee Chair *(No meeting held in September, 2018)*		PAC
	D. Audit, Compliance & Ethics Committee Director Schallock, Committee Chair Open Community Seats – 0 *(Committee minutes included in Board Agenda packets for informational purposes)*		Audit, Comp. & Ethics Comm.
	(3) Minutes – Approval of: a) Special Board of Directors Meeting – August 21, 2018 (1 of 2) b) Special Board of Directors Meeting – August 21, 2018 (2 of 2) b) Regular Board of Directors Meeting – August 30, 2018		Standard

	Agenda Item	Time Allotted	Requestor
	(4) Meetings and Conferences – None (5) Dues and Memberships - None		
22	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
23	Reports (Discussion by exception only) (a) Dashboard – Included (b) Construction Report – None (c) Lease Report – (August, 2018) (d) Reimbursement Disclosure Report – August, 2018) (e) Seminar/Conference Reports 1) CHA Governance Forum - Director Dagostino	0-5 min.	Standard
24	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 on any item not on the agenda.	5-10 minutes	Standard
25	Additional Comments by Chief Executive Officer	5 min.	Standard
26	Board Communications (three minutes per Board member)	18 min.	Standard
27	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session	2 hours	
28	Oral Announcement of Items to be Discussed During Closed Session		
29	Motion to Return to Closed Session (if needed)		
30	Open Session		
31	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
32	Adjournment		

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Report of Independent Auditors

The Board of Directors
Tri-City Healthcare District

Report on the Financial Statements

We have audited the accompanying financial statements of Tri-City Healthcare District (the "District"), which comprise the statements of net position as of June 30, 2018 and 2017, and the related statements of revenues, expenses, changes in net position, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the California Code of Regulations, Title 2, Section 1131.2, *State Controller's Minimum Audit Requirements for California Special Districts*. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Tri-City Healthcare District as of June 30, 2018 and 2017, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that management's discussion and analysis on pages 3 to 12 be presented to supplement the basic financial statements. Such information, although not part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Information

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise the District's basic financial statements. The schedule of net position, June 30, 2018 and schedule of revenues, expenses, and changes in net position for the year ended June 30, 2018 are presented for purposes of additional analysis and are not a required part of the basic financial statements.

The schedule of net position as of June 30, 2018 and schedule of revenues, expenses, and changes in net position for the year ended June 30, 2018 are the responsibility of management and were derived from and relate directly to the underlying accounting and other records used to prepare the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America and the California Code of Regulations, Title 2, Section 1131.2, *State Controller's Minimum Audit Requirements for California Special Districts*. In our opinion, the schedule of net position as of June 30, 2018 and schedule of revenues, expenses, and changes in net position for the year ended June 30, 2018 are fairly stated, in all material respects, in relation to the basic financial statements as a whole.

Irvine, California
[DATE]

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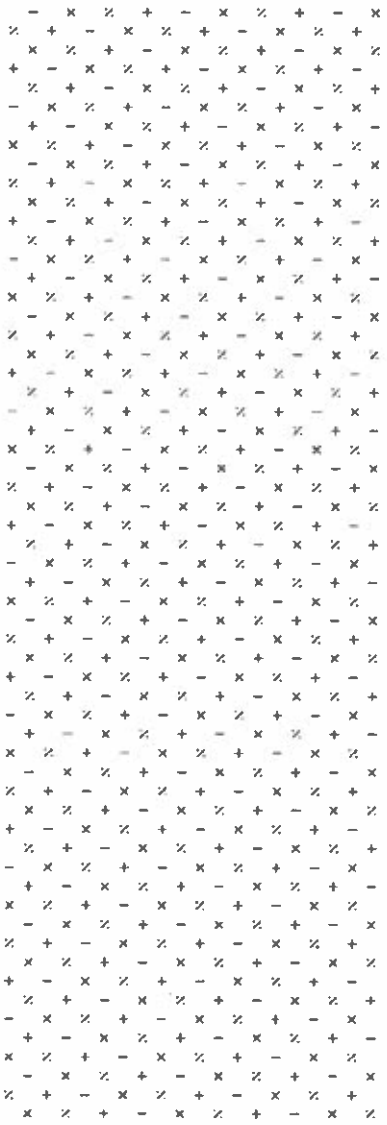
2018 Audit Results: Tri-City Healthcare District

September 20, 2018



Audit Committee

Tri-City Healthcare District

Dear Audit Committee Members:

Thank you for your continued engagement of Moss Adams LLP. We are pleased to have the opportunity to meet with you to discuss the results of our audit of the financial statements and federal program compliance of Tri-City Healthcare District ("the District") for the year ended June 30, 2018.

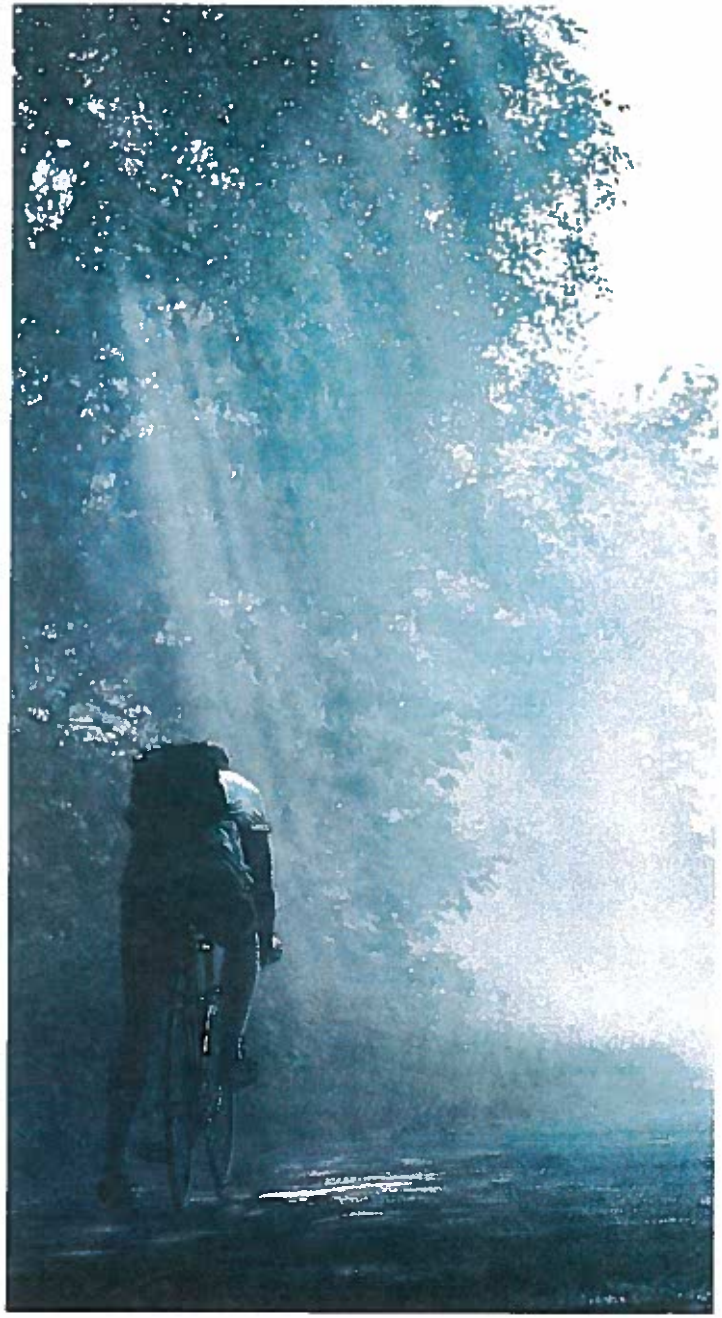
The accompanying report, which is intended solely for the use of the Audit Committee and management, presents important information regarding the District's financial statements and our audit that we believe will be of interest to you. It is not intended and should not be used by anyone other than these specified parties.

We conducted our audit with the objectivity and independence that you expect. We receive the full support and assistance of the District's personnel. We are pleased to serve and be associated with the District as its independent public accountants and look forward to our continued relationship.

We look forward to discussing our report or any other matters of interest with you during this meeting.

Agenda

- Auditor Opinions and Reports
- Communication with Those Charged with Governance
- Management Representation Letter (available upon request)
- Other Information



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Auditor Opinions & Reports

Scope of Services

We have performed the following services for Tri-City Healthcare District:

- Annual financial statement audit as of and for the year ended June 30, 2018
- Annual financial statement audit, including Required Department of Housing and Urban Development ("HUD") Supplementary Information, Single Audit, and Negative Assurance on Compliance with the HUD Regulatory Agreement

We will also perform the following non-attest services:

- Completion of the Auditee portion of the Data Collection Form

Auditor Report on the Financial Statements

Unmodified Opinion

- Financial statements are presented fairly and in accordance with US GAAP

Other Auditor Reports

GAGAS Report on ***Internal Control Over Financial Reporting*** and on ***Compliance*** and ***Other Matters***

- No financial reporting findings to communicate
- No compliance findings to communicate

Report on Compliance with Requirements that could have a ***Direct and Material Effect on Each Major Federal Program*** and on ***Internal Control Over Compliance*** required by the ***Uniform Guidance***

- No control findings to communicate
- No compliance findings to communicate

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Communication with Those Charged with Governance

COMMUNICATION WITH THOSE CHARGED WITH GOVERNANCE

Our Responsibility

Our responsibility under US Generally Accepted Auditing Standards and Government Auditing Standards.

1

To express our opinion on whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, and in accordance with U.S. GAAP. However, our audit does not relieve you or management of your responsibilities.

2

To perform an audit in accordance with generally accepted auditing standards issued by the AICPA, *Government Auditing Standards* issued by the Comptroller General of the United States, and the California (CA) Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for CA Special Districts, and design the audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free of material misstatement.

3

To consider internal control over financial reporting and internal control over compliance as a basis for designing audit procedures but not for the purpose of expressing an opinion on its effectiveness or to provide assurance concerning such internal control.

4

To communicate findings that, in our judgment, are relevant to your responsibilities in overseeing the financial reporting process and administering federal awards. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

COMMUNICATION WITH THOSE CHARGED WITH GOVERNANCE

Planned Scope & Timing of the Audit

It is the auditor's responsibility to determine the overall audit strategy and the audit plan, including the nature, timing and extent of procedures necessary to obtain sufficient and appropriate audit evidence and to communicate with those charged with governance and overview of the planned scope and timing of the audit.

OUR COMMENTS

- The planned scope and timing of the audit was communicated to the District's audit committee at the audit entrance meeting and was included in the engagement letter for the year ended June 30, 2018.
- There were no significant changes to the planned scope and timing of the audit.

COMMUNICATION WITH THOSE CHARGED WITH GOVERNANCE

Significant Accounting Policies & Unusual Transactions

The auditor should determine that the audit committee is informed about the initial selection of and changes in significant accounting policies or their application. The auditor should also determine that the audit committee is informed about the methods used to account for significant unusual transactions and the effect of significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus.

OUR COMMENTS

- Management has the responsibility for selection and use of appropriate accounting policies. The significant accounting policies used by the District are described in the footnotes to the financial statements. Throughout the course of an audit, we review changes, if any, to significant accounting policies or their application, and the initial selection and implementation of new policies. There were no changes to significant accounting policies for the year ended June 30, 2018.
- We believe management has selected and applied significant accounting policies appropriately and consistent with those of the prior year.

COMMUNICATION WITH THOSE CHARGED WITH GOVERNANCE

Areas of Audit Emphasis

- Patient Revenue/Receivables
- Cost Report Settlements, including Supplemental Funding
- Self-Insured Liabilities
- Line of Credit and Long-Term Debt (HUD Financing, Covenant Compliance)
- Single Audit
- MOB Legal Proceedings

COMMUNICATION WITH THOSE CHARGED WITH GOVERNANCE

Management Judgements & Accounting Estimates

The audit committee should be informed about the process used by management in formulating particularly sensitive accounting estimates and about the basis for the auditor's conclusions regarding the reasonableness of those estimates.

OUR COMMENTS

- Management's judgements and accounting estimates are based on knowledge and experience about past and current events and assumptions about future events. We apply audit procedures to management's estimates to ascertain whether the estimates are reasonable under the circumstances and do not materially misstate the financial statements.
- Significant management estimates impacted the financial statements including the following: **allowances for patient accounts receivable; accrual for medical claims incurred but not reported; actuarially determined accruals for worker's compensation and medical malpractice liabilities; and accruals for third party settlements and supplemental funding.**
- We deem them to be reasonable.

COMMUNICATION WITH THOSE CHARGED WITH GOVERNANCE

Patient Accounts Receivable - Lookback Analysis

	2018	2017	2016	2015
Net Patient Accounts Receivable	$46,195,877	$44,016,641	$42,396,754	$43,587,397
Subsequent Cash Receipts 2 months after 6/30	$32,637,965	$31,060,699	$28,396,777	$33,688,323
% Collected 2 months after 6/30	70.7%	70.6%	67.0%	77.3%
Exposure after 2 months collections	$13,557,912	$12,955,942	$13,999,977	$9,899,074
Collected 14 months after 6/30	n/a	$46,861,510	$39,131,542	$46,861,510
% Collected 14 months after 6/30	n/a	106.5%	92.3%	107.5%

COMMUNICATION WITH THOSE CHARGED WITH GOVERNANCE

Management Judgements & Accounting Estimates

Our views about the quantitative aspects of the entity's significant accounting policies, accounting estimates, and financial statement disclosures.

OUR COMMENTS

- The disclosures in the financial statements are clear and consistent. Certain financial statement disclosures are particularly sensitive because of their significance to financial statements users. We call your attention to the following notes:
  - Note 6 – Goodwill
  - Note 8 – Short-term Debt
  - Note 9 – Long-term Debt
  - Note 14 – Commitments and Contingencies
  - Note 15 – Subsequent Events

COMMUNICATION WITH THOSE CHARGED WITH GOVERNANCE

Significant Audit Adjustments & Unadjusted Differences Considered by Management to Be Immaterial

The audit committee should be informed of all significant audit adjustments arising from the audit. Consideration should be given to whether an adjustment is indicative of a significant deficiency or a material weakness in the District's internal control over financial reporting, or in its process for reporting interim financial information, that could cause future financial statements to be materially misstated.

The audit committee should also be informed of uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented that were determined by management to be immaterial, both individually and in the aggregate, to the financial statements as a whole.

OUR COMMENTS

- There were no corrected or uncorrected audit adjustments.

Potential Effect on the Financial Statements of Any Significant Risks & Exposures

The audit committee should be adequately informed of the potential effect on financial statements of significant risks and exposures and uncertainties that are disclosed in the financial statements.

OUR COMMENTS

- The District is subject to potential legal proceedings and claims that arise in the ordinary course of business, which are disclosed in the notes to the financial statements.
  - Medical Office Building Proceeding – Contingencies related to the MOB matter have been disclosed in the financial statements as of and for the year ended June 30, 2018.

COMMUNICATION WITH THOSE CHARGED WITH GOVERNANCE

Difficulties Encountered in Performing the Audit

The audit committee should be informed of any significant difficulties encountered in dealing with management related to the performance of the audit, including disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the District's financial statements, or the auditor's report.

OUR COMMENTS

- No significant difficulties were encountered during our audit.
- We are pleased to report that there were no disagreements with management.

COMMUNICATION WITH THOSE CHARGED WITH GOVERNANCE

Material Uncertainties Related to Events & Conditions/ Fraud & Noncompliance with Laws and Regulations

Any doubt regarding the entity's ability to continue, as a going concern, should be communicated to the audit committee.

Fraud involving senior management and fraud (whether caused by senior management or other employees) that causes a material misstatement of the financial statements should be communicated. We are also required to communicate any noncompliance with laws and regulations involving senior management that come to our attention, unless clearly inconsequential.

OUR COMMENTS

- No such matters came to our attention.
- We have not become aware of any instances of fraud or noncompliance with laws and regulations.

COMMUNICATION WITH THOSE CHARGED WITH GOVERNANCE

Other Material Written Communications

The audit committee should be informed of any significant difficulties encountered in dealing with management related to the performance of the audit, including disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the District's financial statements, or the auditor's report.

OUR COMMENTS

- Management representation letter is available upon request.
- Other than the engagement letter, management representation letter, and communication to those charged with governance, there have been no other significant communications.

COMMUNICATION WITH THOSE CHARGED WITH GOVERNANCE

Management's Consultation with Other Accountants

In some cases, management may decide to consult about auditing and accounting matters. If management has consulted with other accountants about an auditing and accounting matter that involves application of an accounting principle to the District's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts.

OUR COMMENTS

- We are not aware of any significant accounting or auditing matters for which management consulted other accountants.

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #~~14~~18-006

POLICY TITLE: Board of Directors Meeting Minutes

Written minutes shall be produced for all official meetings of the Board of Directors, except for Special Board of Directors meetings that are called to hold a Closed Session and for which the Open Session portion contains only items of routine business of the type usually included in the consent portion of the Open Session agenda of Regular Board meetings. ~~Minutes shall be formatted in accordance with Attachment A~~. The minutes shall include the following:

1. A record of the motion as stated by the Board member who is making the motion, and a record of the Board member seconding the motion.

2. A record of the vote taken. The recording shall reflect the vote of each Board member, and shall include all Ayes, Noes, Abstentions and Absent votes.

3. All Open Sessions of Board of Directors meetings shall be audio ~~or video~~ taped.

4. Because Open Sessions of Board of Directors meetings are audio ~~or video~~ taped, except for Special Board of Directors meetings called to hold a Closed Session and for which the Open Session portion contains only items of routine business, minutes containing statements by individual members "for the record" shall not be recorded and summary minutes are not required.

5. Board of Directors meeting minutes and transcripts of meetings will not be given out to any individual Board member for review, edit or revision prior to presentation to the whole Board.

6. Open Session m~~M~~inutes of the Board of Directors shall be presented to the Board of Directors for review and approval by way of their Board Agenda packet.

7. All original ~~video and/or~~ audiotapes of Board meetings shall be secured, stored, and may be destroyed under the records retention policy of the District.

8. Minutes of closed sessions shall not be produced except as may be reasonably necessary to document consideration of matters for accreditation, compliance, licensing and similar purposes or as required by court order. ~~Draft minutes should be transmitted for review by a secure method.~~ Minutes of closed sessions shall be taken by Board Counsel and/or the Board Executive Secretary. watermarked with Board member's name and presented for approval by the Board in closed session and returned to the Executive Assistant at the conclusion of the Closed Session. ~~by the Board.~~ A minute book of closed sessions shall be maintained by Board Counsel with a copy to be kept and secured by the Board Executive Secretary. Closed session minutes shall be kept confidential and may not be reproduced or

released for purposes other than previously described and only after advice of Board Counsel.

~~8.~~ 9. All documents distributed in the Closed Session including minutes are considered confidential and must not be removed from the Closed Session.

Reviewed by Gov/Leg Committee: 04/13/05
Approved by the Board of Directors: 4/28/05
Reviewed by the Gov/Leg Committee: 8/10/05
Approved by the Board of Directors: 9/22/05
Reviewed by the Gov/Leg Committee: 11/8/06
Approved by the Board of Directors: 12/14/06
Reviewed by the Gov/Leg Committee: 10/10/07
Approved by the Board of Directors: 12/13/07
Reviewed by the Gov/Leg Committee: 10/12/10
Approved by the Board of Directors: 11/04/10
Reviewed by the Gov/Leg Committee: 2/09/11
Approved by the Board of Directors: 2/24/11
Reviewed by the Gov/Leg Committee: 10/10/12, 11/14/12
Approved by the Board of Directors: 12/13/12
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14
Approved by the Board of Directors: 9/25/18

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
September 12, 2018

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 9/28/2018 – 8/31/2020)

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 9/28/2018 through 8/31/2020:

- **GOMEZ, Jessica MD/Ophthalmology (San Diego Retina Associates)**
- **GOODINE, Thomas MD/Orthopedic Surgery FELLOW – Assist ONLY (San Diego Sports Medicine)**
- **LIM, David DO/Emergency Medicine (TeamHealth)**
- **SINGH, Luv MD/Orthopedic Surgery FELLOW – Assist ONLY (San Diego Sports Medicine)**
- **SMITH, David DDS/MD/Oral and Maxillofacial Surgery (VistaMed Oral & Maxillofacial Surgery)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 5
September 12, 2018

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 10/01/2018 -9/30/2020)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 10/01/2018 through 9/30/2020, 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:

- ALLEYNE, Neville, MD/Orthopedic Surgery/Active
- ANAKWENZE, Okechukwu, MD/Orthopedic Surgery/Provisional
- BEDROSIAN, Diane, MD/ Pediatrics/Active
- COOPERMAN, Andrew, MD/Orthopedic Surgery/Active
- CURRY, Jason, MD/Internal Medicine/Provisional
- DAUGHERTY, David, MD/Orthopedic Surgery/Active
- DAVIES, James, MD/Ophthalmology/Active Affiliate
- ELLINI, Ahmad, MD/Pediatric Cardiology/Active Affiliate
- FERBER, Jeffrey, MD/Family Medicine/Active Affiliate
- GLASSER, Judd, MD/Emergency Medicine/Active
- GUPTA, Anshu, MD/ Plastic Surgery/Active
- IYENGAR, Srinivas, MD/Ophthalmology/Active Affiliate
- JUREWITZ, William, MD/Obstetrics & Gynecology/Active
- KHALESSI, Alexander, MD/Neurological Surgery/Provisional
- LIU, Wilson, MD/Family Medicine/Refer and Follow
- LOTAN, Roi, MD/Teleradiology/Provisional
- PENDLETON, Robert, MD/Ophthalmology/Active Affiliate
- PERRIZO, Nathan, DO/ Pain Medicine/Active

Attachment B

- QUESNELL, Tara, DO/Neurology/Provisional
- RIAD, Shareef, MD/Teleradiology/Provisional
- ROSENBERG, Jay, MD/Neurology/Active
- SAMADY, Ioseph, MD/Allergy & Immunology/Refer and Follow
- SEIDEN, Grant, MD/Orthopedic Surgery/Provisional
- SHOWAH, Henry, MD/Emergency Medicine/Active
- SLATER, Madeline, MD/Infectious Disease/Active
- TINIO, Stephen, MD/ Family Medicine/Active
- WHITNEY, Janet, DO/ Wound Care/Active
- YOLER, Katharine, MD/Teleradiology/Active Affiliate
- ZIERING, Robert, MD/Allergy & Immunology/Active Affiliate
- ZIMMERMANN, Andres, MD/Internal Medicine/Refer and Follow

RESIGNATIONS: (Effective date 9/30/2018 unless otherwise noted)

Automatic:

- CHASE, Nicole PA-C/Allied Health Professional

Voluntary:

- CAPELLA, Marina, MD/Pediatrics
- CEPERO, Oscar, MD/Anesthesiology
- CHAUHAN, Aakash, MD/Orthopedic Surgery
- GILSON, George, MD/Obstetrics & Gynecology
- KOCH, Richard, MD/Emergency Medicine
- KINNAIRD, Patrick, MD/Anesthesiology

Attachment B

- **MAEDA, Andrew, MD/Anesthesiology**
- **MENDOZA, Jorge, MD/Teleradiology**
- **PARK, Sue Ann, MD/Pediatrics**
- **PORTER, Anthony, MD/Orthopedic Surgery**
- **SHAPIRO, Mark, MD/Nephrology**
- **VOGEL, Curt, MD/Dermatology**
- **YAGER, Craig, MD/Orthopedic Surgery**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
September 12, 2018

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS
PRIVILEGE RELATED CHANGES

VOLUNTARY RELINQUISHMENT OF PRIVILEGES

- BERDJIS, Farhouch MD — Pediatric Cardiology
- GOKALDAS, Reshma MD — Neurology
- HIGGINS, Steven MD — Cardiology

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and are approved for an additional 6 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by March 31, 2019 would result in these privileges automatically relinquishing.

- GOLTS, Eugene MD — Cardiothoracic Surgery
- GRAMINS, Daniel MD — Cardiothoracic Surgery
- HOWE, Steven MD — Cardiothoracic Surgery
- POLLEMA, Travis DO — Cardiothoracic Surgery

ADDITIONAL EQUIPMENT USE REQUEST

The following practitioners have previously met the initial criteria for the Robotics bundle and have turned in the certificate to utilize the Xi Robotics Equipment:

- PURCOTT, Kari M.D. — OB/GYN

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
September 12, 2018

Attachment C

PROCTORING RECOMMENDATIONS (Effective 9/30/18, unless otherwise specified)

• COCO, Kathleen CNM	Allied Health Professional
• FISCHER, Andrew MD	Emergency Medicine
• GASTELUM, Jennifer MD	Anesthesiology
• GRAMINS, Daniel MD	Cardiothoracic Surgery
• PATEL, Lance MD	Anesthesiology

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT
September 17, 2018

Attachment B

BIENNIAL REAPPRAISALS: (Effective Dates 10/01/2018 – 07/31/2020)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappraisal to the Allied Health Professional stafff effective 10/01/2018 through 07/31/2020, 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:

- **BALLANTINE, Katherine, CNM/Allied Health Professional**
- **CARNELIAN, Alissa, AuD/Allied Health Professional**
- **Elamparo, Kaye, NP/Allied Health Professional**
- **FAZZINO, Dolores, NP, RNFA/Allied Health Professional**
- **FORBES, Beth, RNFA/Allied Health Professional**
- **HERMANN, Linda, PAC/Allied Health Professional**
- **MARTINEZ, Melinda, PAC/Allied Health Professional**
- **SCOTT, Katie, PAC/Allied Health Professional**
- **VENOR, Kristen, CNM/Allied Health Professional**

ANNUAL EVALUATIONS:

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

- Ahumada, Alejandro G., AuD
- Allen, Danielle M., AuD
- Brady, Kristina C., AuD
- Buckley, Alicia N., OT
- Carnelian, Alissa A., AuD, CNIM
- Cowan, John W., PAC
- Crespo, Christopher N., PA-C
- Deatrick, Veronica, NP
- Elamparo, Kaye L., NP
- Fazzino, Dolores L., NP, RNFA
- Forbes, Beth, RNFA
- Frost, Robert, PAC

Attachment B

- Garbaczewski, Stephanie H., PA-C
- Guthrie, Lesli A., AuD
- Hamilton Jr., James N., PA-C
- Hammonds, Tommy D., PA-C
- Hartig, Margaret, NP
- Jaramillo, Elizabeth C., AuD
- Jenkins-Sebastiani, Christina L., AuD
- Johnson, Mark C., PA-C
- Kolt, Thomas L., PAC
- McNally, Paul D., NP
- Murphy, Kayla, CNM
- Savic, Jessica, PA
- Spencer, Matthew J., PAC
- Stahl, Hollis T., PA
- Taylor, Phyllis J., NP
- Tebon, Renee, PAC
- Venor, Kristen A., CNM
- Vierra, Erin, NP

RESIGNATIONS: (Effective date noted below)

- **FREEMAN, Wanda, NP/Allied Health Professional**
- **LAFORTEZA, Jozelle, NP/Allied Health Professional**
- **MIRPOURIAN, Nabat, NP/Allied Health Professional**
- **SILVERWOOD, Cristie, NP/Allied Health Professional**
- **WEICHERT, Rachel, AuD, CNIM/Allied Health Professional**

ADMINISTRATION REVIEW CONSENT AGENDA
September 13, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Hazardous Drugs Procedure	Practice Change	Forward to BOD for Approval
2. HIV Identification Screening Prevention of Perinatal Transmission Standardized Procedure	2 Year Review, Practice Change	Forward to BOD for Approval
3. IV Solution, Storage & Warming of Procedure	3 Year Review, Practice Change	Forward to BOD for Approval
4. Medication Reconciliation Policy	Practice Change	Forward to BOD for Approval
5. Nitrazine Test on Vaginal Fluid Procedure	Practice Change	Forward to BOD for Approval
6. Nutritional Screening Care & Assessment for Infants, Pediatrics & Adolescents Policy	3 Year Review, Practice Change	Forward to BOD for Approval
7. Potential Food and Drug Interactions, Patient Education Policy	3 Year Review, Practice Change	Forward to BOD for Approval
8. Sharps Disposal, Procedural Areas Policy	DELETE	Forward to BOD for Approval
9. Sharps Injuries Prevention Policy	3 Year Review, Practice Change	Forward to BOD for Approval
10. Urine Chemistry Using a Urine Dipstick Measuring Procedure	Practice Change	Forward to BOD for Approval
11. Urine Dipstick Analysis Using Siemens Clintek Status Procedure	Practice Change	Forward to BOD for Approval
Administrative Policies & Procedures		
1. Workplace Violence 463 Policy	3 Year Review, Practice Change	Forward to BOD for Approval
Food & Nutrition		
1. Diet Manual Policy	3 Year Review, Practice Change	Forward to BOD for Approval
Infection Control		
1. Aerosol Transmissible Diseases and Tuberculosis Control Plan IC 11 Policy	Practice Change	Forward to BOD for Approval
2. Cleaning and Disinfection - IC 9 Policy	3 Year Review, Practice Change	Forward to BOD for Approval
3. Philosophy - IC 1 Policy	3 Year Review, Practice Change	Forward to BOD for Approval
Medical Staff		
1. Audit Criteria for Blood UR 8710-540 Policy	3 Year Review, Practice Change	Forward to BOD for Approval
Surgical Services		
. Local Anesthesia in OR Policy	NEW	Forward to BOD for Approval
2. Surgical Supply Stocking, Rotation and Outdate Policy	3 Year Review, Practice Change	Forward to BOD for Approval

ADMINISTRATION REVIEW CONSENT AGENDA
September 13, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Formulary Requests		
1. Gadoversetamide (Optimark) conversion to Gadobutrol (Gadavist)	Modification to Formulary Status	Forward to BOD for Approval
2. Nitroglycerine 0.4mg Spray	Addition to Formulary	Forward to BOD for Approval

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**HAZARDOUS DRUGS**
Purpose:	To ensure the safety of ~~our~~ employees/patients during the administration ~~and patient care of those receiving~~ hazardous drugs within Tri-City **Healthcare District**~~Medical Center~~ (TC**HDMC**)
Supportive Data:	National Institute of Occupational Safety and Health (NIOSH) and Center for Disease Control (CDC)
Equipment:	Cytotoxic bin, yellow chemo waste bags, N-95 mask, double gloves, gown, splash goggles or face shield, protective shoe covers

A. **DEFINITION(S):**

1. Hazardous drugs **(HD)** ~~are drugs known to cause~~: **As defined by the NIOSH Working Group, drugs considered hazardous include those that exhibit one or more of the following six characteristics in humans or animals:**
   a. Carcinogenicity~~—the ability to cause cancer in animal models, humans or both.~~
   b. Teratogenicity **or other development toxicity**~~—the ability to cause defects on fetal development or fetal malformation.~~
   c. Reproductive toxicity in humans
   d. Organ toxicity at low doses in humans or animals
   ~~c.~~**e.** Genotoxicity – the ability to cause a change or mutation in genetic material.
   ~~d.~~**f. Structure and toxicity profiles of new drugs that mimic existing drugs determined hazardous by the above criteria**
2. **NIOSH HD risk stratification:**
   a. Group 1: Antineoplastic drugs (American Hospital Formulary Service [AHFS] Classification 10:00) ~~**[ASHP/AHFS DI 2013]**~~**.**
   b. Group 2: Non-antineoplastic drugs that meet one or more of the National Institute for Occupational Safety and Health (NIOSH) criteria for a hazardous drug.
   ~~e.~~**c. Group 3: Drugs that primarily pose a reproductive risk to men and women who are actively trying to conceive and women who are pregnant or breast feeding, because some of these drugs may be present in breast milk.**

~~2. Hazardous drugs are known to have the potential to cause fertility impairment, which is a major concern for most clinicians.~~

3. ~~These h~~**Hazardous drugsHD consists of certain**~~can be classified as~~ antineoplastics **such as** ~~like~~ **chemotherapy, as well as medications to treat disease states other than cancer**~~cytotoxic agents, biologic agents, antiviral agents and immunosuppressive agents~~.

B. **POLICY:**

1. **This policy applies to** ~~**medications administered during the patients' hospital stay**~~**TCHD staff handling or administering hazardous drugs. Additionally, this policy pertains to TCHD staff handling the bodily fluids of admitted patients who received these drugs during their hospital stay.** ~~TCMC staff working with hazardous drugs and the body fluids of patients receiving these drugs shall adhere to this procedureand reference Patient Care Services (PCS) Procedure:~~

~~1. Disposal of Chemotherapy Waste such as body fluids including sweat, saliva, emesis, urine, feces, semen, vaginal fluid, or blood.~~

2. **Appropriate personal protective equipment (PPE) must be worn when handling HDs including during receipt, storage, transport, compounding (sterile and nonsterile), administration, deactivation/decontamination, cleaning,** ~~and~~ **disinfecting, spill control and waste disposal.**

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Executive Council	Medical Staff Department / Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
08/10, 02/11, 03/12, 06/16, 02/17	03/12, 07/16, 08/17, 05/18	03/12, 07/16, 08/17, 05/18	n/a	09/16, 07/18	04/12, 09/16, 08/18	09/18	05/12, 10/16, n/a	05/12, 11/16

a. See Related Document: Hazardous Drugs, ~~Requirements for~~ Personal Protective Equipment When Handling ~~Group 1 and 2 Agents~~HD.
   i. Chemo-safe gloves must meet American Society for Testing and Materials (ASTM) standard D6978 (or its successor).

3. Only a ~~TCMC~~TCHD ~~trained~~ registered nurse (RN) who has completed the NetLearning "Administering a Hazardous Drug" module may administer a hazardous drug. ~~Training consists of completion of the initial Net-Learning "Administering a Hazardous Drug" module.~~

4. Identification of ~~Hazardous Drugs~~HD:
   a. ~~Hazardous drugs~~HD are identified based on the NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings.
   b. Pharmacy maintains a list of the ~~hazardous drugs~~HD (see ~~current~~Related Document: Hazardous Drug List).
      i. The ~~hazardous drug~~HD list is reviewed and updated at least annually.
      ii. An assessment of risk is performed at least annually to determine alternative containment strategies and/or work practices for Group 3 HDs or any other HDs as determined by TCHD to minimize occupational exposure.
   c. ~~Hazardous drugs~~HD identified by the facility are communicated to all staff that may potentially handle these agents. Methods of communication include, but are not limited to:
      i. Ready access to the hazardous drug list
      ii. Ancillary labels
      iii. Pyxis alerts
      ~~i.~~iv. Electronic Medication Administration Record (eMAR) comments

~~2.~~5. All Group 1 and 2 HDs will have appropriate ancillary labels attached such as "Caution: Hazardous Drug" or "Caution: Chemotherapy". Group 3 does not require additional labeling.

~~1. Safe handling of hazardous drugs is crucial for both the patient and the provider.~~

6. All patients who have received Group 1 and 2 ~~these drugs~~HD ~~in the previous~~within 48 hours, shall be clearly ~~designated as such~~identified by signage ~~that is~~ posted at the patients' bedside designating cytotoxic or hazardous drug therapy.
   a. Receipt of these drugs must be reported during caregiver handoff.

7. Precautions must be taken during administration and until 48 hours after last dose.
   a. Equipment and patient care items which come into contact with these drugs or with body secretions from patients within 48 hours post administration, are considered contaminated and must be handled and disposed of as such.

~~3.~~8. All body fluids sent for laboratory testing, from patients who have received Group 1 and 2 HDs in the previous 48 hours, must be labeled as such.

C. PREPARATION OF HAZARDOUS DRUGS:

1. Injectables:
   a. Group 1 and 2:
      i. All injectable Group 1 and 2 HDs will be prepared by pharmacy under a chemo hood.
      ii. Personnel will double glove with sterile chemo safe gloves, don a chemo gown, face mask and double shoe covers.
         ~~Outer chemo gloves must be sterile.~~
         1) A second pair of shoe covers must be donned before entering chemo IV room and doffed when exiting.
      iii. Drugs will be prepared using a closed system transfer device (CSTD) when vial size permits.
         1) If CSTD not applicable due to vial size or route of administration, ~~luer~~luer~~re~~ locking system must be used.

iv. Tubing will be attached and primed in the hood with a non-HD solution. ~~A sticker will be attached indicating "line primed with active drug".~~

b. Group 3:

i. Parenteral Group 3 HDs may be prepared in positive pressure buffer room using acceptable practices for non-hazardous medications.

2. Non-injectables:

a. Group 1 and 2:

i. All non-injectable Group 1 and 2 HDs will be handled in the following manner:

1) Chemo safe gloves will be used during routine handling of Group 1 and 2 HDs and contaminated equipment.

2) Hazardous medications are not to be repackaged on a high speed packager or other equipment that ~~which~~ may expose other medications to powdered contaminants.

3) Blister pak systems or other re-packaging systems that do not have a risk of exposing other medications to powdered contaminants, may be used to repackage hazardous medications.

4) Any preparation including pouring and counting will be done with equipment that is wiped down after use with hazardous medications.

a) Equipment that enters the chemo hood should be dedicated to this use only.

5) Medications may not be cut, crushed, or diluted on the nursing unit.

a) Cutting or crushing of hazardous oral medications will be done only under a chemotherapy hood by pharmacy.

6) Compounded liquid (solution or crushed medication mixed in a slurry) medications will be:

a) Prepared in the chemotherapy hood by pharmacy

b) Dispensed in an oral syringe

c) Provided to patients from pharmacy when a patient cannot swallow the intact oral solid dosage form (e.g. NGT)

d) Dispensed in a sealable plastic bag in order to contain any inadvertent contamination.

b. Group 3:

i. Non-injectable Group 3 HDs may be prepared ~~like~~the same as non-hazardous medications.

1) It is recommended that men and women of child bearing age or women who are pregnant or breastfeeding:

a) Use double chemo-safe gloves during handling and administration.

b) Use mask ~~if~~when crushing or splitting. May wear gown if risk of splashing.

i) It is not required to crush or split in chemo hood.

~~a)~~c) Take special care to wipe down equipment before use if risk of contamination.

D. <u>TRANSPORTING HAZARDOUS DRUGS:</u>

1. All liquid (parenteral and oral) Group 1 and 2 HDs ~~will~~shall be transported as follows:

a. In a sealable plastic bag ~~be double zip-locked and transported in a chemo cooler to the nursing floor.~~

b. ~~A spill kit must be included.~~Group 1 drugs shall be transported in a chemo cooler with a spill kit and delivered to authorized floors only.

~~All Group 1 HDs will be delivered to authorized floors.~~

~~4.~~2. Liquid and solid Group 3 HDs may be delivered as standard non-HD medications.

~~5.~~E. **ADMINISTERING HAZARDOUS DRUGS:**

~~a. Hazardous drugs will be identified by pharmacy and a warning will be placed in both the medication Pyxis and the electronic medical record (eMAR) to alert the nurse. See Hazardous Drug List.~~

~~b. Hazardous drugs may not be handled with bare hands.~~

1. **When handling and or/administering Group 1 and 2 HDs, personnel shall do the following:**
   - a. **Don ~~disposable gown made of lint free low permeability fabric when there is a risk of splashing. These gowns should have a closed front, long sleeves and elastic or closed cuffs.~~gown. Gowns should be changed if contaminated with drugs or excreta from patients.**
   - ~~i.~~b. **Don~~Always~~ two pairs of** double **chemo-safe** glove**s ~~prior to handling a hazardous drug and its packaging~~**.
   - c. Never score or crush **Group 1 or 2 HDS~~s hazardous drugs~~** (prevents inhalation of the drug).
   - d. Notify pharmacy if **Group 1 or 2 HDs~~a hazardous~~** must be administered via gastric tube (i.e., nasogastric or oral gastric small bore feeding tube).
   - ~~i.~~e. Ensure a yellow puncture-proof cytotoxic waste container is available on the unit (i.e., medication room or designated area)~~. for Group 1 or 2 HDs.~~
   - f. Document all hazardous drug patient education ~~for Group 1 or 2 HDs~~ in the Education All Topics Ad-hoc form under "Medication Topics."
     - i. **Instruct patients to avoid exposing others to any type of body secretions for 48 hours after their last dose.**
     - ii. **When using home toilet, instruct patient to flush twice with the lid down.**
2. **When handling and/or administering Group 3 HDs, personnel may:**
   - a. **Use double chemo-safe gloves during handling and administration.**
   - b. **Use mask if crushing or splitting. May wear gown if risk of splashing.**
3. **Additional PPE Protection:**
   - a. **Eye and face protection:**
     - i. **Personnel may use splash goeggles or a face shield at any time during the handling of Group 1 or 2 HDs when there is a risk of spills or splashing.**
   - b. **Respiratory protection:**
     - ~~6.~~i. **A surgical N95 respirator may be used at any time during the handling of Group 1 or 2 HDs, when there is a risk of inhalation of airborne particles.**

~~7.~~F. **HAZARDOUS DRUG DISPOSAL AND WASTE:**

1. **Refer to TCHD Waste Disposal Guidelines Poster.**

~~a.~~2. Dispose of the following in a yellow puncture proof cytotoxic waste container:
   - a. **Equipment or packaging contaminated with "trace":**
     - ~~i.~~1) Needles and syringes used when administering **Group 1 and 2 HDs~~hazardous drugs~~**.
     - ~~ii.~~2) Non-sharp materials exposed to **Group 1 and 2 HDs ~~a hazardous drug~~** (i.e., pill packaging, IV tubing/empty IV bags, and gloves).
     - ~~iii.~~3) **Group 2 HDs ~~Hazardous drugs~~** in a **solid** pill **or liquid** form~~. that have been contaminated or just need to be wasted.~~
     - ~~b.~~4) Notify environmental services (EVS) when any yellow puncture proof cytotoxic waste container is 2/3 full.

~~i.~~3. **Dispose of the following in a black RCRA container:**
   - ~~1)~~a. **Group 1 HDs in "bulk form":**
     - ~~2)~~i. **IV bag that contains >3% of residual total volume of hazardous drug. Any volume less than this is considered "trace".**
     - ~~c.~~ii. **Solid form of drug (pill or capsule).**
   - b. **Group 2 and 3 medications with RCRA designation.**

~~b.~~c. **If a RCRA container is not located on floor or is not large enough, Group 1 HDs must be transported to pharmacy for disposal. ~~Drug~~Medications shall be placed in ~~double zip-locked~~ a sealed plastic bag and labeled as "chemotherapy".**

~~3.~~4. **All ~~Category~~ non-RCRA Group 3 drugs ~~can~~shall be disposed of in a pharmaceutical waste container~~, unless a Resource Conservation Recovery Act (RCRA) medication~~. Dispose of packaging and gowns in regular waste.**

~~8.~~5. **Group 1 or 2 HDs:** Preventing Exposure to Body Fluid and Contaminated Linen:

a. **When handling body fluids or contaminated linen or equipment, PPE must be worn. ~~(see Appendix A)~~Wear appropriate personal protective equipment (PPE) which may include the following:**

~~i. N-95 mask~~
~~ii. Double gloves~~
~~iii. Gown~~
~~iv. Splash goggles or face shield~~
~~v. Protective shoe covers~~

i. **All disposable equipment (i.e., Foley catheter, bedpan, graduated cylinder, and diapers) used in caring for these patients, must be disposed of in a yellow trace chemotherapy waste container and placed in the designated chemotherapy waste area on the unit.**

b. Disposing of body fluid:~~.~~
   i. Dispose of body fluids in the toilet.
   ii. Do not use the toilet sprayer. Rinse containers with a cup of water to prevent splashing.
   iii. Before flushing toilet, cover open toilet with new chux.
   iv. Flush toilet twice, and discard chux. (New chux to be used with each flush.)
      ~~iv.~~1) **Toilet may be flushed once if equipped with a high pressure flushing mechanism.**
   v. Place PPE and chux in chemotherapy waste bag.
   vi. Non-Oncology units contact EVS to dispose of chemo waste bag when they become 2/3 of the way full.
   vii. Oncology unit will place sealed chemo waste bag in the designated chemotherapy waste area on the unit.

c. All linen exposed to **Group 1 or 2 HDs~~ a hazardous drug~~** or body fluid of a patient that is currently receiving or has received agents in the past 48 hours, must be placed (using gown and **chemo-safe** double gloves~~d~~) in a yellow chemotherapy waste bag and tagged by the EVS with a "Special Handling Ticket" before adding it to the general hospital linen.

~~d. Skin care of incontinent adult receiving hazardous drugs.~~
~~i. Clean patient's skin after voiding or having a bowel movement.~~
~~ii. Apply protective barrier ointment or cream before diapering.~~

~~e.~~ ~~All disposable equipment (i.e., foley catheter, bedpan, graduated cylinder, and diapers) used in caring for these patients must be disposed of in a chemotherapy waste container and placed in the designated chemotherapy waste area on the unit.~~

~~9.~~G. **HD EXPOSURES AND PREVENTION MANAGEMENT:**

1. **Skin care of incontinent adult receiving ~~hazardous drugs~~HD:~~.~~**
   a. **Clean patient's skin after voiding or having a bowel movement.**
   b. **Apply protective barrier ointment or cream before diapering.**
2. In the event of skin exposure to a hazardous drug, remove any contaminated garment and immediately wash contaminated skin with soap and water.

~~a.~~3. In case of eye exposure, immediately flush the eye with saline solution or water for at least five (5) minutes.

~~b. All linen exposed to a hazardous drug or body fluid of a patient currently receiving (or received) agents in the past 48 hours, must be placed (using gown and double gloved) in a yellow~~

~~chemotherapy waste bag and tagged by the EVS with a "Special Handling Ticket" before adding it to the general hospital linen.~~

~~i. Contact EVS when chemo waste linen bag is 2/3 full. EVS will place the chemo waste linen bag in a regular hospital blue linen bag and will place a special handling ticket on the outside of the blue linen bag before it can be placed in the general hospital linen.~~

~~c. Place any disposable contaminated materials into a sealed, leak-proof chemo waste plastic bag. Use the yellow puncture proof cytotoxic containers for sharps or breakable items.~~

~~d. All containers will be clearly labeled citing the hazardous nature of the contents.~~

~~e.~~4. Report any exposures or spills to your Assistant Nurse Manager/Relief Charge Nurse/supervisor.

~~f.~~5. Report any employee exposure to employee health services and/or emergency department.

~~g.~~a. Complete an Illness/Injury Investigation Report.

~~h.~~6. Report patient exposures to the patient's healthcare provider and per **Administrative Policy:** Incident Report-Quality Review Report (QRR) RL Solutions 396 ~~institution policy~~.

~~10.~~H. **HANDLING OF GROUP 1 AND 2 HDS – PHARMACY DEPARTMENT:**

~~Responsibilities of personnel handling hazardous drugsHD:~~

1. **A designated person who is qualified and trained will oversee entity compliance with United States Pharmacopeia (USP) 800 and all applicable laws, regulations and standards, as well as develop and implement appropriate procedures.**
2. **Signs designating HD handling areas will be will be displayed above the entrance.**
   a. **Access to these areas will be restricted to authorized personnel only.**
3. **Receiving:**
   a. **Designated areas must be available for receipt and unpacking of HDs.**
   b. **HDs must be unpacked in an area that is neutral/normal or negative pressure relative to the surrounding areas.**
   c. **Chemotherapy gloves must be worn when unpacking HDs.**
   d. **Receiving and handling of damaged HD shipping containers will be performed as per USP 800 requirements.**

   ~~Refer to Table 4 of USP 800 for requirements when receiving and handling damaged HD shipping containers.~~
4. **Storage:**
   a. **Group 1 and 2 HDs that require compounding, must be stored in the negative pressure buffer room.**
   b. **Refrigerated Group 1 and 2 HDs must be stored in a dedicated refrigerator in the negative pressure buffer room.**
      i. **Exhaust should be located adjacent to the refrigerator's compressor and behind the refrigerator. Solid state engineering (no compressor) may be considered.**

   ~~Other formulations of Group 1 HDs may be outside of IV room but separated from other stock.~~

   ~~a. Group 2 and 3 HDs may be stored with other stock~~

   c. **Group 2 and 3, as well as final dosage forms of Group 1 HD may be stored with other inventory.**
   d. **Drug bins, shelves, and storage areas bear distinctive labels identifying those drugs requiring special handling precautions.**

   ~~All storage bins for 1, 2 and 3 HDs will be labeled with a "Hazardous Drug" sticker.~~
5. **Deactivating, decontaminating, cleaning, and disinfecting:**
   a. **All areas where HDs are handled and all reusable equipment and devices must be deactivated and decontaminated.**
      i. **Additionally, sterile compounding areas and devices must be subsequently cleaned and disinfected.**
      ii. **See Pharmacy: Sterile Compounding Policy for cleaning and disinfecting procedures.**

b. Deactivation/decontamination must occur at least daily (when areas/equipment used), any time a spill occurs, before and after certification, any time voluntary interruption occurs, and if the ventilation tool is moved.
c. Deactivation renders compound inert or inactive.
   i. Example agents include peroxide formulations, sodium hypochlorite
d. Decontamination removes HD substances.
   i. Example agents include 70% isopropyl alcohol, water, peroxide, or sodium hypochlorite

6. Competency Assessment:
   a. Training must occur before personnel independently handle HDs~~.~~:
      i. Overview of TCHDs~~'~~ list of HD and their risks.
      ii. Review of the TCHDs' standards of practice related to handling of HDs.
      iii. Proper use of PPE.
      iv. Proper use of equipment and devices.
      v. Response to known or suspected HD exposure.
      vi. Spill management.
      vii. Proper disposal of HDs and trace-contaminated material.
   b. Competency will be reassessed annually.
   ~~c. Use chemo gloves when handling hazardous drugs for:~~
      ~~i. Unit dosing~~
      ~~ii. Admixing~~
      ~~iii. Preparing for feeding tube~~
      ~~iv. If the packaging is not intact~~
   ~~d. Any hazardous drug sent from the pharmacy (not dispensed from Pyxis) will have a "Hazardous Drug" label attached.~~
   ~~e. Admixing and crushing of hazardous drugs will be done in the chemo hood. The chemo closed system is not necessary.~~
   ~~f. All hazardous drugs will have warnings on the eMAR and the Pyxis system.~~
   ~~g. All vials, bottles, packaging, syringes, etc. will be disposed of in the trace chemotherapeutic waste container.~~

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

1. Administrative Policy: 396 Incident Report-Quality Review Report (QRR) RL Solutions
~~1.~~2. Hazardous Drugs (HD), Personal Protective Equipment When Handling HD
3. Patient Care Services Policy: Chemotherapy Prescribing, Processing and Preparation ~~Policy~~
4. Patient Care Services Procedure: Chemotherapy Administration ~~Procedure~~
~~2.~~5. Patient Care Services Procedure: Disposal of Chemotherapy Waste ~~Procedure~~
6. Patient Care Services Procedure: Disposal of Chemotherapy Waste Such as Body Fluids Including Sweat, Saliva, Emesis, Urine, Feces, Semen, Vaginal Fluid, or Blood ~~Procedure.~~
7. Patient Care Services Procedure: Chemotherapy Exposure, Spills and Handling of Linens Contaminated With Chemotherapeutic Agents And Body Fluids, Accidental Exposure To Radioactive Body Fluids ~~Procedure~~
8. Pharmacy Policy: Sterile Compounding ~~Policy~~
9. TCHD Hazardous Drug List
10. TCHD Waste Disposal Guidelines
~~1.~~11. Environment of Care Policy: Hazardous Material and Waste Management and Communication Plan

J. EXTERNAL LINK(S):

~~D.~~1. USP 800 Table 4

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

1. American Hospital Formulary Service (2013). Drug Information.

2. **Department of Health and Human Services. NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings, (2016). http://www.cdc.gov/niosh/topics/antineoplastic/pdf/hazardous-drugs-list_2016-161.pdf. ~~Accessed 11/16/16.~~**

~~1. Health Waste Management (HCWM). (2006). The 10 categories of hcrw #9 genotoxic/cytotoxic waste.~~

3. National Institute for Occupational Safety and Health. (2004). Preventing occupational exposure to antineoplastic and other hazardous drugs in health care settings. http://www.cdc.gov/niosh/docs/2004-165/#c

4. **US Pharmacopeial Convention. (2016) USP Compounding Compendium~~, 2016~~. ~~pp~~ 85-103.**

Hazardous Drugs (HD), Personal Protective Equipment When Handling ~~Group 1 and 2~~HD

Personal Protective Equipment When Handling ~~Group 1 and 2 Hazardous Drugs~~HD†					
Activity/Description	Double ~~Chemotherapy~~ Gloves	Chemotherapy Gown	Hair, Beard, Face Mask, Shoe Covers	Eye & Face Protection	Respiratory Protection
Receiving Suspected / Broken Supplies	~~All Groups~~✓x	~~Group 1 & 2 Only~~✓x	~~Group 1 & 2 Only~~✓x	~~All Groups~~✓x	~~Group 1 & 2 Only~~✓x
Non-Sterile HD Compounding	~~All Groups~~✓x	~~Group 1 & 2 Only~~✓x	~~Group 1 & 2 Only~~✓x		
Sterile HD Compounding	~~All Groups~~✓x	~~Group 1 & 2 Only~~✓x	~~Group 1 & 2 Only~~✓x		
Administering Liquid HDs	~~All Groups~~✓x	~~Group 1 & 2 Only~~✓x		~~All groups when splashing possible~~All ~~Groups~~ Only when splashing is possible	
Administering Solid HDs	~~All Groups~~✓x				
Crushing/Splitting*	~~All Groups~~✓x	✓x~~All groups when splashing possible~~	✓x	~~All groups when splashing possible~~	~~All Groups~~
Standard or Routine Clean-up	~~All Groups~~✓x	~~Group 1 & 2 Only~~✓x	~~Group 1 & 2 Only~~✓x	~~All Groups~~- Only when cleaning at or above eye level	
Collection and Disposal of Patient Waste	~~All Groups~~✓x	~~Group 1 & 2 Only~~✓x		~~All Groups~~O- nly when splashing is possible	
Spills	~~All Groups~~✓x	~~Group 1 & 2 Only~~✓x	~~Group 1 & 2 Only~~✓x	~~All Groups~~✓x	~~Group 1 & 2 Only~~✓x

†Personal protective equipment is optional for Group 3
*Only Group 3 can by crushed or split outside the Pharmacy Department.

Tri-City Healthcare District Hazardous Drug List

Hazardous Group 1: Antineoplastic drugs

Generic Name	Brand Name	Form	AHFS-Therapeutic Classification
Abiraterone	Zytiga	Oral	Antineoplastic agent
Ado-trastuzumab emtansine	Kadcyla	Inj	Antineoplastic agent
Afatinib Dimaleate	Gilotrif	Oral	Antineoplastic agent
Altretamine	Hexalen	Oral	Antineoplastic agent
Amsacrine	Amsidine	Inj	Not in AHFS (Antineoplastic agent)
Anastrozole	Arimidex	Oral	Antineoplastic agent
Arsenic trioxide	Trisenox	Inj	Antineoplastic agent
Axitinib	Inlyta	Oral	Antineoplastic agent
Azacitidine	Vidaza	Inj	Antineoplastic agent
Bacillus Calmette-Guerin	BCG	Inj	Vaccine
Belinostat	Beleodaq	Inj	Antineoplastic agent
Bendamustine HCL	Treanda	Inj	Antineoplastic agent
Bexarotene	Targretin	Oral, Topical	Antineoplastic agent
Bicalutamide	Casodex	Oral	Antineoplastic agent
Bleomycin	Blenoxane	Inj	Antineoplastic agent
Bortezomib	Velcade	Inj	Antineoplastic agent
Bosutinib	Bosulif	Oral	Antineoplastic agent
Brentuximab vedotin	Adcetris	Inj	Antineoplastic agent
Busulfan	Busulfex	Inj, Oral	Antineoplastic agent
Cabazitaxel	Jevtana	Inj	Antineoplastic agent
Cabozantinib	Cometriq	Oral	Antineoplastic agent
Capecitabine	Xeloda	Oral	Antineoplastic agent
Carboplatin	Paraplatin	Inj	Antineoplastic agent
Carfilzomib	Kyprolis	Inj	Antineoplastic agent
Carmustine	BiCNU	Inj	Antineoplastic agent
Ceritinib	Zykadia	Oral	Antineoplastic agent
Chlorambucil	Leukeran	Oral	Antineoplastic agent
Cisplatin	Platinol	Inj	Antineoplastic agent
Cladribine	Leustatin	Inj	Antineoplastic agent
Clofarabine	Clolar	Inj	Antineoplastic agent
Crizotinib	Xalkori	Oral	Antineoplastic agent
Cyclophosphamide	Cytoxan	Oral, Inj	Antineoplastic agent
Cytarabine	Ara-C, Depocyt	Inj	Antineoplastic agent
Dabrafenib	Tafinlar	Oral	Antineoplastic agent
Dacarbazine	DTIC	Inj	Antineoplastic agent
Dactinomycin	Cosmegen	Inj	Antineoplastic agent
Dasatinib	Sprycel	Oral	Antineoplastic agent
Daunorubicin HCl	Cerubidine	Inj	Antineoplastic agent
Decitibine	Dacogen	Inj	Antineoplastic agent
Degarelix	Firmagon	Inj	Antineoplastic agent
Docetaxel	Taxotere, Docefrez	Inj	Antineoplastic agent
Doxorubicin	Adriamycin, Doxil	Inj	Antineoplastic agent
Enzalutamide	Xtandi	Oral	Antineoplastic agent (not in AHFS)

Generic Name	Brand Name	Form	AHFS-Therapeutic Classification
Epirubicin	Ellence	Inj	Antineoplastic agent
Eribulin mesylate	Halaven	Inj	Antineoplastic agent
Erlotinib	Tarceva	Oral	Antineoplastic
Estramustine phosphate	EMCYT	Oral	Antineoplastic agent
Etoposide	VP-16, Vepesid	Inj, Oral	Antineoplastic agent
Everolimus	Afinitor, Zortress	Oral	Antineoplastic agent
Exemestane	Aromasin	Oral	Antineoplastic agent
Floxuridine	FUDR	Inj	Antineoplastic agent
Fludarabine	Fludara	Inj	Antineoplastic agent
Fluorouracil	5-FU, Adrucil, Carac, Fluoroplex, Efudex	Inj, Topical	Antineoplastic agent
Flutamide	Eulexin	Oral	Antineoplastic agent
Fulvestrant	Faslodex	Inj	Antineoplastic agent
Gefitinib	Iressa	Oral	Antineoplastic agent
Gemcitabine	Gemzar	Inj	Antineoplastic agent
Gemtuzumab ozogamycin	Mylotarg	Inj	Antineoplastic agent
Goserelin	Zoladex	Inj	Antineoplastic agent (hormone modifier)
Histrelin	Supprelin	Inj	Antineoplastic agent (hormone modifier)
Hydroxyurea	Hydrea, Droxia	Oral	Antineoplastic agent
Ibrutinib	Imbruvica	Oral	Antineoplastic agent
Idarubicin	Idamycin	Inj	Antineoplastic agent (not in AHFS)
Idelalisib	Zydelig	Oral	Antineoplastic agent
Ifosfamide	Ifex	Inj	Antineoplastic agent
Imatinib mesylate	Gleevec	Oral	Antineoplastic agent
Irinotecan HCl	Camptosar	Inj	Antineoplastic agent
Ixabepilone	Ixempra	Inj	Antineoplastic agent
Ixazomib	Ninlaro	Oral	Antineoplastic agent
Lapatinib ditosylate	Tykerb	Oral	Antineoplastic agent
Lenalidomide	Revlimid	Oral	Biological response modifier
Lenvatinib	Lenvima	Oral	Antineoplastic agent
Letrozole	Femara	Oral	Antineoplastic agent
Leuprolide acetate	Lupron, Eligard, Viadur	Inj	Antineoplastic agent
Lomustine	CEENU	Oral	Antineoplastic agent
Mechlorethamine	Mustargen, Valchlor	Inj, Topical	Antineoplastic agent
Megestrol	Megace	Oral	Hormone modifier (AHFS=antineoplastic)
Melphalan	Alkeran	Oral, Inj	Antineoplastic agent
Mercaptopurine	Purinethol, Purixan	Oral	Antineoplastic agent
Methotrexate	Trexall, Rheumatrex, Otrexup	Oral, Inj	Antineoplastic agent
Mitomycin	Mutamycin	Inj	Antineoplastic agent

Generic Name	Brand Name	Form	AHFS-Therapeutic Classification
Mitotane	Lysodren	Oral	Antineoplastic agent
Mitoxantrone HCl	Novantrone	Inj	Antineoplastic agent
Nelarabine	Arranon	Inj	Antineoplastic agent
Nilotinib	Tasigna	Oral	Antineoplastic agent
Nilutamide	Nilandron	Oral	Antineoplastic agent
Olaparib	Lynparza	Oral	Antineoplastic agent
Omacetaxine mepesuccinate	Synribo	Inj	Antineoplastic agent
Oxaliplatin	Eloxatin	Inj	Antineoplastic agent
Paclitaxel	Taxol/Abraxane	Inj	Antineoplastic agent
Palbociclib	Ibrance	Oral	Antineoplastic agent
Panobinostat	Farydak	Oral	Antineoplastic agent
Pazopanib HCL	Votrient	Oral	Antineoplastic agent
Pemetrexed	Alimta	Inj	Antineoplastic agent
Pentostatin	Nipent	Inj	Antineoplastic agent
Pomalidomide	Pomalyst	Oral	Antineoplastic agent
Ponatinib	Inclusig	Oral	Antineoplastic agent
Pralatrexate	Folotyn	Inj	Antineoplastic agent
Procarbazine	Matulane	Oral	Antineoplastic agent
Regorafenib	Stivarga	Oral	Antineoplastic agent
Romidepsin	Istodax	Inj	Antineoplastic agent
Ruxolitinib	Jakafi	Oral	Antineoplastic agent
Sonidegib	Odomzo	Oral	Antineoplastic agent
Sorafenib	Nexavar	Oral	Antineoplastic agent
Streptozocin	Zanosar	Inj	Antineoplastic agent
Sunitinib malate	Sutent	Oral	Antineoplastic agent
Tamoxifen	Nolvadex	Oral	Antineoplastic agent
Temozolomide	Temodar	Inj, Oral	Antineoplastic agent
Temsirolimus	Torisel	Inj	Antineoplastic agent
Teniposide	Vumon	Inj	Antineoplastic agent
Thalidomide	Thalomid	Oral	Immunomodulator
Thioguanine	Tabloid	Oral	Antineoplastic agent
Thiotepa	Thioplex	Inj	Antineoplastic agent
Topotecan	Hycamtin	Oral, Inj	Antineoplastic agent
Toremifene citrate	Fareston	Oral	Antineoplastic agent
Trametinib Dimethyl Sulfoxide	Mekinist	Oral	Antineoplastic agent
Tretinoin	Vesanoid, ATRA	Oral, Topical	Antineoplastic agent
Trifluridine/tipiracil (combination only)	Lonsurf	Oral	Antineoplastic agent
Trimetrexate	n/a	Inj	Antineoplastic agent
Triptorelin	Trelstar	Inj	Antineoplastic agent
Valrubicin	Valstar	Inj	Antineoplastic agent
Vandetanib	Caprelsa	Oral	Antineoplastic agent
Vemurafenib	Zelboraf	Oral	Antineoplastic agent
VinBLAStine sulfate	Velban	Inj	Antineoplastic agent
VinCRIStine sulfate	Oncovin	Inj	Antineoplastic agent
Vinorelbine tartarate	Navelbine	Inj	Antineoplastic agent

Generic Name	Brand Name	Form	AHFS-Therapeutic Classification
Vismodegib	Erivedge	Oral	Antineoplastic agent
Vorinostat	Zolinza	Oral	Antineoplastic agent
Ziv-aflibercept	Zaltrap	Inj	Antineoplastic agent

Hazardous Group 2: Non-antineoplastic drugs that meet one or more of the NIOSH criteria for a hazardous drug

Generic Name	Brand Name	Form	AHFS-Therapeutic Classification
Azathioprine	Imuran	Oral, Inj	Immunosuppressant
Cidofovir	Vistide	Inj	Antivirals
Cyclosporine	Neoral, Sandimmune, Restasis	Oral, Inj, Opth	Immunosuppressive agent
Deferiprone	Ferriprox	Oral	Heavy metal antagonist
Dexrazoxane	Zinecard, Totect	Inj	Protective agent
Fingolimod	Gilenya	Oral	Biological response modifier
Leflunomide	Arava	Oral	Disease modifying antirheumatic agent
Liraglutide recombinant	Victoza	Inj	Antidiabetic
Mycophenolate mofetil	Myfortic, Cellcept	Oral, Inj	Immunosuppressive agent
Mycophenolic acid	Myfortic	Oral	Immunosuppressive agent
Nevirapine	Viramune	Oral	Antiviral
Oxcarbazepine	Trileptal	Oral	Anticonvulsants, misc
Phenoxybenzamine HCL	Dibenzyline	Oral	Non selective antiadrenergic blocking agent
Sirolimus	Rapamune	Oral	Immunosuppresive agent
Tacrolimus	Prograf, Hecoria, Astagraf, Protopic	Oral, Inj, Topical	Unclassified therapeutic agent (immunosuppressant)
Teriflunomide	Aubagio	Oral	Immunomodulatory agent
Tofacitinib	Xeljanz	Oral	Disease modifying antirheumatic drugs
Zidovudine	Retrovir, ZDV, Combivir, Trizivir (in combination with Abacavir and Lamivudine)	Oral, Inj	Antiretroviral agent

Hazardous Group 3: Drugs that primarily pose a reproductive risk to men and women who are actively trying to conceive and women who are pregnant or breast feeding, because some of these drugs may be present in breast milk.

Generic Name	Brand Name	Form	AHFS-Therapeutic Classification
Abacavir	Ziagen	Oral	Nucleoside and reverse transcriptase inhibitors
Acitretin	Soriatane	Oral	Dermatological agent
Alitretinoin	Panretin	Topical	Skin and mucous membrane agent, miscellaneous
Ambrisentan	Letairis	Oral	Vasodilating agent
Apomorphine	Apokyn	Inj	Dopamine agonist
Bazedoxifene Acetate	Duavee	Oral	Hormone modifier
Bosentan	Tracleer	Oral	Vasodilating agent

Generic Name	Brand Name	Form	AHFS-Therapeutic Classification
Cabergoline	Dostinex	Oral	Ergot derived dopamine receptor agonist
Carbamazepine	Tegretol	Oral	CNS agent
Cetrorelix acetate	Cetrotide	Inj	Gonadotropin-releasing hormone antagonist
Chloramphenicol	Chloromycetin	Inj	Antibiotic
Choriogonadotropin alfa	Ovidrel	Inj	Gonadotropins
Clomiphene	Clomid	Inj	Ovulation stimulant
Clonazepam	Klonopin	Oral	Benzodiazepine
Colchicine	Colcrys	Oral, Inj	Antigout Agent
Dinoprostone	Cervidil, Prostin, Prepidil	Topical	Oxytocic
Divalproex Na	Depakote	Oral	CNS agent
Dronedarone HCL	Multaq	Oral	Antiarrythmic
Dutasteride	Avodart, Jalyn	Oral	5-alpha reductase inhibitor
Ergonovine/Methylergonovine	Methergine	Oral, Inj	Oxytocic
Eslicarbazepine acetate	Aptiom	Oral	Anticonvulsant
Estradiol	n/a	Inj, Oral, Topical	Estrogen
Estrogen-progestin combinations	n/a	Oral	Contraceptive
Estrogens, conjugated	Premarin	Oral, Inj	Estrogen
Estrogens, esterified	Estratest	Oral	Estrogen
Estropipate	Ogen	Oral	Estrogen
Finasteride	Proscar	Oral	5-alpha reductase inhibitor
Fluconazole	Diflucan	Oral, Inj	Antiinfective agent
Fluoxymesterone	Androxy, Halotestin	Oral	Androgen
Fosphenytoin	Cerebyx	Inj	Hydantoin
Ganciclovir	Cytovene, Zirgan	Oral, Opth, Inj	Antiviral
Ganirelix acetate	Ganirelix, Antagon	Inj	Gonadotropin-releasing hormone antagonist
Human chorionic gonadotropin (HCG)	Pregnyl, Novarel	Inj	Gonadotropin
Icatibant	Firazyr	Inj	Bradykinin B2 receptor agonist
Lomitapide	Juxtapid	Oral	Antilipemic agents, miscellaneous
Macitentan	Opsumit	Oral	Endothelin receptor antagonist
Medroxyprogesterone Acetate	Depo-Provera, Provera	Inj, Oral	Progestins
Mentropins	Menopur, Repronex	Inj	Gonadotropins
Methimazole	Tapazole	Oral	Antithyroid agent
Methyltestosterone	Testred, Android, Methitest	Oral	Androgens
Mifepristone	Mifeprex, Korlym	Oral	Oxytocics
Miltefosine	Impavido	Oral	Antiprotazoal agent
Misoprostol	Cytotec	Oral,	Prostaglandin analog

Generic Name	Brand Name	Form	AHFS-Therapeutic Classification
		Topical	
Nafarelin	Synarel	Nasal	Gonadotropin
Ospemifene	Osphena	Oral	Estrogen agonists-antagonists
Oxytocin	Pitocin	Inj	Oxytocic
Palifermin	Kepivance	Inj	Cell stimulants and proliferants
Paliperidone	Invega	Oral, Inj	Atypical antipsychotics
Pamidronate	Aredia	Inj	Bone resorption inhibitors
Paroxetine	Paxil, Brisdelle, Pexeva	Oral	Selective serotonin reuptake inhibitor
Pasireotide	Signifor	Inj	Somostatin agonists
Pentetate calcium trisodium	Ca-DTPA	Inj	Not in AHFS
Pertuzumab	Perjeta	Inj	Antineoplastic agent
Phenytoin	Phenytek, Dilantin	Oral, Inj	CNS agent
Plerixafor	Mozobil	Inj	Hematopoietic agent
Progesterone	Prometrium	Oral	Progestins
Progestins	Various oral contraceptives	Oral	Contraceptives
Propylthiouracil	PTU	Oral	Antithyroid agent
Raloxifene	Evista	Oral	Estrogen agonists-antagonists
Ribavirin	Rebetol, Moderiba, Copegus, Virazole	Oral, Inh	Antiviral
Riociguat	Adempas	Oral	Vasodilating agent
Risperidone	Risperdal	Oral, Inj	Atypical antipyschotic
Spironolactone	Aldactone	Oral	Diuretic
Telavancin	Vibativ	Inj	Glycopeptide
Temazepam	Restoril	Oral	Benzodiazepine
Testosterone	n/a	Inj, Topical	Androgens
Topiramate	Topamax, Qudexy XR, Topiragen, Trokendi XR	Oral	Antiepileptic
Trastuzumab	Herceptin	Inj	Antineoplastic agent
Ulipristal acetate	Ella	Oral	Contraceptive
Valganciclovir	Valcyte	Oral	Antiviral
Valproate Na- IV	Depacone	Inj	Anticonvulsants, misc
Valproic Acid	Depakene	Oral, Inj	Anticonvulsants, misc
Vigabatrin	Sabril	Oral	Anticonvulsants, misc
Voriconazole	Vfend	Oral, Inj	Antifungal
Warfarin	Coumadin	Oral	Anticoagulant
Ziprasidone HCL	Geodon	Oral, Inj	Atypical antipsychotic
Zoledronic acid	Zometa, Reclast	Inj	Bone resorption inhibitors
Zonisamide	Zonegran	Oral	Anticonvulsants, misc

TRI-CITY MEDICAL CENTER HAZARDOUS MEDICATIONS

GENERIC LIST		TRADE LIST	
Generic Name	Trade Name	Trade Name	Generic Name
Abatacept	Orencia	Androgel, Androderm	Testosterone
Azathioprine	Imuran	Arava	Leflunomide
Chloramphenicol	Chloromycetin	Avodart	Dutasteride
Colchicine	Colchicine	Cellcept, Myfortic	Mycophenolate mofetil
Cyclosporin	Neoral, Sandimmune	Cervidil, Prostin	Dinoprostone
Dinoprostone	Cervidil, Prostin	Chloromycetin	Chloramphenicol
Dutasteride	Avodart	Colchicine	Colchicine
Efavirenz	Sustiva	Cytovene	Ganciclovir
Estradiol	Estrace, Climara, Depo-Estradiol	Estrace, Climara, Depo-Estradiol	Estradiol
Estrogen-progestin combinations	Estratest HS	Estratest HS	Estrogen-progestin combinations
Estropipate	Ogen	Evista	Raloxifene
Finasteride	Proscar	Imuran	Azathioprine
Ganciclovir	Cytovene	Methergine	Methylergonovine
Gonadotropin, chorionic	Pregnyl	Neoral, Sandimmune	Cyclosporin
Infliximab	Remicade	Neutrexin	Trimetrexate glucuronate
Leflunomide	Arava	Ogen	Estropipate
Medroxyprogesterone Acetate	Provera	Orencia	Abatacept
Methylergonovine	Methergine	Pentam, Nebupent	Pentamidine isethionate
Methyltestosterone	Testred	Pitocin	Oxytocin
Mycophenolate mofetil	Cellcept, Myfortic	Podocon-25	Podophyllum resin
Nevirapine	Viramune	Pregnyl	Gonadotropin, chorionic
Oxytocin	Pitocin	Prograf	Tacrolimus
Pentamidine isethionate	Pentam, Nebupent	Prometrium	Progesterone
Podophyllum resin	Podocon-25	Proscar	Finasteride
Progesterone	Prometrium	Provera	Medroxyprogesterone Acetate
Raloxifene	Evista	Rapamune	Sirolimus
Ribavirin	Rebetol, Virazole	Rebetol, Virazole	Ribavirin
Sirolimus	Rapamune	Remicade	Infliximab
Tacrolimus	Prograf	Retrovir	Zidovudine
Tenofovir	Viread	Sustiva	Efavirenz
Testosterone	Androgel, Androderm	Testred	Methyltestosterone
Thalidomide	Thalomid	Thalomid	Thalidomide
Trifluridine	Viroptic	Valcyte	Valganciclovir
Trimetrexate glucuronate	Neutrexin	Viramune	Nevirapine
Valganciclovir	Valcyte	Viread	Tenofovir
Zidovudine	Retrovir	Viroptic	Trifluridine

Hazardous Drug Administration:

1. Hazardous drugs shall be administered by a TCMC trained licensed nurse.
2. Hazardous drugs should not be handled with bare hands.
3. Always double glove when handling a hazardous drug and it's packaging.
4. Never score or crush hazardous drugs.
5. Notify pharmacy if a hazardous drug must be administered via a gastric tube.
6. If directed, dispose of packaging and gloves in a yellow cytotoxic waste container. See order comments for disposal directions.

Chemotherapy List posted on 2 Pavilion.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES
~~STANDARDIZED PROCEDURES MANUAL~~

STANDARDIZED PROCEDURE: HUMAN IMMUNODEFICIENCY VIRUS (HIV) SCREENING, IDENTIFICATION/TREATMENT FOR THE PREVENTION OF PERINATAL TRANSMISSION

I. **POLICY:**

A. Function:
1. To provide guidelines for the RN to identify and provide treatment for obstetric HIV infected patients admitted to Tri-City Medical Center.
2. To identify pregnant patients with positive HIV results and reduce the risk of maternal to child transmission to the newborn.
   a. Allows intrapartum treatment for pregnant patient and fetus.
   b. Allows ongoing treatment for the pregnant patient and exposed newborn during the postpartum period.
3. To identify community resources for pregnant patients who are HIV positive
   a. University of California San Diego (UCSD) Mother and Adolescent HIV Program Hotline: (619)-543-8089.
   b. National Prenatal HIV Consultation and Referral Service: (888-448-8765)
4. To comply with Health codes as outlined in State and Federal laws – January 2008
   a. The state of California requires that all pregnant women are offered HIV screening throughout the pregnancy and at the time of hospital admission

B. Circumstances for Screening
1. Setting: Tri-City Medical Center
2. Supervision: None
3. Exclusions: Emergency Department (ED)

II. **PROCEDURE FOR INPATIENT AREAS, OTHER THAN WOMEN AND NEWBORN ~~CHILDREN'S~~ SERVICES (~~WCS~~WNS), WHO ARE TREATING PREGNANT PATIENTS:**

A. During the patient history, data collection the RN shall complete an HIV risk screening to determine if the patient should be offered HIV testing
1. Each pregnant patient shall receive information about the importance of having an HIV test and documentation of providing this information is noted in the medical record.
2. If patient declines, the refusal shall be documented in the medical record.
~~A.~~3. If patient agrees to HIV testing.
   a. Documentation of the pregnant patient's "acceptance of HIV testing" will automatically generate an order in the electronic medical record for the rapid HIV test lab draw.
   ~~a.~~b. Expect results from the chemistry lab (ext 7909) within two hours once test is drawn.

B. The admitting physician will review the results and discuss the findings and antiretroviral prophylaxis with the patient in a confidential manner as indicated.
1. The admitting physician shall refer the patient with positive results to her obstetrician and/or the maternal child adolescent HIV program as soon as possible to review therapy, method of delivery, infant care, and follow-up.

III. **PROCEDURE FOR LABOR AND DELIVERY (~~WCS~~WNS) ONLY:**

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Executive Council	Infection Control Committee	Pharmacy & Therapeutics Committee	Inter disciplinary Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
03/18	8/12, 1/15, 04/18	8/12, 02/15, 04/18	03/15, 05/18	9/12, 04/15, n/a	11/12, 05/15, 07/18	11/12, 06/15, 08/18	09/18	07/15, n/a	12/12, 07/15

A. During the patient history/prenatal lab data collection, RN shall:
   1. Perform careful screening of the patient's prenatal care or lack of prenatal care
   2. Review the patient's prenatal form for results of the prenatal HIV test. If documented test results are negative or are positive with the woman being currently treated, document results in the medical record.
      a. Refer to the ~~WCS~~**WNS** Procedure: "HIV Intrapartum, **Postpartum and Newborn** Treatment for the Prevention of Perinatal Transmission" for patients in labor with positive results.
   3. If no test results are available:
      a. Contact the provider's office and obtain the HIV test results if the prenatal indicates the test was done, but results not on the chart.
      b. Assess patient's risk factors and offer HIV testing for the following indications:
         i. Pregnant patients who have unknown HIV results
         ii. Pregnant patients who declined HIV testing in a prenatal setting, and have risk factors associated HIV exposure
         iii. Pregnant patients who are at high risk for becoming infected and have negative HIV results in the clinic setting may be offered a second HIV test in the third 3rd trimester
      c. For patient's meeting the indications listed for the Rapid HIV screen discuss the following in a confidential setting:
         i. The purpose and rationale for the test
         ii. The risk and benefits of the test
         iii. Her ability to decline the test
   4. Provide the patient with a copy of the **Protecting Yourself and Your Baby information form** ~~Perinatal HIV Testing Information Form~~ provided by the California Department of Health Services and the Office of AIDS.
   5. Obtain consent. Only verbal consent is required for running the test.
   6. Document any refusal of the HIV test in the medical record and note the reason why if possible.
   7. After obtaining verbal consent for the HIV test, draw the tubes of blood (small red and purple top tubes) for prenatal labs (RN or lab)
      a. An order shall be generated as a task for the L&D RN
      b. A rapid HIV test shall be run STAT by the chemistry lab when labeled tubes are received and accompanied with the completed requisition
      c. Results will be called to the attending provider by the chemistry lab. Expect the results in about 2 hours (Chemistry lab, ext. 7909).
   8. The attending provider will provide test results to the patient. The lab will automatically run a confirmatory HIV test with results available with 7-10 days.
      a. If the result is negative, no further treatment is necessary.
      b. If the result is positive and the woman is not in labor:
         i. Physician will review treatment options, and discuss antiretroviral prophylaxis with the mother in a confidential manner.
         ii. The patient will be referred to the UCSD maternal child adolescent HIV program as soon as possible to review therapy/method of delivery, infant care, and follow-up.
      c. If the results are positive and the woman is in labor, obtain order for antiretroviral therapy
         i. Refer to ~~WCS~~**WNS** Procedure: "HIV Intrapartum, **Postpartum and Newborn** Treatment for the Prevention of Perinatal Transmission", and PPO: "HIV Intrapartum Treatment"
   9. Contact the Social Work department and submit a consult order for crisis intervention or postpartum counseling using the key words "Rapid Test Response." This wording alerts the Social Work staff that the patient is a newly screened HIV patient who may need

referral to the appropriate community resources, i.e., WE CARE, County Social Services, etc.

IV. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. Current California RN license.
B. Initial Evaluation: Orientation
C. Ongoing Evaluation: Annually ~~Skills Lab~~

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

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

VI. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All healthcare providers who have successfully completed the requirements as outlined above are authorized to direct and perform HIV Identification and Screening, Prevention of Perinatal Transmission Standardized Procedure.

VII. RELATED DOCUMENTS:

A. **Protecting Yourself and Your Baby - Sample (available via external link: http://www.sbcounty.gov/uploads/dph/publichealth/documents/mcah_cpsp_hiv_testing_information.pdf)**
B. **WNS Procedure: HIV Intrapartum, Postpartum and Newborn Treatment for the Prevention of Perinatal Transmission**

~~VII.~~VIII. REFERENCES:

A. American Academy of Pediatrics **on Fetus and Newborn** and American College of Obstetricians and Gynecologists **Committee on Obstetric Practice Guidelines for Perinatal Care, 8th Edition,** ~~2012~~**2017**. *Guidelines for Perinatal Care Sixth Edition.* Washington, DC
B. AAP Policy Statement, Committee on Pediatric AIDS 120(6) e1547. Diagnosis of HIV-1 Infection in children younger than 18 months in the United States. Washington, DC
C. 682 Assembly Bill –CHAPTERED
D. ACOG Committee Opinion # ~~418~~ **635**~~(9/08)~~, Prenatal and Perinatal Human Immunodeficiency Virus Testing: Expanded Recommendations. **Obstetrics & Gynecology: June 2015 – Volume 125 – Issue 6 – p 1544 - 1547**~~November, 2004~~
E. ACOG Committee Opinion #389, Human Immunodeficiency Virus*, December, 2007
F. California Law: Assembly Bill No. 1676
G. California Perinatal Quality Care Collaborative, 2008 Standards of Care for the Prevention of Perinatal Transmission (HIV Toolkit)
H. **AAP Redbook 30th Edition 2015**~~Pickering LK, ed. *2009 Red Book: Report of the Committee on Infectious Diseases.* 28th ed. Elk Grove Village, IL: American Academy of Pediatrics.~~
I. **Recommendations for the Use of Antiretroviral Drugs in Pregnant Women with HIV Infection and Interventions to Reduce Perinatal HIV Transmission in the United States, May 30, 2018. https://aidsinfo.nih.gov/guidelines/html/3/perinatal/508/maternal-hiv-testing-and-identification-of-perinatal-hiv-exposure**~~Public Health Service Task Force. Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States, April 29, 2009. http://aidsinfo.nih.gov/guidelines/perinatal\perinatal (Updated yearly.)~~
J. Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health-Care Settings. MMWR Recommendations and Reports, September 22, 2006/55 (RR14); 1-17.Revised CDPH Perinatal Policy (2008)
K. National HIV/AIDS Perinatal HIV Consultation and Referral Service 24 hr Hotline: 1-888-448-8765

L. UCSD Medical Center, Woman's and Infant's Department Policy/Procedure: "HUMAN IMMUNODEFICIENCY VIRUS PREVENTION OF PERINATAL TRANSMISSION" (8/15/09).
M. ACOG Committee Opinion #595, Preexposure Prophylaxis for the Prevention of Human Immunodeficiency Virus. May 2014.
N. ACOG Committee Opinion # ~~596~~**635**, ~~Routine~~ **Prenatal and Perinatal** Human Immodeficiency Virus **Testing: Expanded Recommendations Obsterics & Gynecology: June 2015 – Volume 125 – Issue 6 – p 1544 - 1547**~~Screening. May 2014.~~
O. Simpson, K. R., & Creehan, P.A. Perinatal Nursing 4th edition 2014, pp. 679-680 Association of Women's Health Obstetric and Neonatal Nurses
P. "Aids info" from Department of Health and Human Services: aidsinfo.nih.gov

SAMPLE

State of California—Health and Human Services Agency
California Department of Public Health

MARK B HORTON, MD, MSPH
Director

ARNOLD SCHWARZENEGGER
Governor

Protecting Yourself and Your Baby

If you are pregnant or think you may be pregnant, you need to know about HIV, the virus that causes AIDS.

Pregnancy is a time to take care of yourself and get regular medical checkups for your health and your baby's health. Your health care provider will ask you questions and check you for conditions so that you and your baby can be as healthy as possible. As part of your routine prenatal care or when you are in labor and delivery, you will be tested for HIV unless you decline. HIV testing during pregnancy is the best choice for you and your baby.

What is HIV?
Human Immunodeficiency Virus (HIV) is a disease that weakens the immune system, making it hard for the body to fight infections.

How is HIV transmitted?
HIV is primarily spread by having unprotected sex or sharing needles with an HIV-infected person. Most women in the US have been infected with HIV through sex with men.

A pregnant woman who is HIV infected or who has AIDS can pass HIV to her baby during pregnancy, delivery, and while breastfeeding.

How will an HIV test help my baby?
An HIV test will help you and your baby by alerting you to the need for treatment if your HIV test is positive. Treatment during pregnancy, labor and delivery can help decrease the risk of transmitting HIV to your baby.

Doctors have learned that if you are infected with HIV, treatment with appropriate medication can greatly reduce your chances of giving HIV to your baby.

What if I test HIV positive?
If you are HIV positive, you will want to discuss treatment options with your health care provider. They will likely recommend medication that is considered safe in pregnancy. You may be encouraged to continue the medication after delivery for your own health, depending on a number of factors.

You can protect yourself from HIV by:
- Using a latex/polyurethane condom (male or female) when you have sex even if you are pregnant. Use only water-based lubricants. Oil-based lubricants will weaken condoms and make them less effective.
- Not sharing needles for injecting drugs, steroids, vitamins, tattooing, or piercing.

Other resources for help:
Call the California HIV/AIDS Hotline at 1-800-367-2437 (AIDS) for HIV referral and consultation resources including experts of prenatal HIV treatment in your local area.

CDPH 8682 No signature required (1/08)

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**IV SOLUTION, ~~STORAGE & WARMING~~ & REFRIGERATION OF**
Purpose:	To provide guidelines for ~~storage and~~ warming **and refrigeration** of IV solution bags, Arthromatic and Uromatic irrigation solution bags, and plastic irrigation solution containers.

A. **PROCEDURE:**

1. It is recommended that IV solution bags, **plastic irrigation solution containers (sterile water and saline) and irrigation solution bags** be stored at room temperature **77°F** (25°C) and excessive heat should be avoided; however IV solution bags of volumes greater than 150mL may be placed in monitored warming units **per manufacturer guidelines**~~with the following considerations:~~.
   - ~~a. **B. Braun Excel®**~~
     - ~~i. IV solution bags in their overpouches may be warmed to a temperature not to exceed 104° F (40°C) for a maximum of 4 weeks and must be labeled with the 4-week expiration date.~~
     - ~~ii. IV solution bags that have been warmed and not used within 4 weeks must be discarded and not returned to storage.~~
   - ~~b. **Baxter Viaflex®**~~
     - ~~i. IV solution bags in their overpouches may be warmed to a temperature not to exceed 104° F (40°C) for a maximum of 14 days and must be labeled with the 14-day expiration date.~~
     - ~~ii. IV solution bags that have been warmed and not used within 14 days must be removed from the warming units and marked appropriately as having been warmed; not to be subsequently returned to the warming unit but may continue to be used at room temperature until the labeled manufacturer's expiration date provided they have not been warmed more than once.~~

~~2. It is recommended that plastic irrigation solution containers (sterile water and saline) be stored at room temperature 77°F (25°C) and excessive heat should be avoided; however they may be placed in monitored warming units with the following manufacturer's considerations:~~
   - ~~a. **B. Braun**~~
     - ~~i. Plastic irrigation solution containers may be warmed to a temperature not to exceed 104° F (40°C) for a maximum of 4 weeks and must be labeled with the 4-week expiration date.~~
     - ~~ii. Plastic irrigation solution containers that have been warmed and not used within their applicable 16-hour or 4-week expiration must be discarded and not returned to storage.~~
   - ~~b. **Baxter**~~
     - ~~i. Plastic irrigation solution containers may be warmed to a temperature not to exceed 104° F (40°C) for a maximum of 4 weeks and must be labeled with the 4-week expiration date.~~
     - ~~ii. Plastic irrigation solution containers that have been warmed and not used within 72 hours/4 weeks must be removed from the warming units and marked appropriately as having been warmed; not to be subsequently returned to the warming unit but may continue to be used at room temperature until the labeled manufacturer's expiration date provided they are unopened and have not been warmed more than once.~~

~~3. It is recommended that irrigation solution bags be stored at room temperature 77°F (25°C) and excessive heat should be avoided; however they may be placed in monitored warming units with the following manufacturer's considerations:~~
   - ~~a. **B. Braun**~~

Patient care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Executive Council	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
07/09;8/12, 05/18	08/12, 06/18	08/12, 07/18	n/a	07/18	09/12, 08/18	09/18	10/12, n/a	11/12

~~i. Irrigation solution bags in their overpouches may be warmed to a temperature not to exceed 150ºF (66ºC) for a maximum of 14 days and must be labeled with that expiration date.~~

~~ii. Irrigation solution bags that have been warmed and not used within 14 days must be discarded and not returned to storage.~~

~~b. Baxter~~

~~i. Arthromatic® and Uromatic® irrigation solution bags in their overpouches may be warmed to a temperature not to exceed 113º F (45ºC) for a maximum of 14 days and must be labeled with that 14 day expiration date.~~

~~ii. Arthromatic® and Uromatic® irrigation solution bags that have been warmed and not used within their applicable 72 hour or 14 day expiration date must be removed from the warming units and marked appropriately as having been warmed; not to be subsequently returned to the warming unit but may continue to be used at room temperature until the labeled manufacturer's expiration date provided they have not been warmed more than once.~~

2. **Warming units:**

~~4.~~**a.** The temperature of all solution warming units shall be monitored daily and recorded. If the temperature has risen above the acceptable set limit, the solutions shall be discarded.

~~5.~~**b.** All flexible solution bags shall remain in their overwrap/overpouch until use to ensure ~~that the~~ solution integrity is maintained. Elevated temperatures increase water vapor transmission and therefore may result in decreased volumes with increased solute concentration. Such effects can be minimized when the overwrap/overpouch is left in place.

~~6. In order to protect from damage, solutions should not come into direct contact with any metal components in the warming unit.~~

~~7.~~**c.** The manufacturer's expiration date and the warmer expiration date must both be checked and verified as current for all solutions prior to use.

~~8.~~**d.** All solutions must be visually inspected for discoloration and/or bottle distortion prior to use. Visual changes should not occur if temperatures remain below the maximum limits.

~~9.~~**3.** The use of autoclaves or microwave oven radiation to warm or thaw solutions is not allowed.

~~10.~~**4.** Contrast:

a. Contrast materials may be maintained in a controlled temperature warmer not exceeding **37°C** ~~degrees Celsius~~ in their original packing unopened for up to 30 days.
b. Contrast that is slow moving may require a rotation schedule to minimize warming time.
c. Contrast shall be dated before placing in the warmer.
d. Expiration dates shall be checked every Monday and solutions that expire before the next Monday shall be removed and discarded.
e. Discoloration may occur if contrast remains in the warmer for extended time periods.
f. After 30 days in the warmer, contrast material shall be discarded.

5. **Refrigeration:**

a. All solutions (IV and irrigation, bags and bottles) may be refrigerati~~oned~~ for up to six (6) months.
b. All solutions in the refrigerator must be tagged and dated with this 6-month expiration date.
c. Acceptable refrigerator temperature range is 36-46°F (2-8°C).
~~f.~~d. Discard solutions that have not been used by the 6-month refrigeration expiration date or manufacturer's expiration date, whichever occurs first.

~~B. REFERENCES:~~

~~1. B. Braun Medical, Inc, Letter dated May 8 2009~~
~~2. Baxter Healthcare Corporation Letter dated January 22, 2009~~
~~3. Baxter Healthcare Corporation Letter dated March 5, 2009~~

~~C.~~B. FORM(S):

1. Refrigerator Temperature Monitoring Log
~~1.~~2. Warmer Temperature Monitoring Log

C. RELATED DOCUMENT(S):~~ATTACHMENT FOUND ON THE INTRANET~~

~~Warmer Temperature Monitoring Log (Celsius)~~

~~2.~~1. Solution Outdate Reference Guide (06/2018)

D. REFERENCE(S):

1. Puertos, E. (2014). Extended Stability of Intravenous 0.9% Sodium Chloride Solution After Prolonged Heating or Cooling. Hospital Pharmacy; 49(3): 269-272.

Tri-City Medical Center
ADVANCED HEALTH CARE FOR YOU

Year:
Location:

Refrigerator Temperature Monitoring Log (Drugs)
Definition: Drugs require 36f to 46f Food requires 41 or less
Cold = Refrigerator = 36 to 46 Fahrenheit (Same as 2 to 8 Centigrade)
Guidelines:
- Mark an "X" (NICU Initials) in the corresponding box for the observed temperature daily.
- Shaded area indicates that the temperature is outside the range; documem corrective action.
- If temp is outside of range : 1.) Adjust thermostat & monitor results in 1 hour
  2.) If not correct within 1 hour contact Engineering @ /148
  3.) Relocate contents to an alternative location with appropriate temperature control
  4.) Record actions taken and resolution

- Contact Pharmacy Ext. 3012 , If quetions about stability of medications at room temperature.
- **Medication refrierators must be cleaned/Defrosted monthly. See documentation below.**

Note: If the small freezer setion is used for storage Use a separate freezer log. If not used monitoring is not required If unit closed on weekend or holiday, write closed in column

Temperature (°F)

AM

	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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Date	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

Temperature (°F)

PM

	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
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Date	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

Problem/ Action/ Resolution- Record with reference to above date. Use reverse side to report additional problems

Date	Problem	Action Taken	Resolution Achieved

Keep This Record for 36 Months then Discard

Tri-City Medical Center

WARMER TEMPERATURE MONITORING LOG

Year: _____ Month: _____ Location: _____

Definition: **Blanket Warmer:** Maximum 130°F (Recommended range 110°F-130°F); **Contrast Media** requires 59°F to 99°F (15°C to 37°C); **Irrigation/IV Solutions** require 59°F to 104°F (15°C to 45°C)

Guideline: Mark an "X" in the corresponding box for the observed temperature daily. Mark an "X" in the corresponding box for content of warmer daily. Shaded area indicates that the temperature is outside the range; document corrective action.

IF TEMPERATURE IS OUTSIDE OF ACCEPTABLE RANGE:

1) Notify Clinical Engineering @ x7148 and place a Work Order. 2) Relocate contents to an alternate location with appropriate temperature control. 3) Record actions taken and resolution.

All Contrast Media and Irrigation/IV Solutions must be dated when placed in the warmer. Dispose of Contrast Media after 28 days & Irrigation/IV Solutions after 28 days in warmer.

Temperature (°F) — BLANKET WARMER (Upper Cabinet)

136																														
134																														
132																														
130																														
128																														
126																														
124																														
122																														
120																														
118																														
116																														
114																														
112																														
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108																														
106																														
104																														
Day of Month	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

Temperature (°F) — FLUID WARMER (Lower Cabinet)

116																														
112																														
108																														
104																														
100																														
96																														
92																														
88																														
84																														
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Day of Month	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
Contrast Media																															
Irrigation Solution																															
None																															

Problem/Action Resolution Documentation – Record with reference to above date. **KEEP THIS RECORD ON FILE FOR 36 MONTHS, THEN DISCARD.**

Date	Problem	Action Taken	Resolution Achieved

Tri-City Medical Center
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SOLUTION OUTDATES

REFRIGERATOR

- All solutions (IV and irrigation, bags and bottles) are good for **6 MONTHS** in the refrigerator.
- All solutions in the refrigerator must be tagged & dated with this 6-month expiration date.
- Acceptable refrigerator temperature range is 36-46°F (2-8°C).
- Discard solutions that have not been used by the 6 month refrigeration expiration date or manufacturer's expiration date (whichever occurs first).

WARMER

- Solutions may be warmed according to manufacturer guidelines (see grids below).
- All solutions in the warmer must be tagged & dated with the appropriate warmer expiration date.
- If the temperature in the warming unit rises above the acceptable range, all fluids must be discarded.
- Discard fluids that have not been used by the manufacturer's maximum time limit for warming or manufacturer's expiration date (whichever occurs first).

IV BAGS

Must remain in plastic overwrap

MANUFACTURER	MAXIMUM TEMPERATURE	MAXIMUM TIME LIMIT
B. Braun Excel	104°F (40°C)	4 weeks
Baxter Viaflex Solutions must be size 150ml or greater and must be more than 3 months from manufacturer expiration date.	104°F (40°C)	14 days

IRRIGATION BOTTLES

MANUFACTURER	MAXIMUM TEMPERATURE	MAXIMUM TIME LIMIT
B. Braun	104°F (40°C)	4 weeks
Baxter	122°F (50°C)	60 days

IRRIGATION BAGS

MANUFACTURER	MAXIMUM TEMPERATURE	MAXIMUM TIME LIMIT
B. Braun	150°F (66°C)	14 days
Baxter Arthromatic® & Uromatic® Solutions must remain in plastic overwrap and must be more than 3 months from manufacturer expiration date.	104°F (40°C)	14 days

References:

1. Baxter Healthcare Corporation Letter dated June 8, 2018
2. Baxter Healthcare Corporation Letter dated November 30, 2017
3. B. Braun Medical, Inc. Letter dated May 29, 2012
4. B. Braun Medical, Inc. Letter dated August 4, 2009

Revised 6/8/2018 JLS

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 9/05	**SUBJECT: Medication Reconciliation**
REVISION DATE(S): 6/03, 5/05, 4/09, 7/12	~~**POLICY NUMBER: IV.JJ**~~
Patient Care Services Content Expert Approval:	**12/17**
Clinical Policies & Procedures Committee Approval:	~~**08/16**~~**05/18**
Nurse Executive Council Approval:	~~**09/16**~~**07/18**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	~~**11/16**~~**07/18**
Medical Executive Committee Approval:	~~**11/16**~~**08/18**
Administration Approval:	**09/18**
Professional Affairs Committee Approval:	~~**01/17**~~ **n/a**
Board of Directors Approval:	**01/17**

A. **POLICY:**

1. Medication reconciliation is an interdisciplinary process between the **physician,** patient, nurse~~,~~ **and** pharmacy~~, and physician~~ designed to decrease medication Adverse Drug Events/Adverse Drug Reactions (ADE/ADR) and ensure accuracy in the list of the patient's current medications at each change in level of care or at discharge.
2. All Inpatients shall have all medications reconciled within 24 hours of admission. The final outcome of medication reconciliation is to obtain and document a complete and accurate list of the patient's current medications upon the patient's admission to the organization.
~~2. Justice Involved Patient- Medication list will be obtained from the correctional institution not from the patient.~~
3. The most up to date, reconciled medication list is provided at all transitions of care.
4. When the patient is discharged, the reconciled list of medications is explained to the patient and the process documented.
5. The final reconciled medication list is faxed by Medical Records to the primary care provider (PCP) or other physicians that will follow up with the patient after discharge.
6. **A good faith effort will be made to perform a modified medication reconciliation process in a non-twenty-four hour setting and includes different patient circumstances, such as the confused, unconscious or observation ~~patient~~status.**
   - **a. A good faith effort to collect a home medication list (medication history) will be ~~done~~made, but does not require dose, route, and frequency**
   - **b. Outpatient imaging intravenous iodinated contrast studies.**
     - **i. For diabetic patients on oral diabetic medications, this list (medication history) is scanned to the pharmacy which is then reviewed by the pharmacist.**
     - **~~6.~~ii. At the end of an outpatient encounter, patients will be taught the importance of managing their diabetic medication.**

~~B. MODIFIED MEDICATION RECONCILIATION PROCESS:~~

~~1. Modified medication reconciliation process shall be done in areas where medications are not used, used minimally, or used for short duration including but not limited to, Emergency Department, Special Procedures, Outpatient Radiology Imaging Contrast Studies, Outpatient Behavioral Health, Outpatient Chemotherapy, Occupational Medicine, Wound Center, Aesthetics Center, Outpatient Specialty Services and Crisis Stabilization Unit.~~

~~a. Home medication list must be obtained, but does not require dose, route, and frequency.~~

~~b. Current list of home medications does not need to be provided to the patient. If the patient is confused, a list shall be provided to the family/responsible party.~~
~~i. If there are short-term medications, the patient is provided a list with short-term medication addition(s).~~
~~c. Complete documented medication reconciliation is required when chronic medications are prescribed, when there is a change to the patient's medications, or the patient is admitted.~~
~~d. When a patient is discharged from the hospital at the end of an outpatient encounter, patients will be taught the importance of managing their medication information.~~
~~e. When complete medication reconciliation is required, a list is provided to the patient and/or the primary care provider upon discharge.~~

~~C.~~**B. ~~INPATIENT MEDICATION RECONCILIATION~~ PROCESS:**

1. All medications shall be reconciled upon:
   a. Admission
   b. Intra-facility transfer (change in level of care)
   c. Discharge

~~d.~~**2.** The nurse shall review and complete **a~~the Medication~~ medication ~~by History~~ history**~~screen~~. Every effort will be made to obtain drug name, dose, frequency and route. At a minimum, drug name will be obtained.

~~e.~~**a.** The patient's medication history may be obtained from either the patient, family members, **caregiver** and/or legal representative ~~who are present at the time of admission~~ or from **an alternate source (for example** Surescript**)** if consent is obtained **as needed**. ~~The admitting nurse shall determine if they are reliable historians.~~
   i. If the patient, family, or legal representative is able to provide accurate data, no additional source of information is required.

~~f.~~**b.** In cases when neither the patient nor the family is considered a reliable source, alternative sources shall be located. Consider the following:
   i. **Alternate source such as** Surescript database if consent obtained **as needed**
   ii. Review the patient's current medical record
   ~~iii. Discuss with family members and/or caregivers when they are available for patients who are unaccompanied on admission~~
   iii. Contact the patient's current pharmacy to determine or validate his/her current medications
   iv. If patient was admitted from a care facility, contact previous care facility to verify the patient's current medications.

~~iv.~~**c. Justice Involved Patient- Medication list (medication history) will be obtained from the correctional institution not from the patient.**

~~g.~~**3.** Pharmacy personnel may assist with the medication reconciliation process as a resource.

~~h.~~**4.** The Admitting Physician/Allied Health Professional (AHP) is required to review, complete and reconcile, Admission Medication Reconciliation information in **the electronic health record** ~~Cerner~~ collected upon admission of the patients within 24 hours.

~~i.~~**a.** Once Admission Medication Reconciliation List has been completed and all medications reconciled, the complete list of the patient's medication (MAR) shall be used as the most complete and accurate medication list.

~~2.~~**5.** If new information is later obtained, the physician/AHP or nurse may update the ~~Medication~~ **medication ~~by History~~ history in electronic health record (EHR)**~~List in Cerner~~.

~~3.~~**6.** Intra-Facility Transfer (Change in Level of Care):
   a. All medications will be reviewed and revised as appropriate when the patient is being transferred to the next level of care
   ~~i. Electronic Orders:~~
   ~~1)~~**i.** The physician/AHP will access the Transfer Medication Reconciliation function and will reconcile each medication on the active medication list to either be continued or not continued for the next level of care.

~~4.~~**7.** Discharge:

a. All medications will be reviewed against HOME medications to create a final discharge medication list
   ~~i. Electronic Orders:~~
   ~~1)~~**i.** The physician/AHP will complete the ~~Discharge~~ **discharge** ~~Mediation~~ **medication** ~~Reconciliation~~ **reconciliation** ~~application in Cerner~~**in electronic health record (EHR)** and will reconcile each medication on the active medication list and home list to either be continued or not continued upon discharge. New medications will be added as required.
      ~~2)~~**1)** Prescriptions to be completed, **including but not limited to:**
         a) ePrescribe – electronic prescription transmitted to the patient's pharmacy
         b) Printed on the unit and handed to the patient
         c) Handwritten on personal (physician's) prescription pad

b. The nurse shall print and deliver the Patient's Discharge Instructions, which includes the reconciled medications to the patient and/or family. ~~These can be printed in English or Spanish.~~ Education will be provided on any new medications that are being ordered for the patient.

c. Medical Records shall send a Transition of Care form which includes the discharge medications to the attending physician/AHP and consultant(s) listed in the patient's medical record the day following discharge. This final step in the medication reconciliation process ensures the physicians/AHPs are notified of the list of medications and other instructions given to the patient upon discharge.

d. Justice Involved patients will follow progressive care discharge process.

C. RELATED DOCUMENT(S):

1. **Patient Care Services Policy: Physician/Allied Health Professionals (AHP) Inpatient Orders ~~Policy~~**
~~c.~~**2. Patient Care Services Policy: Transfer of Patients, Intra-Facility**

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**NITRAZINE TEST ON VAGINAL FLUID**
Purpose:	To assist in the evaluation of vaginal fluid for the presence of amniotic fluid.
Supportive Data:	The nitrazine test is a screening test performed on amniotic fluid to evaluate a suspected rupture of membranes. A Registered Nurse (RN) is authorized to perform this procedure. Testing is under the supervision of the Laboratory Point of Care (POC) Coordinator and under the jurisdiction of the Laboratory Medical Director.
Equipment:	Nitrazine paper Sterile gloves

A. **SPECIMEN:**
1. Patient Preparation:
   a. This procedure may be performed during a speculum examination.
2. Type of Specimen:
   a. Vaginal Fluid

B. **QUALITY CONTROL (QC):**
1. QC Materials: Normal and abnormal urine control vials
2. Test the normal and abnormal controls per POC testing.
3. Perform QC each day testing is performed and when a new vial is opened.
4. Document results on the Point of Care Quality Control Log.
5. If the control results are not within acceptable limits the test is considered invalid and further patient testing is not allowed until corrective action steps are successful and documented.

C. **PROCEDURE:**
1. Perform hand hygiene and apply gloves.
2. Verify patient identification according to policy.
3. Swab the fluid pooling in the vagina or along the sidewall of the vagina (avoiding the cervix) using a cotton tip applicator.
4. Touch the applicator to the test paper ensuring the chemically treated paper is totally moistened.
5. Read the nitrazine paper immediately.
   a. Nitrazine paper is a multi-parameter test paper with a wide range of colors used to interpret the alkaline nature of amniotic fluid.
   b. Normal amniotic fluid is neutral (pH 7.0) or slightly alkaline (pH 7.25).
   c. In the presence of amniotic fluid the moistened nitrazine paper will change from a yellow color to a dark blue color.
6. Compare the paper visually to the color scale printed on the outside of the box.

D. **REPORTING RESULTS:**

Color	pH	Report As
Yellow	5.0	Negative: Membranes probably not ruptured
Olive	5.5	
Olive-green	6.0	
Blue-green	6.5	Positive: Membranes probably ruptured
Blue-gray	7.0	
Deep blue	7.5	
Unclear or other color	?	Equivocal: May be due to blood, cervical mucus or semen

Patient Care Services Content Expert	Clinical Policies & Procedures	Nursing Executive Council	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
7/03, 4/04, 4/06, 6/09, 07/15, 05/18	07/11, 08/15, 0718	08/11, 09/15, 07/18	03/16, 08/18	n/a	10/11, 04/16, 08/18	09/18	11/11, 05/16, n/a	11/11, 05/16

E. **DOCUMENTATION:**

1. Record the result int~~o~~n the **electronic health record**~~Nursing Progress Record~~. Enter the following:
   a. Date and time.
   b. Result – **negative, positive or equivocal**
   c. Name **of person performing test if recording for another person** ~~or initials of the operator~~

F. **LIMITATIONS:**

1. The nitrazine test is not considered a definitive test for diagnosing ruptured membranes.
2. A false negative result may occur if there has been prolonged rupture of membranes (longer than 24 hours) or when only a small quantity of fluid is present.
3. A false positive may occur if vaginal secretion has been contaminated with blood, urine or antiseptic solution. The pH of blood, vaginal mucus and some secretions associated with vaginal infection is also alkaline.

G. **REGULATORY COMPLIANCE:**

1. Nitrazine test is considered a waived test under **Clinical Laboratory Improvement Amendments** (CLIA) 88 Federal Regulations.
2. Personnel performing the testing must be certified prior to performing patient testing. Certification is achieved through a training program coordinated by the nursing education department in conjunction with the lab. Competency is assessed and documented annually. Competency records are maintained on the nursing units.
3. Proficiency testing is coordinated through the laboratory staff and performed by testing personnel on the nursing units.

H. **FORM(S):**

~~3.~~1. **Point of Care Quality Control Log L&D Urine Dipstick and Nitrazine**

~~H.~~I. **REFERENCE(S):**

1. Kennedy, B.B., Ruth, J.R., Martin, E.J. (2009). *Intrapartum management modules – A perinatal education program (4th ed.)*. Wolters Kluwer Health/Lippincott Williams & Wilkins: Philadelphia, PA.
2. Clinical Laboratory Improvement Amendments of 1988 Federal Regulations

~~Tri-City Medical Center Clinical Laboratory-Point of Care | 4002 Vista Way Oceanside CA 92056 (760) 940-7974~~

POINT OF CARE QUALITY CONTROL LOG

~~MISCELANEOUS WAIVED TESTINGL~~ & D URINE DIPSTICK AND NITRAZINE

Unit: Month: Year: 2017 Lab Review:	Instructions: 1. Refer to test procedure for instructions on maintenance of test table, insert, meter and Calibration bar, and how to perform Quality Controls. 2. Indicate Lot #s. Verify Reagents and Controls are not expired. 3. Indicate Corrective Actions if QC fails at the bottom of the form. 4. IF no testing performed, indicate "No Patient tests" 5. Questions: Point of Care Coordinator x7974. 6. Completed Log is stored in Lab.

Unit:	LD		LD			LD	QC Pass? QC/Reagents not expired? If yes, sign.
Test:	URINE DIPSTICK Lot # ---------- Exp. : ----------		NITRAZINE Lot # ---------- Exp. : ----------			Maintenance of test table, insert & meter. Cleaned & Disinfected	
DATE	Both levels PASS (✓)		NEG pH=4.5-6	POS pH=6.5->=9		(✓)	OPERATOR
lot QC Reagent	Level 1	Level 2	Level 1	Level 2			
lot Lot# Exp.:	Lot#_____ Exp.	Lot#_____ Exp.	Lot#_____ Exp.	Lot#_____ Exp.			
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Calibration bar inspected & cleaned if needed Monthly (✓) POCC Initials: Date:

QC Fail? CORRECTIVE ACTIONS:

[Indicate below: e.g. Check expiration dates. Repeat. Try new reagent and/or new QC, repeat. Contact lab with repeated fails.]

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE:	**3/88**	**SUBJECT:**	**Nutritional Screening, Care, and Assessment for Infants, Pediatrics & Adolescents**
REVISION DATE(S):	**10/04, 01/07, 10/07, 01/08, 01/11**	~~**POLICY NUMBER: VI.L**~~	

Patient Care Services Content Expert Approval:	**07/18**
Clinical Policies & Procedures Committee Approval:	**~~03/15~~07/18**
Nurse Executive Committee Approval:	**~~03/15~~07/18**
Department of Pediatrics:	**08/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~05/15~~08/18**
Administration Approval:	**09/18**
Professional Affairs Committee Approval:	**~~06/15~~ n/a**
Board of Directors Approval:	**06/15**

A. **DEFINITIONS:**
1. Malnourished or Nutritionally at Risk:
   a. Five (5) percent or greater weight loss over one month
   b. Body Mass Index (BMI) Percentile less than 5th percentile and greater than or equal to the 95th percentile
      i. Indication of underweight and overweight/obesity
   c. Weight below 5th percentile on growth chart
   d. Decreased percentage scores of height and/or weight
   e. Increased metabolic requirements
   f. Low birth weight (less than 2500 grams) or prematurity (less than 37 weeks)
   g. Inadequate provision or tolerance of nutrients/feedings (rate or volume)

B. **POLICY:**
1. The Registered Dietitian shall provide nutrition assessment, consultation, and/or medical nutrition therapy for patients, families, and for medical professionals providing care for infant, pediatric or adolescent patients.
2. Referrals for a nutrition assessment are generated if certain criteria are met via the admission database and/or as requested by the physician. Clinical Dietitians shall assess nutritional status of triggered patients within 48 hours of referral, considering age of patient, disease states, diet history, medical history, and laboratory values.
3. Referrals for nutrition assessment are generated if the following criteria are met upon completion of the admission data base:
   a. Currently receiving **total parental nutrition** (TPN)/enteral feedings
   b. Unplanned weight loss
   c. Presence of pressure ulcer or skin breakdown
   d. Eating disorder
   e. Impaired nutrient intake, nausea, vomiting, diarrhea
   f. Intake of less than 50% normal in 3 days
   g. Aspiration risk
   h. BMI Percentile less than 5th percentile and greater than or equal to the 95th percentile
4. Additional criteria for infants and pediatric patients include:

a. Weight/length less than 5th percentile or greater than or equal to 95th percentile on growth charts for children under two (2) years of age
b. Difficulty with suck/swallow
c. Poor weight gain
d. Failure to thrive
e. Presence of enteral tube/button

5. The dietitian shall complete the assessment with consideration of:
   a. Diet order
   b. Diagnosis
   c. Chronological age and/or gestational age
   d. Weight
   e. Height or length
   f. Head circumference as appropriate
   g. Food allergies
   h. Diet prior to admission
   i. Birth weight - if available
   j. History of weight changes
   k. Potential drug nutrient interactions
   l. Labs and biochemical values: to include, among others, serum albumin, **hemoglobin** (Hgb), **hematocrit** (Hct), **mean corpuscular volume** (MCV)
   m. Feeding problems such as chewing, swallowing, and appetite changes
   n. Nutrition/diet history
   o. Psychosocial, physiological, social and/or environmental issues
   p. Clinical assessment changes
   q. Any other general nutrition concerns
   r. BMI percentile
6. Clinical dietitian shall document nutrition assessment in the electronic medical record. Assessments shall be based on the following information provided by admission assessment, review of history and physical, physician notes, other disciplines' notes, and interview with patients, parents, or nursing:
   a. Diet order
   b. Diagnosis
   c. Age
   d. Weight, height
   e. Food allergies
   f. Labs and biochemical values: pertinent to assessment
   g. History of weight changes
   h. Feeding problems such as chewing, swallowing, appetite
   i. Psychosocial, physiological, social and/or environmental issues
   j. Nutrition/diet history
   k. Pregnancy/Lactating
   l. BMI percentile
7. The Dietitian shall also calculate the following:
   a. Weight for height percentile or weight for age/weight for height percentile
   b. Weight change percentile
   c. BMI percentile
   d. Estimation of calories and is based on the child's age, gender, weight, disease state, and nutrition status
   e. Grams of protein per day
   f. Fluid requirements
8. A nutrition care plan shall be developed and individualized based on assessment and shall meet specific needs of the patient. Goals shall be individually determined with delineation of methods of achievement of goals and time frames.

9. Normally nourished and malnourished children who have adequate intake to satisfy nutrient requirements shall be monitored on at least a 3-day follow-up basis or as indicated by nursing/physician referral.
10. Normally nourished and malnourished children who have inadequate intake may require nutrition support (i.e., parenteral or enteral nutrition) after 5 days of inadequate nutrition intake. These patients shall be monitored on a 1-3 day follow-up basis or as indicated by nursing/physician referral.

Estimated Energy and Protein Requirements/Dietary Reference Intakes			
Age (yr)	Protein g/kg/d	~~K~~kcal/Kg/d	~~K~~kcal/d
0.0-0.5	2.2	108	~~K~~kg x 108
0.5-1.0	1.5	98	~~K~~kg x 98
1-3	1.3	102	1300
4-6	1.2	90	1800
7-10	1.0	70	2000
Males: 11-14 15-18	 1.0 0.9	 55 45	 2500 3000
Females: 11-14 15-18	 1.0 0.8	 47 40	 2200 2200

11. Clinical Dietitian shall confer with Physician, Registered Nurse, and/or Pharmacist regarding pertinent factors affecting nutrition status (i.e., medication, intake and output (I&O), ~~intake,~~ Braden Score).
12. Clinical Dietitian shall provide and document follow-up visits for patients assessed at risk as necessary or at least every three (3) days depending on medical status and revise therapy as indicated. Patients with adequate intake shall be followed throughout their stay with documentation in the medical record within at least seven (7) days. Follow-up assessment is documented on the Nutrition Reassessment powerform, to include nutrient intake, tolerance to diet, weight changes, laboratory parameters, and I&O. Follow-up assessments may be triggered sooner as warranted by change in status.
13. Clinical Dietitian shall provide nutrition counseling and education explaining rationale to patient/parent/significant other as ordered by physician, as requested by nursing, or family, or as deemed appropriate by RD.
    a. Documentation of education is completed on the Patient/Family Education All Topics PowerForm.
    b. Relevant nutrition and education and referral information are documented in the discharge plan.
14. Standard adult and pediatric menus and snacks are utilized. If enteral formulas are required, adult formulas are utilized for children ages 7-12 and adolescents; pediatric formulas are used for children ages 1-6. Infant formulas are available as 20-kcal/oz and can be concentrated to 24 kcal/oz, 27-kcal/oz, or 30-kcal/oz as needed.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 10/96	**SUBJECT: Potential Food and Drug Interactions, Patient Education**
REVISION DATE(S): 6/03, 8/05, 03/08, 03/11	**~~POLICY NUMBER: V.B~~**

Patient Care Services Department Approval:	**06/18**
Clinical Policies & Procedures Committee Approval:	**~~08/15~~07/18**
Nursing Executive Council Approval:	**~~09/15~~07/18**
Pharmacy & Therapeutics Committee Approval:	**~~09/15~~07/18**
Medical Executive Committee Approval:	**~~10/15~~08/18**
Administration Approval:	**09/18**
Professional Affairs Committee Approval:	**~~11/15~~ n/a**
Board of Directors Approval:	**12/15**

A. **POLICY:**

1. The Pyxis MedStation will prompt the nurse to assess the educational needs of the patient when one of the medications below has been added to a patient's profile and the nurse makes a withdrawal of the medication-:
   a. Warfarin (Coumadin)
2. Nursing may obtain a current Drug/Nutrient interaction education sheet from a hospital approved information resource.
3. Nursing will provide this information to the patient/family/caregiver if any of the above medications are started in the hospital and are intended for continued use at home and as deemed necessary from the patient assessment.
4. Patient education and counseling on drug/nutrient interactions may also be initiated by a physician order or another health care professional after assessment of knowledge deficits, and/or by the patient/caregiver request.
5. Nursing may make a consult request from Clinical Pharmacist and/or Clinical Dietitian for additional patient education as indicated.
6. Documentation of counseling and materials provided will be documented in the patient education section of the patient record and in the patient's discharge instructions.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MA

DELETE
Incorporate information into PCS Sharp Injuries Prevention; Procedural Areas
Rename to "Sharps Injury Prevention & Disposal; Procedural Areas"

ISSUE DATE: 7/09, 11/12

SUBJECT: Sharps Disposal; Procedural Areas

REVISION DATE: 03/18 DELETE

POLICY NUMBER: XI.J

Patient Care Services Content Expert Approval:	**04/18**
Clinical Policies & Procedures Committee Approval:	**~~12/12~~04/18**
Nursing Executive Committee Approval:	**~~12/12~~04/18**
Operating Room Committee Approval:	**07/18**
Medical Executive Committee Approval:	**~~02/13~~08/18**
Administration Approval:	**09/18**
Professional Affairs Committee Approval:	**~~03/13~~ n/a**
Board of Directors Approval:	**03/13**

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

~~1. To provide guidelines for the safe disposal of sharp objects: pre-operatively, intra-operatively and post-operatively to minimize the potential for injury.~~

~~B. **POLICY:**~~

~~1. Items considered "sharps":~~
- ~~a. Needles of any type~~
- ~~b. Disposable stylets~~
- ~~c. Pins - Steinmann, K-wires (threaded and smooth)~~
- ~~d. Knife blades~~
- ~~e. Cautery tips~~
- ~~f. Disposable endoscopic instruments (Trocars, clip appliers)~~
- ~~g. Disposable Staplers /Clip appliers/scissors/dissectors that are protruding or contain a knife blade.~~
- ~~h. Chest tube trocars~~
- ~~i. Staplers~~
- ~~j. I.V. tubing trocar~~
- ~~k. Vial-O-Jet and Bag-O-Jet~~
- ~~l. Saw blades~~
- ~~m. Drill bits~~
- ~~n. Drain trocars~~
- ~~o. Glass items (ie, medication vials, ampules, bottles, etc.)~~
- ~~p. Anything potentially sharp~~

~~2. The scrub person is responsible for the disposal of sharps from the operative field.~~
- ~~a. Needle counting holders should be used when appropriate and closed before discarding into puncture resistant sharps container.~~
- ~~b. All sharps shall be disposed of in the appropriate puncture resistant container.~~

~~3. The circulator is responsible for the disposal of sharps used off the field into a puncture resistant container.~~

~~4. The anesthesiologist is responsible for the disposal of sharps used by him/her in a puncture resistant sharps disposal container.~~

~~5. Puncture resistant sharps disposal containers are to be routinely replaced and not allowed to overfill. Containers should be replaced when ¾ full.~~

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

1. ~~AORN Perioperative Standards and Recommended Practices, 2012 Edition.~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~MANUAL~~

ISSUE DATE: **6/09~~, 11/12~~**	**SUBJECT:** **Sharps ~~Injuries~~Injury Prevention & Disposal; Procedural Areas**
REVISION DATE(S): **~~03/18~~11/12**	**~~POLICY NUMBER: XI.I~~**

Patient Care Services Content Expert Approval:	**03/18**
Clinical Policies & Procedures Committee Approval:	**~~12/12~~04/18**
Nursing Executive Committee Approval:	**~~12/12~~04/18**
Operating Room Committee Approval:	**07/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~02/13~~08/18**
Administration Approval:	**09/18**
Professional Affairs Committee Approval:	**~~03/13~~ n/a**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. To provide guidelines for safe handling **and disposal** of "sharps"~~:~~ pre-operatively, intra-operatively and post-operatively to minimize the potential for injury~~.~~ **and reduce bloodborne pathogen exposure.**

B. **DEFINITION:**

1. Sharps: – Any disposable or reusable items that **has**~~have~~ the potential to cause a cut or puncture injury. **Examples include, but are not limited to:**
   - **a. Needles**
   - **b. Stylets**
   - **c. Pins and wires**
   - **d. Knife blades**
   - **e. Cautery tips**
   - **f. Disposable sharp instruments (e.g., clip appliers, scissors, staplers, dissectors)**
   - **g. Reusable sharp instruments (i.e., sharp retractors)**
   - **h. Trocars**
   - **i. Vial and bag decanters with a spike**
   - **j. Saw blades**
   - **k. Drill bits**
   - **l. Broken glass (e.g., ampules, broken vials and bottles)**

~~1.~~**2. Bloodborne pathogens: Pathogenic microorganisms that are present in human blood and can cause disease (e.g., hepatitis B virus [HBV], hepatitis C virus [HCV], human immunodeficiency virus [HIV])**

C. **PRE-OPERATIVELY:**

1. All ~~S~~sharps will be opened onto ~~a~~**the** sterile field so ~~that~~ they are visible to the scrub personnel during case setup.
2. ~~A clamp~~**An instrument** shall be used to load blades onto knife handles.

D. **INTRA-OPERATIVELY:**

1. **Surgical team members should use a neutral zone or** ~~A~~ "hands-free~~"~~ technique ~~is used~~ when possible and practical **for passing sharp instruments, blades and needles**~~between the surgeon(s) and scrubbed personnel~~.

a. Designate an area as the "neutral zone" where the ~~knife~~**escalpel**, needle or other sharp object is laid down.
b. Only one person at a time touches an instrument or sharp in the neutral zone.
c. A basin/container (i.e., emesis basin) can be used to pass the ~~knife blade~~**escalpel** between the surgeon and scrub. The ~~knife~~**escalpel** is placed in the basin/container, and then can be set in the neutral zone. The surgeon removes the ~~knife~~**escalpel**; uses and returns ~~used knife~~**it** to the basin. The scrub then removes the basin/container from the neutral zone as soon as is safely possible.
d. The neutral zone must be kept free from clutter. Remove sharps or other instruments as quickly as is safely possible.

2. When hands free technique is not possible or practical due to the requirements of the procedure, use extreme caution when passing sharps to avoid injury. **Maintain situational awareness of all sharps on the sterile field.**
3. Control and **identify**~~identification of~~ the location of sharps ~~assists into~~ avoid~~ing~~ injury. Know how many and where sharps are at all times during the surgical procedure. ~~Especially watch for the return of sharps from the surgeon.~~
   a. **Sharps should be confined and contained in specified areas of the sterile field or within a sharps containment device.**
   b. **Keep sharps visible. DO NOT place sharps where they cannot be seen (i.e., under basins, towels or instrument pans).**
   ~~2.~~c. **When a scrub person is relieved, either temporarily or permanently, both the oncoming and off-going staff members are to identify the location and type of sharps. Identification of sharps can be confirmed with the count.**
4. **When feasible, perioperative team members should use syringes, needles and intravenous (IV) catheters that incorporate safety-engineered features, such as needle-free IV systems and retractable syringes and scalpel blades.**
~~3.~~5. ~~Atraumatic needles and other s~~**S**uture needles are passed and retrieved with a needle holder.
   a. Load ~~atraumatic~~ needles from the suture package with minimal handling and as close to the time of use as possible.
   b. ~~The r~~**R**eturn ~~of a~~ used needles ~~will be placed into~~ the appropriate **needle** container ~~such as a needle book~~. Do not handle ~~needle~~ or reposition ~~the~~ needles before or after ~~being placed~~**placing them** in the needle ~~book~~**container**. **Bury the sharp end of the needle in the foam mat, when possible.**
   c. Encourage the surgeon to cut the ~~atraumatic~~ needle ~~of~~**off** the suture before tying the suture.
   d. Use caution when loading free needles.
~~4.~~6. Syringe needles are not to be re-capped, unless the medical procedure dictates recapping the needle, and then only by a one-hand**ed** technique.
   a. Syringes with needles are placed in the neutral zone for passing between ~~surgeon and scrub~~**surgical team members**.
   b. If refilling of the syringe is necessary, remove and replace the needle with ~~a clamp~~**an instrument**.
   c. After use, place the needle and syringe in a visible and safe place. The needle ~~can~~**may** be removed from the syringe with ~~a clamp~~**an instrument** and placed in the needle ~~book~~**container**.

~~5. Always know the location and quantity of sharps, especially needles and blades.~~
~~a. Keep sharps visible. DO NOT place sharps where they can not be seen (i.e., under basins, towels or instrument pans).~~

7. ~~When a scrub person is relieved, either temporarily or permanently, both the oncoming and off-going staff members are to identify the location and type of sharps. Identification of sharps can be confirmed with the count.~~**An instrument should be used to pick up sharp items (e.g., scalpel blades, suture needles) that have fallen off the sterile field.**
8. **Whenever possible, scrubbed team members should wear two pairs of surgical gloves, one over the other, during surgical and other invasive procedures that have the potential for exposure to blood, bodily fluids, or other potentially infectious materials.**

a. **Double gloving minimizes bloodborne pathogen exposure.**
b. **When double gloves are worn, a perforation indicator system is preferred, using a colored pair of gloves worn beneath a standard pair of gloves.**

E. **POST-OPERATIVELY:**

1. **All disposable sharps shall be disposed of in an appropriate puncture-proof container.**
   a. **The scrub person is responsible for disposing sharps from the sterile field.**
   b. **The circulating nurse is responsible for disposing sharps used off the sterile field.**
   c. **The anesthesiologist/anesthesia tech is responsible for the disposal of sharps used by him/her during the procedure.**

~~1.~~**2.** Disposable sharps are placed in a bio-hazardous puncture proof container.
   a. Needles are placed in the needle ~~book~~**container, which** ~~and the needle book~~ is carefully secured before being placed in the puncture proof **biohazardous waste** container.
   b. Knife blades are removed from the handle using ~~a clamp~~**an instrument.** DO NOT ~~use fingers to~~ remove a knife blade **by hand.**
   c. Disposable sharps that do not fit in the needle book (i.e., staplers, trocars, used k-wires, etc.) are placed in ~~a sharps container~~**an appropriate puncture-proof container (i.e., recycling bin or sharps container).** DO NOT leave exposed disposable sharps on the case cart.
   d. **Reusable sharp instruments (e.g., sharp retractors) shall be separated into a basin prior to sending the case cart to the decontamination area.**

3. **Puncture resistant sharps disposal containers are to be routinely replaced and not allowed to overfill. Containers should be replaced when ¾ full.**

F. **REFERENCES:**

~~c.~~1. **Conner, R. (2018). Guidelines for Perioperative Practice, 2018 Edition. Denver, CO: Association of PeriOperative Registered Nurses.**

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**URINE CHEMISTRY USING A URINE DIPSTICK, MEASURING**
Purpose:	To outline nursing responsibilities for testing urine using dipsticks.
Supportive Data:	A ~~r~~Registered ~~n~~Nurse (RN) ~~or licensed vocational nurse (LVN)~~ may perform this procedure. Testing using a urine dipstick is under the direction, authority, jurisdiction and responsibility of the Laboratory Director. Urine dipstick testing is considered definitive for the purpose of care and diagnosis.
Equipment:	Timer Paper Towel

A. **POLICY:**

1. Urine dipsticks are inert plastic strips which have attached different reagent papers for measuring urine chemistries. The dipstick provides a rapid, simple method for measuring pH, leukocytes, nitrite, protein, glucose, ketones, urobilinogen, bilirubin, blood, and hemoglobin in urine specimens. Testing is considered definitive for the purposes of care and diagnosis

B. **PROCEDURE:**

1. Verify Quality Control (QC) has been completed within at least 24 hours.
   a. **Quality Control: Two levels of quality control (QC) must be tested daily before performing patient tests and when opening a new vial of test strips.**
   a. **Store QC vials in the refrigerator when not in use and bring to room temperature before use (10-15 minutes). An open vial of QC is good for 30 days at room temperature. Mix well prior to testing**
   b. Complete QC and record in log ~~if not done~~.
2. Collect voided urine in a clean container. A first-morning specimen is preferred, but random collections are acceptable.
   a. Test the urine within two hours (test immediately if testing for bilirubin or urobilinogen). If unable to test within two hours, refrigerate the specimen immediately and bring to room temperature before testing.
   b. Label the sample if the test is not performed at the bedside and in the presence of the patient.
   c. Mix well before testing.
3. Immerse the test strip ~~briefly (no longer than 1 second)~~ into the container of urine~~.~~ **and remove immediately.**
   a. Make sure the reagent pads are totally immersed.
4. Draw the edge of the strip along the rim of the container to remove excess urine.
5. Turn the test strip on its side and tap once on an absorbent paper towel to remove excess urine.
   a. This also prevents the possible mixing of reagent chemicals which can produce reading difficulties.
6. Wait the appropriate time (per manufacturer's recommendation) and read the test. Accurate timing is essential.
   a. Color changes that occur after 2 minutes are of no clinical value.
   b. Match the test strip to the color and record results.
      i. Be sure the strip is properly oriented to the color chart on the test strip container.
      ii. Color changes that occur only along the edges of the pads should be ignored. Careful removal of excess urine will eliminate this effect.
7. Storage:
   a. Store all unused strips in the original bottle.
   b. Store at room temperature.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Executive Committee	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
7/03,4/04,11/06,7/09,08/11, 04/15, 06/18	09/11, 05/15, 07/18	10/11, 05/15, 07/18	03/16, 08/18	n/a	11/11, 04/16, 08/18	09/18	1/12, 05/16, n/a	01/12, 05/16

c. Do not remove desiccant from bottle.
d. Do not store in direct sunlight.
e. Do not use strips after their expiration date.
f. Once opened, strips are good until the expiration date listed on the bottle or six months after the open date, whichever is sooner.

B. **REFERENCE RANGES:**

Test:	Glucose	Bilirubin	Ketones	Specific Gravity	Blood	pH	Protein	Urobilinogen	Nitrite	Leukocytes
Normal:	Neg	Neg	Neg	1.010–1.035	Neg	4.6-8.0	Neg	Neg	Neg	Neg

C. **LIMITATIONS:**

1. Protein: A visibly bloody urine may cause elevated results.
2. Blood: Capoten (captopril) may reduce sensitivity. Certain oxidizing contaminates, such as hypochlorite, may produce false positive results. Microbal peroxidase associated with **urinary tract infection** (UTI) may cause false positive reaction.
3. Leukocytes: Elevated glucose (**greater than or equal to [**>= 3-g/dL) may cause decreased test results. The presence of cephalexin, cephalothin, or high concentration of oxalic acid may cause decreased test results. Tetracycline may cause decreased reactivity and high levels of the drug may cause a false negative reaction. Positive results may occasionally be due to contamination of specimen by vaginal discharge.
4. Nitrite: Pink spots or pink edges should not be interpreted as a positive result. A negative result does not rule out significant bacteriuria. False negative results may occur with shortened bladder incubation of the urine, absence of dietary nitrate, or the presence of nonreductive pathological microbes.
5. Glucose: Ketone bodies reduce the sensitivity of the test; a moderately high ketone levels (~~40~~ **40**mg/dL) may cause false negatives for specimens containing a small amount of glucose (75-125-mg/dL) but the combination of such ketone levels and low glucose levels is metabolically improbable in screening.
6. Ketones: False trace results may occur with highly pigmented urine specimens or those containing large amounts of levodopa metabolites. Compounds such as mesna that contain sulfhydryl groups may cause false positive or an atypical color reaction.
7. pH: Bacterial growth by certain organisms may cause a marked alkaline shift (ph >8), usually because of the urea conversion to ammonia.
8. Specific Gravity: Highly buffered alkaline urines may cause low readings, while the presence of moderate quantities of protein (100-750 mg/dL) may cause elevated readings.
9. Bilirubin: Atypical colors (colors that are unlike the negative or positive color blocks shown on the color chart) may indicate that bilirubin-derived bile pigments are present in the urine sample and may be masking the bilirubin reaction. These colors may indicate bile pigment abnormalities and the urine specimen should be tested further (send to lab).
10. Urobilogen: Atypical color reactions may be obtained in the presence of high concentration of p-amino benzoic acid. False negative results may be obtained if formalin is present. Strip reactivity increases with temperature.

D. **DOCUMENTATION:**

1. Document the results in electronic health record~~. If test performed by a Licensed Vocational Nurse (LVN), the LVN should report the result to RN as appropriate~~.
2. **Document QC results on the log sheet.**

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

1. **Point of Care Quality Control Log L&D Urine Dipstick and Nitrazine**
~~1. Quality Control Log~~

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

1. Siemens Healthcare Multistix Package Insert. TN30516A. 06/2010.

~~Tri-City Medical Center Clinical Laboratory Point of Care | 4002 Vista Way Oceanside CA 92056 (760) 940-7974~~

POINT OF CARE QUALITY CONTROL LOG

~~MISCELANEOUS WAIVED TESTING~~L & D URINE DIPSTICK AND NITRAZINE

Unit:	Instructions:
Month: Year: 2017	1. Refer to test procedure for instructions on maintenance of test table, insert, meter and Calibration bar, and how to perform Quality Controls. 2. Indicate Lot #s. Verify Reagents and Controls are not expired. 3. Indicate Corrective Actions if QC fails at the bottom of the form. 4. IF no testing performed, indicate "No Patient tests" 5. Questions: Point of Care Coordinator x7974. 6. Completed Log is stored in Lab.
Lab Review:	

Unit:	LD		LD		LD	QC Pass? QC/Reagents not expired? If yes, sign.
Test:	URINE DIPSTICK Lot # ---------- Exp. : ----------		NITRAZINE Lot # ---------- Exp. : ----------		Maintenance of test table, insert & meter. Cleaned & Disinfected	
DATE	Both Levels PASS (✓)		NEG pH=4.5-6	POS pH=6.5>=9	(✓)	OPERATOR
LOT QC Reagent	Level 1	Level 2	Level 1	Level 2		
LOT Lot # Exp.:	Lot#_____ Exp._____	Lot#_____ Exp._____	Lot#_____ Exp._____	Lot#_____ Exp._____		
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Calibration bar inspected & cleaned if needed Monthly (✓) POCC Initials: Date:

QC Fail? CORRECTIVE ACTIONS:

[Indicate below: e.g. Check expiration dates. Repeat. Try new reagent and/or new QC, repeat. Contact lab with repeated fails.]

Tri-City Medical Center	~~Distribution:~~ Patient Care Services

PROCEDURE:	URINE DIPSTICK ANALYSIS USING SIEMENS CLINITEK STATUS + CONNECT
Purpose:	To provide an accurate and reliable method for reading urine dipstick results. Test results may provide information regarding the status of carbohydrate metabolism, kidney and liver function, acid-base balance, and urinary tract infection.
Supportive Data:	A Registered Nurse (RN) ~~or Licensed Vocational Nurse (LVN)~~ may perform this procedure. Testing is under the direction, authority, jurisdiction, and responsibility of the Laboratory Director.
Equipment:	Siemens Clinitek Status Analyzer (Analyzer together with base component) Siemens Multisix 10SG dipstick Paper towel to blot 2 levels Quality Control (QC) (current manufacturer provided by lab)

A. **PRINCIPLE :**

1. The Clinitek Status analyzer is for in vitro diagnostic use in the semi-quantitative detection of ~~albumin,~~ bilirubin, blood (occult), ~~creatinine,~~ glucose, ketone (acetoacetic acid), leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen in urine samples.
   a. The Clinitek Status+ Analyzer provides more regulatory control than the previous Clinitek Status model, including connectivity options and QC lockout functions.
2. If the movement of the test table is irregular or slow, this may be due to:
   a. Heavy build up of dried urine on the test table—clean the test table
   b. Low battery power—replace the batteries or use the power supply.
3. Substances that cause abnormal urine color may affect the readability of test pads on the reagent strips (see **Substances/Conditions Affecting Test Results**~~Attachment A~~).

B. **SPECIMEN:**

1. First-morning void specimen is preferred. If not available, use a specimen that has incubated in the bladder for at least 4 hours. A random-void specimen is acceptable, but may not register positive nitrite results.
2. Collect in a clean dry container.
3. Label with patient identification.
4. Test within one hour of collection or refrigerate for up to 24 hours and bring to room temperature before testing. (Bilirubin and urobilinogen decrease with time).

C. **PROCEDURE:**

1. Quality Control: Two levels of quality control (QC) must be tested daily before performing patient tests and when opening a new vial of test strips.
   a. Store QC vials in the refrigerator when not in use and bring to room temperature before use (10-15 minutes). An open vial of QC is good for 30 days at room temperature. Mix well.
   b. If QC needs to be performed, the "Strip Test" button will not be available, and the QC button will say "QC Test Due".
   c. Select the QC button.
   d. Select "QC Strip Test"
   e. Operator: Select "Enter New Operator Name". Enter operator 'name' by
      i. Scanning badge barcode
      ii. Typing ~~alpha~~-CERNER code
      iii. Toggle to numeric and type numeric – Employee ID

Patient Care Services Content Expert	Clinical Policies & Procedures	Nursing Executive Council	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
5/13, 05/15, 06/18	6/13, 05/15, 07/18	6/13, 05/15, 07/18	03/16, 08/18	n/a	7/13, 04/16, 08/18	09/18	09/13, 05/16, n/a	09/13, 05/16

f. Control: Select "Enter Lot and Expiration Date".
   i. Scan the barcode for the QC lot number.
   ii. Adjust the year and month of the expiration date.
   iii. Strip: Select "Enter new lot and expiration date".
   iv. Scan the barcode assigned to the vial of strips in use.
   v. Adjust the year and month of the expiration date.

g. Prepare Test:
   i. Mix the QC Vial well. Press "Start". You have 8 seconds to complete the following steps:
      1) Wet each pad of the strip with control material.
      2) Tap the edge of the strip onto a paper towel to remove excess liquid.
      3) Place the strip in the test strip holder with the test pads facing up. Slide the strip to the end of the holder.
      4) At the end of the 8 second countdown, the test strip holder will pull into the instrument and the strip will be read. The instrument will compare the results obtained with pre-programmed expected results and determine a PASS or FAIL.
      5) Dispose of the strip and wipe clean the test strip holder.
      6) Repeat any levels of Failed QC as necessary.
      7) Verify strips and QC has been stored properly and are not expired.
      8) Re-mix sample well.
      9) Clean the test-table insert.
      10) Refer to additional troubleshooting steps at the end of this procedure.
      11) Contact the lab for support.

h. Record results on the Waived Testing QC log.

D. **PATIENT TEST:**

1. Select "Strip Test"
2. Operator: Select "Enter New Operator Name". Enter operator 'name' by
   a. Scanning badge barcode
   b. Typing alpha-CERNER code
   c. Toggle to numeric and type numeric- Employee ID
3. Patient Information: Select "Enter New Patient"
   a. Enter the Patient's Last Name
   b. Enter the Patient's ID
4. Strip: Select "Enter new lot and expiration date".
   a. If available, select "use last lot". Or,
   b. Scan the barcode assigned to the vial of strips in use.
   c. Adjust the year and month of the expiration date.
5. Prepare Test:
   a. Mix the sample well. Press "Start". You have 8 seconds to complete the following steps:
   b. Fully immerse the dipstick into the urine. Tilt slightly to the side ensuring all strip pads are wet. Slowly pull the strip out, dragging the edge of the strip along the rim of the vial to catch excess liquid.
   c. Place the strip in the test strip holder with the test pads facing up. Slide the strip to the end of the holder.
   d. At the end of the 8 second countdown, the test strip holder will pull into the instrument and the strip will be read. ~~(The analyzer automatically~~
   e. **The analyzer automatically** ~~Performs~~ **performs** a calibration each time a strip is read. Do not push or pull the test table or bump the instrument while it is calibrating.)
   f. While the strip is reading, select the color and clarity of the urine.
   g. Dispose of the strip and wipe clean the test strip holder.

~~g.~~

6. Recall Results:
   a. From the main Select screen, touch the Recall Results button.
   b. Select to review Patient or Quality Control tests.
   c. Test results are listed chronologically, with the most recent being at the top. Use the up and down arrows to scroll and highlight the result you would like to recall. Touch Select to view.
   d. You may print. Touch done when finished.

E. **LIMITATIONS:**

1. Interfering substances may cause false positive or false negative results. Refer to ~~attachment A~~ **related documents** at the end of the procedure.
2. To Report Results
   a. Results reported by the meter:

Test	Abbreviation	Units	REFERENCE RANGES:	
			Normal	Abnormal
Glucose	GLU	mg/dL	Negative	100 500 250 ≥1000
Bilirubin	BIL		Negative	Small Moderate Large
Ketone	KET	mg/dL	Negative	Trace 80 15 ≥160 40
Specific Gravity	SG		≤ 1.005 1.020 1.010 1.025 1.015 1.030 ≥ 1.035	N/A
Blood	BLO		Negative	Trace Moderate Small Large
pH	pH		5.0 6.5 8.0 5.5 7.0 8.5 6.0 7.5 ≥9.0	N/A
Protein	PRO	mg/dL	Negative	Trace, 30, 100, ≥ 300
Urobilinogen	URO	E.U./dL	0.2 1.0	2.0 4.0 > 8.0
Nitrite	NIT		Negative	Positive
Leukocytes	LEU		Negative	Trace Moderate Small Large

   b. Critical Values:
      i. Glucose greater than or equal to 1000 mg/dL shall be reported to patient's licensed health care provider (RN or MD)
   c. Detectable Range for Reagant Area and Sensitivity:

F. **METER MAINTENANCE AND CLEANING:**

1. The test table is to be kept clean if the analyzer is to operate properly.
2. Nursing shall be responsible for the daily cleaning of the test table insert and weekly cleaning of the meter.
   a. To clean the Test Table Insert:

i. Remove the insert and thoroughly clean with a hospital approved disinfectant.
ii. Rinse both sides under running water
iii. Dry and replace insert

b. To clean the Meter:
i. Turn analyzer off
ii. Wipe the outside with a damp (not wet) cloth and mild detergent
1) May use a hospital approved disinfectant after wringing out excess liquid
2) Avoid liquid from enter the printer compartment and under touch display

3. Lab shall perform other cleaning and maintenance to include cleaning of test table and white calibration bar monthly.

a. To clean the Calibration Bar:
i. Remove the insert from the test table.
ii. Remove the test table by pulling it slowly out of the analyzer.
iii. Drain the drip tray, if necessary.
iv. Examine the white calibration bar on the test table for dirt or discoloration under good lighting. If it appears dirty or discolored, wet a cotton-tipped stick or lint free cloth with distilled water and gently wipe and clean the calibration bar.
v. Do not scratch, touch or mark the Calibration bar.
vi. Allow the calibration bar to air dry.
vii. Insert the test table and table insert back.

~~viii.~~G. **FORM(S):**

~~4.~~1. **Point of Care Quality Control Log L&D Urine Dipstick and Nitrazine**

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

1. Substances/Conditions Affecting Test Results
~~1. Quality Control Log~~

~~H.~~I. **REFERENCE:**

1. Siemens Healthcare Multistix Product Insert..TN30516A Rev. 06/10
2. Siemens Clinitek Status Connect System Operator's Guide
3. (135955) Rev. B, 2011-06

~~I.~~J. **TECHNICAL ASSISTANCE:**

1. Siemens HealthCare Technical Care Center: 1-877-229-3711 Option 13; option 2

~~Tri-City Medical Center Clinical Laboratory Point of Care | 4002 Vista Way Oceanside CA 92056 (760) 940-7974~~

POINT OF CARE QUALITY CONTROL LOG

~~MISCELANEOUS WAIVED TESTING~~L & D URINE DIPSTICK AND NITRAZINE

Unit:	Instructions:
Month: Year: 2017	1. Refer to test procedure for instructions on maintenance of test table, insert, meter and Calibration bar, and how to perform Quality Controls. 2. Indicate Lot #s. Verify Reagents and Controls are not expired. 3. Indicate Corrective Actions if QC fails at the bottom of the form. 4. IF no testing performed, Indicate "No Patient tests" 5. Questions: Point of Care Coordinator x7974. 6. Completed Log is stored in Lab.
Lab Review:	

Unit:	LD		LD			LD	
Test:	URINE DIPSTICK Lot # --------------- Exp. : ---------------		NITRAZINE Lot # --------------- Exp. : ---------------			Maintenance of test table, Insert & meter. Cleaned & Disinfected	QC Pass? QC/Reagents not expired? If yes, sign.
DATE	Both Levels PASS (✓)		NEG pH=4.5-6	POS pH>6.5->=9		(✓)	OPERATOR
LOT: QC Analyzed	Level 1	Level 2	Level 1	Level 2			
LOT: Lot # Exp.:	Lot#________ Exp.	Lot#________ Exp.	Lot#______ Exp.	Lot#______ Exp.			
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Calibration bar inspected & cleaned if needed Monthly (✓) POCC Initials: Date:

QC Fail? CORRECTIVE ACTIONS:

(Indicate below: e.g. Check expiration dates. Repeat. Try new reagent and/or new QC, repeat. Contact lab with repeated fails.)

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Substances/Conditions Affecting Test Results

The following table includes specific substances and conditions that may affect test results.

Test Name	*False Positive or Increased values*	*False Negative or Decreased values*
Glucose		• Ketones (greater than or equal to 40 mg/dL) may affect a 75 to 125 mg/dL glucose level
Bilirubin	• Indican™ (indoxyl sulfate) may impart a yellow-orange to red color on the pad • Metabolites of Lodine™ (etodolac)	• Small amounts (less than 0.4-mg/dL) may need to be detected with ICTOTEST® Reagent Tablets **(Send to lab)** • Urine specimen was more than one hour old (instability of bilirubin).
Ketone	• Highly pigmented urines • Large amounts of levodopa (L-dopa) metabolites • Compounds that contain sulfhydryl groups	
Specific Gravity	• Moderate (100 – 750 mg/dL) quantities of protein	• Highly buffered/alkaline urines
Blood	• Oxidizing contaminants (e.g. bleach) • Microbial peroxidase from urinary tract infections	• Capoten® (Captopril)
pH	• Bacterial growth that converts urea to ammonia	
Protein	• Visibly blood urine	
Urobilinogen	• *p*-aminosalicylic acid (PAS) and sulfonamides • *p*-aminobenzoic acid (PABA) may cause atypical color development	• Formalin • Urine specimen more than one hour old (instability of urobilinogen)
Nitrite		• Infections caused by organisms that don't contain reductase • Urine was not in bladder long enough (at least 4 hours) • Absence of dietary nitrate
Leukocytes	• Contamination by vaginal discharge	• Elevated glucose (greater than or equal to 3,000 mg/dL) • Cephalexin (Keflex®) or Cephalothin (Keflin®) • High concentrations of oxalic acid • Tetracycline

Tri-City Health Care District
Oceanside, California

Administrative Policy ~~Manual~~
Human Resources

ISSUE DATE: 01/00 SUBJECT: Workplace Violence Prevention Plan

REVISION DATE(S): 10/12 POLICY NUMBER: 8610-463

Administrative Human Resources Department Approval:	~~11/15~~07/18
Administrative Policies & Procedures Committee Approval:	07/18
~~Human Resources Committee Approval:~~	~~11/15~~
Medical Executive Committee Approval:	08/18
Organizational Compliance Committee Approval:	n/a
Administration Approval:	09/18
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/15

A. EXECUTIVE SUMMARY

1. Violence is occurring all throughout the world and over time has filtered in the workplace. Overall, violent assaults remain fairly rare, although healthcare workers may be at higher risk for attacks compared to other professions. With this in mind, Tri-City Healthcare District (TCHD) is committed to providing a work environment that is safe and every effort is made to reduce or eliminate threats or acts of workplace violence.
2. The California Occupational Safety and Health Administration (Cal/OSHA) Standards Board adopted SB 1299, a new health care workplace violence prevention regulation that mandates the ~~. The first phase of the regulation was effective April 1, 2017, which related to reporting requirements and recordkeeping. The final phase will become fully effective April 1, 2018. Therefore, the Workplace Violence Prevention Plan,~~ assessments of the workplace, hazards identified, corrective measures put into place, and staff trained ~~must be implemented by the 2018 due date~~.
3. The Workplace Violence Prevention Plan (WVPP) is part of the organization's Injury and Illness Prevention Plan (IIPP). The WVPP is in effect at all times in every unit (including Outpatient areas), services and operations.
4. Key Elements of the WVPP include:
   a. Identifying management positions with the responsibility for administering the WVPP
   b. Coordination with other employers of employees (contractors, registries, vendors) regularly working at TCHD
   c. Identifying and evaluating safety and security risks
   d. Investigating acts of violence/violent incidents
   e. Hazards corrections/mitigations
   f. Communication plan with employees and others
   g. Designing, coordinating and implementing the training
   h. Incident reporting by employees, contracted labor, registries, and regularly on-site vendors
   i. Incident reporting to Cal/OSHA
   j. Recordkeeping/Incident Log
   k. Annual Program Review

B. DEFINITION OF WORKPLACE VIOLENCE

1. Workplace Violence: means any act of violence, threat of violence or aggressive behavior that occurs in the work setting. The term workplace violence shall not include lawful acts

of self-defense or defense of others. Workplace violence includes the following:

a. The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury.
b. An incident involving the threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the employee sustains an injury.
c. Examples of violence acts may include, but are not limited to assault, battery, beatings, stabbings, shooting, rape, psychological traumas, threatening or obscene phones calls, verbal abuse, stalking, sworn or shouted at, intimidation or harassment of any kind.

2. Four workplace violence types:
   a. "Type 1 violence" means workplace violence committed by a person who has no legitimate business in the worksite, and includes violent acts by anyone who enters the workplace with the intent to commit a crime
   b. "Type 2 violence" means workplace violence directed at employees by customers, clients, patients, students, inmates, or any other for whom an organization provides services
   c. "Type 3 violence" means workplace violence against an employee by a present or former employee, supervisor, or manager
   d. "Type 4 violence" means workplace violence committed in the workplace by someone who does not work there, but has , or is known to have had, a personal relationship with an employee
3. Zero Tolerance: Violence of any kind as defined above will not be tolerated in the workplace.

C. SCOPE
1. All Departments, Units, Service Lines, Employees, Medical Staff, Registry or Traveler staff, On-site Vendors/Contractors, Patients, Family members and Visitors

D. RESPONSIBILITIES
1. The Manager of Safety/Environment of Care Safety Officer is responsible to initiate, implement, maintain and administer the WVPP. The Manager of Safety/ Environment of Care Safety Officer may delegate duties, tasks and assignments via the Workplace Violence Prevention (WVPP) (sub-committee of the Environmental Health & Safety Committee).
2. The Manager of Employee Health is responsible to initiate, implement, maintain and administer the IIPP.
3. Each Department Director/Manager/Supervisor and Employers (On-site Contractors/Vendors) of other employees is responsible for implementing, complying and supporting the WVPP.
4. Each employee and other employees (contractors/vendors) are responsible for implementing, complying and supporting the WVPP.

E. PLAN DEVELOPMENT
1. WVPP development requires a multidisciplinary team approach, which includes Leadership, Management, along with employees and their representatives in developing, implementing, and reviewing the plan.
2. The development, implementation, and annual review of the plan will be coordinated through the Workplace Violence Prevention sub-committee in conjunction with active involvement of employees and their representatives.

F. COMMUNICATION
1. WVPP information and updates are communicated through the following means:

a. Annual WVPP evaluation and review
b. Annual training (type of training is dependent on the roles, departments and specific risks associated with the job duties or environment)
c. Department Specific Training (example: CPI Non-Violent Crisis Intervention)
d. Net Learning self-learning module
e. Power Minutes or Hot Topic educational flyers
f. Workplace Safety Poster (Information on how to contact Safety/Security Officers and report concerns via RL Solutions)
g. Department Staff Meetings

2. Employees are encouraged to report safety concerns to the Safety Officer, Security, Risk Management, Employee Health and their Director, Manager or Supervisor
3. Attempts will be made throughout the year to solicit active participation of employees and their representatives in the review, creation, design and implementation of the WVPP and all training materials and sessions. The following methods will be used to solicit active participation:
   a. Power Minutes or Hot Topic educational flyers
   b. Net Learning modules
   c. Training session debriefings
   d. Staff meetings
   e. Safety Symposiums
   f. Safety fairs

G. TRAINING

1. All employees working in the facility, units, service lines, or operations shall be provided initial training, followed by annual refresher training on the WVPP.
2. In addition to District employees, WVPP training is required for:
   a. Registry Staff/Travelers
   b. On-Site Contractors that conduct regular business on TCHD property (example: Aramark, Cardinal Health, Stericycle)
3. ~~Licensed Independent~~Allied Health Professionals not employed by the district and volunteers are not required to be trained by Cal/OSHA, but are highly encouraged to be familiar with the WVPP
4. The level of training on WVPP depends on the roles, departments and specific risks associated with the job duties or environment:
   a. Low risk: Net Learning self-learning module
   b. High risk: Non-Violent Physical Crisis Intervention (NVCI) training
5. Employees/supervisors performing patient care contact activities in higher-risk areas (example: Emergency Department ~~([ED])~~, Behavioral Health Unit ~~([BHU])~~, Crisis Stabilization Unit ~~([CSU])~~, and Lift Team) ~~and those employees' supervisors~~ are required to attend annual formal Non-Violent Physical Crisis Intervention (NVCI) training~~, (8 hours initial, 4 hours annual renewal)~~.
6. Employees assigned to respond to alarms or other notifications of violent incidents or whose assignments involve confronting or controlling persons exhibiting aggressive or violent behavior (example: Security Officers) shall be provided training prior to initial assignment and at least annual thereafter.
7. Non Violence Crisis Intervention training shall include:
   a. General and personal safety measures;
   b. Aggressive and violent predicting factors;
   c. The assaults cycle;
   d. Characteristics of aggressive and violent patients and victims;
   e. Verbal and physical maneuvers to defuse and prevent violent behavior;
   f. Strategies to prevent physical harm;
   g. Restraining techniques;
   h. Appropriate use of medications as chemical restraints;

i. An opportunity to practice the maneuvers and techniques included in the training with other employees they work with, including a meeting to debrief the practice session.

8. An annual review of the educational training materials and programs will be conducted with active engagement of employees and their representatives.
9. Employees will be provided a means of asking questions, providing feedback or suggestions related to all training programs during face-to-face training and also with online training where a response will be provided within one business day.

H. RISK ASSESSMENTS

1. A risk assessment is required for all departments, units, service lines, (including Outpatient areas), and services that include:
   a. Environmental risk factors;
   b. Community-based risk factors;
   c. Area surrounding the facility such as employee parking areas and other outdoor surroundings;
   d. Include a review of workplace violence incidents that have occurred in each facility, department, unit, operations, (including Outpatient areas), and services within the previous year, whether or not an injury occurred;
   e. Risk assessments will be conducted annually or whenever conditions change that could affect safety;
   f. The risk assessment shall be used to identify locations and situations where violent incidents are more likely to occur;
   g. Active engagement of employees and their representatives.

I. HAZARD CORRECTION

1. Engineering and work practice controls shall be used to eliminate or minimize employee exposure to the identified hazards to the extent feasible.
2. TCHD shall take measures to protect employees from imminent hazards immediately, and shall take measures to protect employees from identified serious hazards within seven business days of the discovery of the hazard.
3. When an identified corrective measure cannot be implemented within the seven business day timeframe, (such as a project that requires Office of Statewide Health Planning and Development [OSHPD] approval), TCHD shall take interim measures to abate the imminent or serious nature of the hazard while completing the permanent control measures.
4. Active engagement of employees and their representatives will be included in the hazard corrective measures whenever feasible.
5. Examples of Hazard Corrections include, but are not limited to the following:
   a. Emergency Department:
      i. Electronic access control
      ii. Panic buttons
      iii. Closed Circuit Television (CCTV) cameras
      iv. Security Officer Station – Posted 24 hours per day
      v. Zero Tolerance Posters
   b. Behavioral Health Unit / Crisis Stabilization Unit:
      i. Electronic access control
      ii. CCTV
      iii. Panic Buttons
      iv. Security Officer posted on unit 24 hours per day
   c. Maternal Child Health Units:
      i. Electronic access control
      ii. Access Control System
      iii. CCTV

iv. Department policy in place for identifying visitors
v. Department procedure for uniquely identifying mother-infants
vi. Teaching program to educate parents or guardians to explain the security processes
vii. Unique identification for staff members
viii. Unique visitor badge system with automatic time sensitive "VOID" process

d. Neonatal Intensive Care Unit:
   i. Electronic access control
   ii. The Maternal Child Health units are protected with active video surveillance systems on entrances and exits of the units. Additionally, the unit has electronic access control systems for entrances and exits that alarm if unauthorized entry or exit occurs

e. Pharmacy Department:
   i. Electronic access control
   ii. Infrared Security System

f. Business Office:
   i. Electronic access control
   ii. Panic button
   iii. Local area surveillance system

g. Human Resources department:
   i. Panic buttons
   ii. Access Control System
   iii. CCTV

h. Adult Critical Care Unit:
   i. Electronic access control
   ii. Local camera system

i. Patient Representative Office:
   i. Panic button

J. <u>PATIENT AND VISITOR ASSESSMENT</u>

1. Patients are assessed upon Admission to all areas except the Progressive Care Unit (PCU) and the Neonatal Intensive Care Unit (NICU) to identify and evaluate patient-specific risk factors. The assessment history is aimed at identifying factors that may indicate the patient has a higher likelihood for workplace violence, such as use of illicit drugs or alcohol, psychiatric condition or diagnosis associated with increased risk of violence, any condition or disease process that would cause confusion and/or disorientation, or history of violence. The Expanded Aggressive Behavior Risk Assessment Tool (e-ABRAT) is being used. These patients will have a ~~color sticker~~ violet horseshoe magnet that is placed on their door to alert others that there may be a potential for increased violent behaviors.
2. Additionally, clinicians order an Interdisciplinary Plan of Care (IPOC) with applicable goals and interventions for patients that have been identified as a higher risk for potential violence. The IPOC is called Adult Safety/Violence/Restraints.
3. If a violent event occurs, it will be documented in the electronic health record in IView.
4. Visitors that have demonstrated or have a potential for demonstrating violent behaviors will be immediately reported to management, security and the Administrative Supervisor. Staff will be informed of visitors of concern during their handoff report on their patients.

K. <u>VIOLENT INCIDENT REPORTING (INTERNAL AND EXTERNAL TO CAL/OSHA)</u>

1. Internal reporting of workplace violence incidents ~~may~~shall be accomplished by several means:
   a. During normal business hours Monday – Friday, employees ~~may~~shall contact Employee Health (EH) by dialing the Incident Reporting Hotline "7050" or visiting the EH office.

b. After hours and weekends, incidents ~~may~~shall be reported by dialing the Incident Reporting Hotline "7050" and notifying the Administrative Supervisor.
c. For serious incidents, such as a death or injury requiring hospitalization the employees' supervisor, manager or director shall be contacted and that individual will immediately contact the administrator on-call and the Manager of Safety/EOC Safety Officer.
d. Employees ~~may~~shall report incidents of violence or unsafe conditions ~~via RL Solutions on the Intranet. (Username: Employee ID number and Password: rl (RL in lowercase letters))~~and complete a Quality Review Report.

2. External reporting of workplace violence incidents to Cal/OSHA shall be completed for incidents involving any of the following:
   a. The use of physical force against a hospital employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury.
   b. An incident involving the use of a firearm or other dangerous weapon, regardless of whether the employee sustains and injury.
   c. An incident involving the death of an employee, hospitalization greater than 24 hours, one or more days away from work (which includes the day of the incident), restricted work or transfer to another job, medical treatment beyond "First Aid", loss of consciousness, significant injury, or psychological trauma or stress as a result of the workplace violence incident.
3. Timeframes for reporting to Cal/OSHA:
   a. Shall be reported online to Cal/OSHA within 24 hours if the incident involves:
      i. A fatality or an injury that requires inpatient hospitalization for a period in excess of 24 hours.
      ii. Any incidents involving a firearm, dangerous weapon, loss of limb, or serious degree of permanent disfigurement.
      iii. An urgent or emergent threat to the welfare, health, or safety of hospital personnel (potential exposure to death or serious physical harm).
   b. Shall be reported online to Cal/OSHA within 72 hours if the incident involves:
      i. All other incidents not listed above in section 3.a.i,ii, iii
      ii. The hospital shall submit an initial report with all information available within the allotted timeframe. There are no obligations by Cal/OSHA for the hospital to update the report online if additional information is made available at a later date.
   c. Telephone reports to Cal/OSHA
      i. The Cal/OSHA WVPP regulations states that employers must continue to report immediately by telephone to the nearest District Office of the Division of Occupational Safety & Health any serious work-connected injury, illness or death as required by Title 8, California Code of Regulations, Section 342(a).
         1) Local District Office:
            a) San Diego District Office
               i) 7575 Metropolitan Drive
               ii) Suite 207
               iii) San Diego, Ca. 92108
               iv) Telephone: 619-767-2280
         2) Cal/OSHA does not accept telephone reporting in place of the online reporting noted in 3.a.b. The telephone reporting is a separate requirement for incidents involving the death or serious work-connected injury.
         3) Immediately means as soon as practically possible, but no longer than 8 hours after the hospital knows of the death or serious injury.

In extreme exigent circumstances the timeframe for reporting to Cal/OSHA may be extended up to 24 hours maximum.

4) Information required when completing a telephone report:
   a) Time and date of accident/event
   b) Employer's name, address and telephone number
   c) Name and job title of the person reporting the accident
   d) Address of accident/event site
   e) Name of person to contact at accident/event site
   f) Name and address of injured employee(s)
   g) Nature of injuries
   h) Location where injured employee(s) was/were taken for medical treatment
   i) List and identity of other law enforcement agencies present at the accident/event site
   ~~a)~~j) Description of accident/event and whether the accident scene or instrumentality has been altered.

L. VIOLENT INCIDENT LOG/RECORD KEEPING

1. Records of workplace violence hazards identification, evaluation, and correction shall be created and maintained in accordance with ~~Title 8,~~ California Code of Regulations, Title 8~~Section 3203(b) & 5120(e)(1)(B)~~.
2. Training records shall be created and maintained for a minimum of 1 year*, per ~~Title 8,~~ California Code of Regulations, Title 8~~Section 3203(b)~~. The records must include details with date of training, contents or summary of the training sessions, names and qualifications of persons conducting the training, and the names and job titles of all the persons attending the training sessions.* In addition, ~~Title 22,~~ California Code of Regulations, Title 22~~Section 70214~~ states that orientation and competency validation must be documented in the employees file for the duration of their employment.
3. Violent Incident Logs must be maintained for a minimum of five years~~, per Title 8,~~ California Code of Regulations, Title 8~~Section 3342(h)(3)~~.
4. All records required by this subsection shall be made available upon request to the Chief of the Division of Occupational Safety and Health or his/her representative (Cal/OSHA Investigators) for examination and copying.
5. All records required by this section shall be made available to employees and their representatives, on request, for examination and copying (at no charge to the employee).

M. VIOLENT INCIDENT INVESTIGATION

1. A post-incident response and investigation shall be completed for any employee, contractor, or other individuals that are covered by the WVPP, and have been involved in an act of violence or threat of violence. Steps that shall be taken in the event of a incident of violence (not limited to):
   a. Provide immediate medical care or first aid to employees or covered individuals who have been injured in the incident;
   b. Conduct a post-incident debriefing as soon as possible after the incident with all employees, supervisors, and security involved in the incident;
   c. Completion of the Workplace Violence~~t~~ Incident Report form *(titled: Workplace Violence~~t~~ Incident ~~Online~~ Report ~~– Dated: March 22, 2017~~);*
   d. The Security Department will conduct a Security Crime/Incident Report for any incidents that cause injury or have a high probability of causing injury, psychological trauma or stress;
   e. All violent incidents will be reviewed through the WVPP sub-committee and reported up to the EHSC, and finally up to the Board of Directors (annually).

N. ANNUAL REVIEW OF THE WVPP

1. An annual review of the WVPP must be completed at the end of each fiscal year. The goal of the annual evaluation is to evaluate the effectiveness of the plan and any actions implemented throughout the plan year. The annual review of the WVPP shall include:
   a. Staffing, including staffing patterns and patient classification systems that contribute to, or are insufficient to address, the risk of violence;
   b. Sufficiency of security systems, including alarms, emergency response, and security personnel availability;
   c. Job design, equipment, and facilities;
   d. Security risk associated with specific units, areas of the facility with uncontrolled access, late-night or early morning shifts, and employee security in areas surrounding the facility such as employee parking areas and other outdoor areas;
   e. Review of the Violent Incident Log.
2. Additional limited review may be required following new procedures, processes or information. An updated review of the plan shall be completed whenever necessary, as follows:
   a. To reflect new or modified tasks and procedures, changes in staffing, engineering controls, construction or modifications of the facilities, evacuation procedures, alarm systems and emergency responses;
   b. To include newly recognized workplace violence hazards;
   c. To review and evaluate workplace violence incidents that result in a serious injury or fatality; or
   d. To review and respond to information indicating that the WVPP is deficient in any area.

O. RELATED DOCUMENT(S):
1. Environment of Care: Security Management Plan
2. Workplace Violence Incident Report

P. REFERENCE(S):
~~The TCHD Security Management Plan~~
1. The Joint Commission: EC.01.01.01, 02.01.01, 03.01.01, 04.01.01
2. Cal/OSHA Workplace Violence Prevention in Healthcare
3. ~~Title 8,~~ California Code of Regulations, Title 8, Section 3203(b); 5120(e)(1)(B); 3342(h)(3).
4. ~~Title 22,~~ California Code of Regulations, Title 22, Section 70214
~~2.~~5. California Hospital Association, Healthcare Workplace Violence Prevention: How to comply with the Cal/OSHA regulations, January 2017.

~~B. PURPOSE:~~
~~1. Tri-City Healthcare District (TCHD) is committed to providing a work environment that is safe and free of threats or acts of workplace violence.~~

~~C. DEFINITIONS~~
~~1. Acts or Threats of Violence Defined. TCHD expressly prohibits conduct on TCHD premises that constitutes unlawful violence or a credible threat of violence.~~
~~2. "Unlawful Violence" means any assault or battery, or stalking as prohibited in Section 646.9 of the Penal code, but shall not include lawful acts of self-defense or defense of others.~~
~~3. "A credible threat of violence" means a knowing and willful statement or course of conduct that would place a reasonable person in fear for his/her safety, or the safety of his/her immediate family, and that serves no legitimate purpose.~~
~~4. General examples of conduct prohibited by this policy include, but are not limited to, the following:~~
   ~~a. Threatening to harm or harming an individual or his/her family, friends, associates, or their property.~~
   ~~b. Fighting or challenging another individual to a fight.~~

c. Intimidation through direct or veiled verbal threats, or through physical threats, such as obscene gestures, grabbing, and pushing.

d. Making harassing or threatening telephone calls; sending harassing or threatening letters, , texts, emails, or other correspondence.

e. Intimidating or attempting to coerce an employee to do wrongful acts that would affect the business interests of TCHD.

f. Harassing surveillance or stalking, which is engaging in a pattern of conduct with the intent to follow, alarm, or harass another individual, which presents a credible threat to the individual and causes the individual to fear for his/her safety, or the safety of his/her immediate family, as defined in *Civil Code* section 1708.7.

g. Making a suggestion or otherwise intimating that an act to injure persons or property is appropriate behavior.

h. Use of a personal or TCHD-issued tool in a threatening manner toward another.

i. Unauthorized possession of firearms (loaded or unloaded), weapons, or any other dangerous devices on TCHD property. This includes "look-alike" weapons, such as toy guns. Weapons and dangerous devices may include, but are not limited to the following: blackjacks, slingshots, metal knuckles, explosive substances, dirks, daggers, gas- or spring-operated guns, knives, razor blades, and clubs

D. POLICY:

1. TCHD is committed to providing a safe, violence-free workplace and strictly prohibits employees, consultants, customers, patients, physicians, visitors, or anyone else on TCHD premises engaging in a TCHD-related activity from engaging in Unlawful Violence or making credible threats of violence. As part of this policy, TCHD seeks to prevent workplace violence before it begins and reserves the right to deal with behavior that suggests a propensity towards violence even prior to any violent behavior occurring.

E. REPORTING:

1. TCHD employees must report actual or suspected violations to their manager or to any supervisory employee. Supervisors must report actual or suspected violations to the Chief Human Resources Officer and to Security immediately. TCHD employees must report, to Human Resources, any domestic violence temporary restraining orders ("TROs") or injunctions in which the employees are named as petitioners or respondents.

F. INVESTIGATIONS:

1. All reports of Unlawful Violence or credible threats of violence will be investigated promptly and thoroughly and shall be reported to the appropriate authorities by the Security Department. Such investigations cannot be kept confidential, but TCHD will take reasonable steps to prevent retaliation of any kind against any TCHD who has reported Unlawful Violence or a credible threat of violence, or who has cooperated in any investigation of Unlawful Violence or credible threat of violence.

G. CORRECTIVE ACTION AND DISCIPLINE:

1. If TCHD determines that Unlawful Violence or a credible threat of violence has occurred, TCHD will take appropriate corrective action and will take disciplinary action against offending employees, up to and including termination. If such acts, or threats of, are by non-employees, TCHD will take appropriate measures to ensure the safety of staff, including reporting all such incidents to the appropriate authorities.

H. EMPLOYEE ASSISTANCE PROGRAM:

1. Any employee who believes that he/she may have a problem that could lead to violent behavior is encouraged to use TCHD's Employee Assistance Program (EAP). The EAP is a professional, confidential counseling service that is available to all personnel and members of their household to assist in resolving emotional difficulties, marital and family conflict, stress,

~~chemical dependence, conflicts at work, and other concerns. The EAP counselor can help to clarify a problem and to develop an action plan during the counseling session.~~

~~2.~~6. ~~Further information regarding TCHD's Employee Assistance Program may be obtained from your supervisor or from the Human Resources Department.~~

WORKPLACE VIOLENCE INCIDENT REPORT

Completion of each section is required.

Section 1: *(To Be Completed by Victim if able)*

Hospital facility: TRI-CITY MEDICAL CENTER	**Date of incident:**
Employee: **Emp#**	**Department:** **Extension:**
Hospital representative and contact information: Jeff Surowiec, surowiecja@tcmc.com 760-940-3076	**Time of incident:**

1. Who was the aggressor? *(check one)*

- ☐ Patient(s)
- ☐ Spouse /partner of patient (current or former)
- ☐ Family of patient
- ☐ Friend of patient
- ☐ Stranger
- ☐ Supervisor/manager
- ☐ Spouse /partner of employee (current or former)
- ☐ Family of employee
- ☐ Friend of employee
- ☐ Co-worker
- ☐ Licensed independent medical provider
- ☐ Former employee
- ☐ Outside vendor
- ☐ Aggressor not listed above_____

2. Was a risk assessment completed (EBRAT)?

☐ Yes ☐ No ☐ N/A (aggressor was not a patient)

3. Where did the incident occur? *(check as many as apply)*

- ☐Emergency room **Room** _____
- ☐Urgent care
- ☐Behavioral-health unit
- ☐CSU
- ☐Surgery
- ☐Labor & delivery
- ☐Radiology & imaging
- ☐Onsite ambulatory outpatient clinic
- ☐Offsite ambulatory outpatient clinic
- ☐Inpatient **DEPT:**_____ **Rm** _____
- ☐Admissions/registration
- ☐Pharmacy
- ☐Seclusion/restraint room
- ☐Administrative offices
- ☐Cafeteria
- ☐Kitchen
- ☐Storage room/area
- ☐Lobby/reception area
- ☐Hallway
- ☐Stairway
- ☐Waiting room
- ☐Restroom/bathroom
- ☐Break room
- ☐Parking lot
- ☐Outside premises
- ☐Location not listed above_____

4. What type of incident occurred? *(check all that apply)*

- ☐Biting by aggressor
- ☐Choking
- ☐Grabbing
- ☐Hair pulling
- ☐Kicking
- ☐Punching/slapping
- ☐Pushing/pulling
- ☐Scratching
- ☐Shooting
- ☐Spitting at/on
- ☐Stabbing
- ☐Striking
- ☐Rape/attempted rape
- ☐Unwanted physical sexual contact
- ☐Type of physical force not listed above_____
- ☐Use of (i.e., assault with) firearm or other dangerous weapon:
  - ☐Gun
  - ☐Knife
  - ☐Furniture/furnishings (e.g., lamp)
  - ☐Medical equipment
  - ☐Other weapon

Section 2: *(To be completed by Security/Leadership)*

1. How many employees were injured?

2. Was Medical Attention Obtained: Yes _____ **No** _____ **Will Seek Private Physician** _____

3. What types of injuries were known to be sustained? *(check all that apply)*

- ☐Death
- ☐Amputation
- ☐Asphyxiation/suffocation
- ☐Burns
- ☐Bruising/abrasion
- ☐Cut/puncture
- ☐Dislocation/fracture
- ☐Head injury
- ☐Internal injury
- ☐Open wound
- ☐Sprain/strain
- ☐Stress/psychological impairment
- ☐Injury type not listed above_____
- ☐Injury type unknown by the hospital at this time
- ☐ N/A –No known injured employees at this time (Restriction: if checked, no other boxes can be checked)

4. At the time of the incident were any of the injured employees: *(check all that apply-*

- ☐On break/lunch
- ☐Arriving/leaving the facility
- ☐Working past scheduled shift
- ☐No special circumstances apply (Restriction: if checked, no other boxes can be checked)
- ☐Don't know specific circumstances (Restriction: if checked, no other boxes can be checked)
- ☐N/A –No known injured employees (Restriction: if checked, no other boxes can be checked)

5. If another employer's employees are affected, describe that employer(s):*(check all that apply)*

☐ N/A –No employees of other employers affected (Restriction: if checked, no other boxes can be checked)

☐Contractor providing services to the hospital
If known: Company name_____ Company phone number_____ **(not required)**

☐Vendor
If known: Company name_____ Company phone number_____ **(not required)**

☐Don't know the type of employer

6. Did the use of physical force or a dangerous weapon begin while an employee was alone with the aggressor?
☐ Yes ☐ No

7. Did the use of physical force or a dangerous weapon begin while an employee(s) was in an isolated area?
☐ Yes ☐ No

8. Did the use of physical force or a dangerous weapon begin in a *location* that was unfamiliar or new to the employee(s)? ☐ Yes ☐ No ☐ Don't know if location was unfamiliar or new to employee(s)

9. At the time of the use of physical force or a dangerous weapon was any employee *doing a task* that was unfamiliar or new to them? ☐ Yes ☐ No ☐ Don't know if task was unfamiliar or new to employee(s)

10. During the use of physical force or a dangerous weapon, was the employee(s) assisted by: *(check all that apply)*

☐Internal security
☐Assistance provided that is not listed above
☐Hospital emergency response team
☐Nearby employees
☐Local law enforcement in response to 911 call
☐Employee received no assistance

11. If local law enforcement was contacted via 911, what assistance did they provide? *(check all that apply)*

Responding Agency _____ **Incident Number** _____-

☐N/A local law enforcement not called (Restriction: if checked, no other boxes can be checked)
☐Local law enforcement did not respond
☐Officers provided assistance via phone
☐Officers deployed to the scene
☐De-escalated the situation without physically subduing the aggressor
☐Physically intervened and subdued the aggressor(s)
☐Arrested the aggressor(s)
☐Assistance provided that is not listed above

12. Is there a continuing threat to employees due to unresolved engineering, work practice, and/or administrative controls that need to be addressed? ☐ Yes ☐ No

13. Which of the following are planned or under consideration for addressing the continuing threat? *(check all that apply)*

☐ **Engineering control modifications**

If known, please provide type of engineering control:
☐Physical layout (incl. accessible escape routes, unimpeded line of sight)
☐Physical access control
☐Physical barriers
☐Alarm system
☐Lighting
☐Monitoring systems (e.g., metal detectors, closed circuit video, mirrors)
☐Removing/securing objects with weapon potential
☐Reducing overcrowding in waiting room
☐Other engineering control modification

☐ **Work practice control modifications:** _____

If known, please provide the type of control:
☐Increased staffing levels
☐Added/increased security personnel
☐Additional employee training
☐Implementation or change in buddy system
☐Improved communication among staff about aggressive/violent patients
☐Reduced waiting times
☐Other work practice modification

☐ **Other type of modification**

☐**Further investigation to identify appropriate exposure control measures is in progress** (investigation includes speaking with involved employees).

☐ **N/A -No continuing threat to employees** (Restriction: if checked, no other boxes can be checked)

14. To whom else in the organization was this event reported: ☐ Risk Management ☐ C-Suite ☐ Admin Supervisor ☐ Department Manager

Reporting Staff Name: _____ Emp. # : _____ Date: _____

** E-mail completed form to Safety Officer - Jeff Surowiec / surowiecja@tcmc.com

Safety Officer Review: _____ **Date:** _____ **Completed:** __ **Follow Up: Y** __ **N** __

1. Was the incident reported to the nearest Cal/OSHA Enforcement District Office under Title 8, CCR, Section 342? ☐Yes ☐ No
(COMPLETED BY SAFETY OFFICER)
Reported by _____ **Date:** _____

2. Which district office was the incident reported to? If the incident was not reported to a district office, please select N/A.

(COMPLETED BY SAFETY OFFICER) _____ **DATE:** _____

Tri-City Medical Center
Oceanside, California

FOOD AND NUTRITION SERVICES

ISSUE DATE: 10/88 **SUBJECT: Diet Manual**

REVISION DATE(S): 8/06, 1/10, 2/12

Food & Nutrition Department Approval:	**02/17**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**07/18**
Medical Executive Committee Approval:	**08/18**
Administration Approval:	**09/18**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/12**

A. **POLICY:**

1. Food and Nutrition may adopt a diet manual for standardized nutrition care practices as compiled by other facilities or organizations, i.e. the ~~American Dietetic Association~~ **Academy of Nutrition and Dietetics (AND)** .
2. Available nutrition care manuals are reviewed and a suitable one is adopted.
3. Nutritional deficiencies of any diet (not in compliance with the RDA's/RDI's) are identified.
4. The diet manual is utilized as a guide to ordering diets.
5. A copy of the diet manual is provided for each patient care unit via the Intranet after the receipt of approval from the medical staff. The ~~ADA~~ **AND** Nutrition Care Manual is available as a web based manual via the TCMC Intranet under Clinical References.
6. The Director of Food & Nutrition reviews the ~~ADA~~ **AND** Nutrition Care Manual on an ongoing basis. All therapeutic diets outlined in the Nutrition Care Manual are reviewed. ~~"Mark-up notes" are attached online to further explain and define usage of these diets as pertaining to TCMC physician ordering practices~~. A meal plan crosswalk is defined to identify typical diet orders and the appropriate nutrition therapy (see below). Additionally, the formulary is customized to TCMC.
7. The Nutrition Care Manual (diet manual), along with any edits specific to TCMC, is reviewed and/or revised every three years and is approved by the Pharmacy & Therapeutics Committee.

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

1. **Tri-City Medical Center Nutrition Care Manual Meal Plan Crosswalk**

Meal Plan Crosswalk

The following table maps what was formerly called diets to the corresponding nutrition therapy food lists and sample menus in the client education. The nutrition therapy corresponds to the diet that may have used in earlier diet manuals and is roughly organized by NCM section.

To view **foods allowed or foods to limit/avoid** for a given disease, click on "foods" within the chart next to the corresponding nutrition therapy. To view a **sample menu** for a given disease, click on "menu" within the chart next to the corresponding nutrition therapy.

Nutrient Lists are found in Resources>Nutrient Lists or by clicking HERE.

Diets	Nutrition Therapy	Spanish
Normal Nutrition		
For more information on how to individualize, see the Normal Nutrition section. House diet, general diet, normal diet	General, Healthful Nutrition; Large Print General, Healthful Vegetarian Nutrition	General, Healthful Nutrition
-	1,500 Calorie 5 Day Menus	-
-	1,800 Calorie 5 Day Menus	-
	Nutrient Lists	-
	Breastfeeding / Pregnancy / Reproduction	
Diet for Breastfeeding Mothers	Breastfeeding/Lactation—Exclusive: Foods; Menu	Breastfeeding/Lactation—Exclusive
	Breastfeeding/Lactation—Supplementing: Foods; Menu	Breastfeeding/Lactation—Supplementing
Normal Pregnancy	Pregnancy: Foods; Menu	Pregnancy
	Vegetarian Pregnancy	-
	Morning Sickness: Foods; Menu	-
Multiple Gestation	Multiple Gestation: Foods; Menu	-
-	Gestational diabetes: Menu	Gestational Diabetes
-	Pica: Foods; Menu	-
-	Preeclampsia and Eclampsia: Food; Menu	Preeclampsia and Eclampsia
	Vegetarian Nutrition	
Vegetarian diet	General, Healthful Vegetarian Nutrition	-
	Lacto-ovo Vegetarians: Menu	-
	Red Meat Avoider: Menu	-
	Vegan: Menu	-
	Kosher	
Kosher diet	Kosher section: Kosher 101; Kosher fish and seafood; Kosher rules of thumb	-
Anemia		
Iron rich diet	Iron rich Nutrition Therapy	Iron rich
-	Iron Deficiency Anemia: Foods; Menu	-
High calorie, high protein diet	Sickle Cell Anemia: Foods; Menu	-
	High calorie, high protein Nutrition Therapy (Large Print)	High calorie, high protein
Behavioral Health		
Tyramine restricted diet	Tyramine restricted Nutrition Therapy (MAOI);	Tyramine restricted

	Foods; Menu; Drug-Nutrient Interaction Information	
-	Schizophrenia: Menu	-
Patient education for individuals taking protection drugs	Sobriety: Foods; Menu	-
	Guidelines for High-Calorie Nutrition Therapy (Large Print)	-
High-calorie, high-protein diet	High-calorie, high-protein Nutrition Therapy (Large Print)	High-calorie, high-protein
Burns		
High-calorie, high-protein diet	Burns: Foods; Menu	-
	High-calorie, high-protein Nutrition Therapy (Large Print)	
Cardiovascular Disease		
Low-sodium diet	Low-sodium Nutrition Therapy	Low-sodium
Cardiac diet	Nutrition Therapy to Reduce Cholesterol and Sodium	-
DASH diet	Heart Failure Nutrition Therapy: Foods; Menu	-
-	Hypertension Nutrition Therapy: Foods; Menu	-
Vitamin K diet	Vitamin K Nutrition Therapy	Vitamin K
-	Stroke Nutrition Therapy: Foods; Menu	-
Heart-healthy diet	Heart-healthy Nutrition Therapy: Menu	-
Step I & II diets	Coronary Artery Bypass Graft (CABG): Foods; Menu	-
	High Triglyceride Nutrition Therapy: Foods; Menu	-
	High Cholesterol Nutrition Therapy: Foods; Menu	-
	Myocardial Infarction Nutrition Therapy: Foods; Menu	-
-	Transient Ischemic Attack (Mini-Stroke): Foods; Menu	-
Diabetes		
Glucose tolerance test	Glucose Tolerance Test	-
Exchange lists for meal planning	Choose Your Foods: Exchange Lists for Diabetes	Choose Your Foods
Consistent carbohydrate diet	Carbohydrate counting: Foods; Menu	Carbohydrate Counting
	Carbohydrate counting for vegetarians	-
Carbohydrate counting for diabetes	Diabetes Type 1 Nutrition Therapy: Menu	-
	Diabetes Type 2 Nutrition Therapy: Menu	-
	Vegetarian Diabetes Type 2 Nutrition Therapy: Menu	-
-	Gastroparesis Nutrition Therapy: Menu	-
Gestational diabetes	Gestational Diabetes Nutrition Therapy: Menu	Gestational Diabetes
-	Reactive hypoglycemia Nutrition Therapy: Menu	Reactive Hypoglycemia
-	Pre-Diabetes	-
Dysphagia/Modified Consistency		
Stage 1 Pureed diet	Dysphagia Level 1 Pureed: Foods; Menu	Dysphagia Level 1
Stage 2 Ground/minced diet / Mechanically altered diet	Dysphagia Level 2 Mechanically Altered: Foods; Menu	Dysphagia Level 2
Stage 4 modified general diet	Dysphagia Level 3 Advanced: Foods; Menu	Dysphagia Level 3
Food Hypersensitivities		
Gluten-free diet	Gluten-free Nutrition Therapy: Menu	Gluten-free
-	Celiac Disease Nutrition Therapy: Foods; Menu	-
-	Fructose Intolerance Nutrition Therapy: Menu	-
Lactose-controlled diet	Lactose-controlled Nutrition Therapy: Menu	-
	Lactose Intolerance Nutrition Therapy: Foods;	-

	Menu	
-	Multiple Food Allergies Nutrition Therapy: Foods; Menu	-
-	Corn Allergy Nutrition Therapy: Foods; Menu	-
-	Egg Allergy Nutrition Therapy: Foods; Menu	-
-	Fish Allergy Nutrition Therapy: Foods; Menu	-
-	Milk Allergy Nutrition Therapy: Foods; Menu	-
-	Peanut Allergy Nutrition Therapy: Foods; Menu	-
-	Shellfish Allergy Nutrition Therapy: Foods; Menu	-
-	Soy Allergy Nutrition Therapy: Foods; Menu	-
-	Tree Nut Allergy Nutrition Therapy: Foods; Menu	-
-	Wheat Allergy Nutrition Therapy: Foods; Menu	-
Gastrointestinal Disease		
Fat controlled diet (50 g/day)	Fat-restricted Nutrition Therapy: Menu; 5-day Menus	Fat-restricted
-	Cirrhosis Nutrition Therapy: Foods; Menu	-
-	Crohn's & Ulcerative Colitis Nutrition Therapy: Foods; Menu	Crohn's
	Gallbladder Nutrition Therapy: Foods; Menu	-
Gastroesophageal reflux disease diet (GERD)	Gastroesophageal Reflux Disease (GERD): Foods; Menu	-
	Hepatitis Nutrition Therapy: Foods; Menu	-
	Pancreatitis Nutrition Therapy: Foods; Menu	-
Low fiber diet	Low-fiber Nutrition Therapy; 5-Day Menus	Low-fiber
	Constipation Nutrition Therapy: Foods; Menu	-
-	Crohn's & Ulcerative Colitis Nutrition Therapy: Foods; Menu	Crohn's
-	Diarrhea Nutrition Therapy: Foods; Menu	-
	Diverticulitis: Foods; Menu	-
-	Colostomy Nutrition Therapy: Foods; Menu	Colostomy
Ostomy placement	Ileostomy Nutrition Therapyy: Foods; Menu	-
	High fiber Nutrition Therapy	High fiber
High fiber diet	Diverticulosis	-
	Irritable Bowel Syndrome (IBS) Nutrition Therapy: Foods; Menu	-
Esophageal surgery	Esophageal Surgery Nutrition Therapy: Foods; Menu	-
Gastric surgery	Gastric surgery Nutrition Therapy: Foods; Menu	-
Gastroparesis	Gastroparesis Nutrition Therapy: Menu	-
Soft diet/Wired Jaw diet	Jaw Fracture Nutrition Therapy: Foods; Menu	-
-	Nutrition Therapy for Nausea and Vomiting: Foods	-
-	Peptic Ulcer Nutrition Therapy: Foods; Menu	-
HIV/AIDS		
-	HIV/AIDS Nutrition Therapy: Food Planner	-
Inborn Errors of Metabolism		
-	Galactosemia Nutrition Therapy: Foods; Menu	-
-	Phenylketonuria Nutrition Therapy: Foods; Menu	-
Modified Consistency		
Clear liquid diet	Clear Liquid Diet Information: Menu	-
Full liquid diet	Full Liquid Diet Information	-
Pureed diet	Pureed Nutrition Therapy: Foods; Menu	-
Mechanically altered diet	Mechanically Altered Nutrition Therapy: Foods; Menu	-
Soft diet	Soft Nutrition Therapy: Foods; Menu	-

Musculoskeletal Conditions		
High-calorie, high-protein diet	High-calorie, high-protein Nutrition Therapy (Large Print)	High-calorie, high-protein
	Nutrition Therapy for People with Amputations: Menu	-
Purine-restricted diet	Low-Purine Nutrition Therapy: Menu	-
	Gout: Foods; Menu	-
-	Osteoarthritis Nutrition Therapy: Foods; Menu	-
High-calcium diet	Osteoporosis Nutrition Therapy: Foods; Menu	-
-	Rheumatoid Arthritis Nutrition Therapy: Foods; Menu	-
Neurological		
Ketogenic diet	Epilepsy nutrition therapy: Foods; Menu	-
High-calorie, high-protein diet	Guidelines for High-Calorie Nutrition Therapy (Large Print)	-
	High-calorie, high-protein Nutrition Therapy (Large Print)	High-calorie, high-protein
Oncology		
-	Oncology handouts	-
-	Considerations for Head and Neck Cancer (Large Print)	-
-	Considerations for Head and Neck Cancer, Prevention (Large Print)	-
Oral Health		
Modified consistency diets (also see Dysphagia)	Difficulty Eating (Large Print)	Difficulty Eating (Large Print)
-	Difficulty Eating—Diabetes (Large Print)	Difficulty Eating—Diabetes (Large Print)
-	Dentures (Large Print)	Dentures (Large Print)
-	Partial Dentures (Large Print)	Partial Dentures (Large Print)
-	Orofacial Pain (Large Print)	-
-	Dry Mouth (Xerostomia) (Large Print)	Dry Mouth (Xerostomia)
-	Reduce Side Effects of Medications (Large Print)	-
-	Post-Oral Surgery (Large Print)	Post-Surgery (Large Print)
-	Post-Oral Surgery—Diabetes (Large Print)	Post-Surgery—Diabetes (Large Print)
Pulmonary		
-	Chronic Obstructive Pulmonary Disorder (COPD): Menu	-
-	Pulmonary Nutrition Therapy: Menu	Pulmonary
Renal		
	Kidney Disease	
-	Acute Kidney Injury Nutrition Therapy: Foods; Menu	-
Pre-end-stage renal disease Low-potassium diet (2,000 mg/day)	Chronic Kidney Disease-CKD Stage 5 Nutrition Guidelines: Foods; Menu	
Renal Replacement Therapy End-stage renal disease hemodialysis	Hemodialysis	-
	Peritoneal dialysis	-
-	Nephrotic Syndrome Nutrition Therapy: Foods; Menu	-
	Bladder and Urinary Tract Disease	
Low-oxalate diet (<40 mg/day to 50 mg/day)	Urinary Tract Stones Nutrition Therapy: Menu	-
	Urolithiasis (Kidney/Urinary Stones) Nutrition Therapy: Foods	-
-	Urinary Tract Infections (UTI) Nutrition Therapy: Menu	-
Sports Nutrition		

-	~~Nutrition Therapy for Endurance Athletes: Menu (2,500kcal); Menu (4,500kcal)~~	-
-	~~Nutrition Therapy for Strength Athletes: Menu (3,500kcal)~~	-
-	~~Nutrition Therapy for Team Sports: Menu~~	-
-	~~Weight Gain/High Calorie Meal Plan for Athletes: Menu (3,500-3,800 kcal); Menu (5,100-5,400 kcal)~~	-
-	~~Weight Loss Nutrition Therapy for Athletes: Menu (1,800-2,000 kcal); Menu (2,200-2,400 kcal)~~	-
~~**Transplant**~~		
~~Low-microbial diet~~	~~Low-microbial Nutrition Therapy~~	-
	~~Transplant – Hematopoietic Stem Cell: Foods~~	-
~~Five-stage diet progression for graft versus host disease~~	~~Transplant – Organ: Foods; Menu~~	-
~~**Weight Management**~~		
	~~***Bariatric Surgery***~~	
-	~~Bariatric Surgery Blended and Pureed: Menu~~	-
-	~~Bariatric Surgery Soft: Menu~~	-
-	~~Banded Gastroplasty Discharge~~	-
-	~~Roux-en-Y Gastric Bypass Discharge~~	-
	~~***Overweight and Obesity***~~	
-	~~Weight Loss Tips: Foods; Menu~~	~~Weight Loss Tips~~
~~Calorie Controlled Diets for Weight Loss / Caloric-restricted menus~~	~~1,200 Calorie 1 Day Menu; 5 Day Menus~~	~~5 Day Menu~~
	~~1,300 Calorie 1 Day Menu~~	-
	~~1,400 Calorie 1 Day Menu~~	-
	~~1,500 Calorie 1 Day Menu; 5 Day Menus~~	-
	~~1,600 Calorie 1 Day Menu~~	~~5 Day Menu~~
	~~1,700 Calorie 1 Day Menu~~	-
	~~1,800 Calorie 1 Day Menu; 5 Day Menus~~	~~5 Day Menu~~
	~~1,900 Calorie 1 Day Menu~~	-
	~~2,000 Calorie 1 Day Menu~~	-
	~~2,200 Calorie 1 Day Menu~~	-
	~~***Underweight***~~	
~~High-calorie, high-protein diet~~	~~High-calorie, high-protein Nutrition Therapy (Large Print)~~	~~High-calorie, high-protein~~
	~~Underweight Nutrition Therapy: Foods; Menu; Recipes~~	-
~~**Wound Care**~~		
~~Short Term Nutrition Therapy for People with Skin Breakdown~~	~~Pressure Ulcers Nutrition Therapy: Foods; Menu~~	-
~~High-calorie, high-protein diet~~	~~High-calorie, high-protein Nutrition Therapy (Large Print)~~	~~High-calorie, high-protein~~

Tri-City Medical Center Nutrition Care Manual Meal Plan Crosswalk

The following table maps the condition to the corresponding diet available at TCMC and nutrition therapy food lists and sample menus in the client education.

Condition	TCMC Diets	Client Education	Translations Available	
Addiction		Sobriety Nutrition Therapy (Large Print): Foods; Menu		
Anemia		Iron-Deficiency Anemia		

		Nutrition Therapy: Foods, Menu		
	~~Iron-Rich Diet~~	Iron-Rich Nutrition Therapy	Spanish	
		Sickle Cell Disease Nutrition Therapy: Foods; Menu		
Bariatric Surgery	Bariatric Clear Liquid Diet	Bariatric Liquid Protein Supplements	Spanish (new 2016)	
		Bariatric Surgery Soft Protein-Rich Foods Nutrition Therapy	Spanish (new 2016)	
		Bariatric Surgery Vitamin and Mineral Supplements	Spanish (new 2016)	
		Roux-en-Y Gastric Bypass/Sleeve Gastrectomy Discharge Nutrition Therapy		
		High-Calorie, High-Protein Nutrition Therapy (Large Print)	Spanish	
		High-Calorie, High-Protein Recipes		
		Suggestions for Increasing Calories and Protein	Spanish	
Burns		Burns Nutrition Therapy: Foods; Menu	Spanish (new 2016)	
Cardiovascular Disease	Cardiac Diet, Low Cholesterol	Cardiac-TLC Nutrition Therapy (Large Print): Foods; Menu		
		Coronary Artery Bypass Graft (CABG) Nutrition Therapy: Foods; Menu	Spanish (new 2016)	
		Heart Failure Nutrition Therapy (updated 2016)	Spanish	
		Heart Failure Nutrition Therapy for the Undernourished	Spanish (new 2016)	
		Heart-Healthy Eating Fiber Tips	Spanish	
		Heart-Healthy Eating Label Reading Tips	Spanish	
		Heart-Healthy Eating Nutrition Therapy (Large Print): Menu (Note: Under Review for Revision)	Spanish	
		Heart-Healthy Eating: Cooking Tips	Spanish	
		Heart-Healthy Eating: Omega-3 Fatty Acids	Spanish	
		Heart-Healthy Eating: Shopping Tips	Spanish	
		Heart-Healthy Eating: Soy Protein	Spanish	
		Heart-Healthy Eating: Sterol and Stanol Tips	Spanish	
		High Cholesterol Nutrition Therapy: Foods; Menu	Spanish (new 2016)	

		High Triglycerides Nutrition Therapy (Large Print): Foods; Menu		
		Hypertension Nutrition Therapy: Foods; Menu (updated 2016)	Spanish (new 2016)	
	2gm Sodium Diet. No Added Salt Diet	Low-Sodium Nutrition Therapy (updated 2016)	Spanish (new 2016)	
		Reduce Cholesterol and Sodium	REMOVED	
		Sodium-Free Flavoring Tips		
		Stroke Nutrition Therapy: Foods; Menu	Spanish	
		Transient Ischemic Attack (Ministroke) Nutrition Therapy: Foods; Menu	Spanish	
		Vitamin K and Medications	Spanish	
Diabetes	Carbohydrate Controlled Diet	Carbohydrate Counting for People with Diabetes	Spanish	
		Carbohydrate Counting for Vegetarians with Diabetes		
		Carbohydrate Counting for People with Cystic Fibrosis–Related Diabetes		
	No Concentrated Sweets Diet	Choose Your Foods: Food Lists for Diabetes (updated 2016)	Spanish (new 2016)	
		Diabetes Label Reading Tips	Spanish	
	Sweet Success Diet	Gestational Diabetes Nutrition Therapy	Spanish (new 2016)	
	Gluten-Free /Carbohydrate Controlled ~~Diet~~Diet	Gluten-Free Carbohydrate Counting for People with Celiac Disease and Diabetes	Spanish (new 2016)	
		Hypoglycemia (Not Caused by Diabetes) Nutrition Therapy	Spanish	
		Type 1 Diabetes Nutrition Therapy	Spanish	
		Type 2 Diabetes Nutrition Therapy	Spanish	
		Type 2 Diabetes Vegetarian Nutrition Therapy		
		Using Nutrition Labels: Carbohydrates		
Dysphagia	Pureed Diet	Dysphagia Level 1: Pureed Foods	Spanish	
		National Dysphagia Diet: Level 1 Tips		
	Mechanical Soft Ground Diet	Dysphagia Level 2: Mechanically Altered	Spanish	

		National Dysphagia Diet: Level 2 Tips		
	Mechanical Soft Chopped Diet	Dysphagia Level 3: Advanced		
		National Dysphagia Diet: Level 3 Tips	Spanish	
Eating Disorders		Anorexia Nervosa Meal Planning Tips		
		Binge Eating Disorder Meal Planning Tips		
		Bulimia Nervosa Meal Planning Tips		
Food Allergies		Corn Allergy Nutrition Therapy: Foods; Menu	Spanish	
		Corn Allergy Tips		
		Egg Allery Nutrition Therapy: Foods; Menu	Spanish	
		Egg Allergy Tips		
		Fish Allergy Nutrition Therapy: Foods; Menu	Spanish	
		Fish Allergy Tips		
		Fructose Intolerance Nutrition Therapy: Menu		
		Galactose-Controlled Nutrition Therapy: Menu		
	No Dairy Diet, No Milk	Milk Allergy Nutrition Therapy: Foods; Menu	Spanish	
		Milk Allergy Tips		
		Multiple Food Allergies Nutrition Therapy: Foods; Menu	Spanish	
		Managing Multiple Food Allergies Tips		
		Peanut Allergy Nutrition Therapy: Foods; Menu	Spanish	
		Peanut Allergy Tips		
		Shellfish Allergy Nutrition Therapy: Foods; Menu	Spanish	
		Shellfish Allergy Tips		
		Soy Allergy Nutrition Therapy: Foods; Menu	Spanish	
		Soy Allergy Tips		
		Tree Nut Allergy Nutrition Therapy: Foods; Menu	Spanish	
		Tree Nut Allergy Tips		
		Wheat Allergy Nutrition Therapy: Foods; Menu	Spanish	
		Wheat Allergy Tips		

		5 Sample Menus for Gradually Increasing Fiber		
	Gluten Free Diet	Celiac Disease Nutrition Therapy: Foods; Menu (updated 2016)	Spanish (new 2016)	
		Celiac Disease Healthy Eating Tips (updated 2016)	Spanish (new 2016)	
		Celiac Disease Label Reading Tips (updated 2016)	Spanish (new 2016)	
		Cirrhosis Nutrition Therapy: Foods; Menu	Spanish (new 2016)	
		Colostomy Nutrition Therapy: Foods; Menu (updated 2016)	Spanish	
		Constipation Nutrition Therapy: Foods; Menu	Spanish (new 2016)	
		Constipation Meal Planning Tips	Spanish (new 2016)	
		Diarrhea Nutrition Therapy: Foods; Menu	Spanish (new 2016)	Chinese (new 2016)
		Esophageal Surgery Nutrition Therapy		
Gastrointestinal Disease	Low Fat Diet	Fat-Restricted Nutrition Therapy	Spanish	Chinese (new 2016)
		Fat Restricted Nutrition Therapy Sample 5-Day Menus		
	Fiber-Restricted Diet (Low-residue diet)	Fiber-Restricted Nutrition Therapy (updated 2016)	Spanish (new 2016)	
		Gallbladder Nutrition Therapy: Foods; Menu		
		Gastric Surgery Nutrition Therapy: Foods; Menu Removed for Update	Spanish (new 2016)	
	Bland Diet	Gastroesophageal Reflux Disease (GERD) Nutrition Therapy: Foods; Menu	Spanish	
		Gastroparesis Nutrition Therapy (updated 2016)	Spanish (new 2016)	
	Gluten Free Diet	Gluten-Free Nutrition Therapy: Menu	Spanish	
		Hepatitis Nutrition Therapy: Foods; Menu		
	High Fiber Diet	High-Fiber Nutrition Therapy (Large Print): Menu	Spanish	
		Getting More Fiber Cooking Tips		
		Ileostomy Nutrition Therapy	Spanish (new 2016)	

		Inflammatory Bowel Disease (IBD) and Crohn's Disease Nutrition Therapy: Foods; Menu		
		Irritable Bowel Syndrome (IBS) Nutrition Therapy: Foods; Menu	Spanish	
		Jaw Fracture Nutrition Therapy: Foods; Menu	Spanish (new 2016)	
	Lactose Free Diet	Lactose-Controlled Nutrition Therapy: Foods; Menu	Spanish	
		Lactose Intolerance Label Reading and Cooking Tips		
		Low-Fiber Nutrition Therapy: Foods; Menu	Spanish	
		Nausea and Vomiting Nutrition Therapy: Foods	Spanish	Chinese (new 2016)
		Pancreatitis Nutrition Therapy (updated 2016)	Spanish (new 2016)	
		Pancreatitis Label Reading Tips		
		Peptic Ulcer Nutrition Therapy: Foods; Menu		
		Whipple Surgery Nutrition Therapy (updated 2016)	Spanish (new 2016)	
	Regular Diet	General, Healthful Nutrition Therapy (Large Print)	Spanish	
	Kosher Diet	Kosher Dietary Guidelines (updated 2016)		
		20 Ways to Enjoy More Fruits and Vegetables	Spanish	
		Eating Right for a Healthy Weight	Spanish	
		Eating Right Tips for Older Adults	Spanish	
		Healthy Eating on the Run	Spanish	
General, Healthful Nutrition		Power Up with Breakfast	Spanish	
		Shop Smart Get the Facts on Food Labels		
		Smart Snacking for Adults and Teens	Spanish	
		16 Health Tips for 2016		
		25 Healthy Snacks for Kids	Spanish	
		Good Nutrition Reading List		
		Healthy Eating Tips for Vegetarians	Spanish	
		Color Your Plate with Salad		
		Eating Right with Less Salt	Spanish	

		Eating Right on a Budget	Spanish	
		Eat Right with MyPlate	Spanish	
		Everyday Eating for a Healthier You		
HIV/AIDS		Exercise for HIV/AIDS Patients		
		Food Safety for HIV/AIDS		
		HIV/AIDS Managing Diarrhea		
		HIV/AIDS Managing Nausea and Vomiting		
		HIV/AIDS Micronutrients (Vitamins and Minerals)		
		HIV/AIDS Nutrition Therapy		
		Nutrition Recommendations to Reduce Side Effects of Medications		
Inborn Errors of Metabolism		Phenylketonuria (PKU) Tips		
Modified Consistency	Mechanical Soft Diet	Mechanically Altered Foods Nutrition Therapy (Large Print): Foods; Menu		
	Pureed Diet	Pureed Foods Nutrition Therapy (Large Print); Foods; Menu		
	Soft Diet	Soft Foods Nutrition Therapy (Large Print): Foods; Menu		
Neurological		Epilepsy Nutrition Therapy: Foods; Low GI Menu		
		Modified Atkins Menu;		
		Kitchen Tips		
		Guidelines for High-Calorie Nutrition Therapy (Large Print)		
Nutrient Lists		Calcium Content of Foods	Spanish	
		High-Calcium Foods List	Spanish	
		Fiber Content of Foods	Spanish	
		High-Fiber Foods List	Spanish	
		Lower-Fiber Foods List	Spanish	
		Iron Content of Foods	Spanish	
		High-Iron Foods List	Spanish	
		Magnesium Content of Foods	Spanish	
		High-Magnesium Foods List	Spanish	
	Low Phosphorus Diet	Phosphorus Content of Foods	Spanish	
		Potassium Content of Foods		Chinese (New 2016)

		High-Potassium Foods List	Spanish	
	Low Potassium Diet	Lower-Potassium Foods List	Spanish	
		Protein Content of Foods	Spanish	
	High Protein Diet	High-Protein Foods List	Spanish	
		Sodium (Salt) Content of Foods	Spanish	
		Lower-Sodium (Salt) Foods List	Spanish	
		Vitamin K Content of Foods	Spanish	
		Water Content of Common Foods and Beverages		
Older Adults		Finger Foods		
		Food Sources of Vitamins and Minerals		
		Fiber Tips		
		Tips for Adding Calories		
		Tips for Adding Protein		
Metabolic Syndrome	Carbohydrate Controlled / Cardiac Diet	Metabolic Syndrome Menu (New for 2016)	Spanish (new 2016)	
Mood Disorders	Tyramine-Restricted Diet	Tyramine-Restricted Nutrition Therapy: Menu	Spanish	
Musculoskeletal		Amputations: Menu	Spanish (new 2016)	
		Osteoarthritis Nutrition Therapy: Foods; Menu		
		Rheumatoid Arthritis Nutrition Therapy: Foods; Menu		
Reproduction		Breastfeeding Nutrition Therapy (New for 2016)	Spanish (new 2016)	
		Gestational Diabetes Nutrition Therapy		
		Morning Sickness Nutrition Therapy: Foods; Menu		
		Multiple Gestation Nutrition Therapy: Foods; Menu		
		Pica Nutrition Therapy: Menu		
		Preeclampsia/Eclampsia Nutrition Therapy: Foods; Menu;	Spanish	
		Preeclampsia and Eclampsia Label Reading Tips;		
		Preeclampsia and Eclampsia Meal Planning Tips		
		Pregnancy Nutrition Therapy: Foods; Menu	Spanish	
		Healthy Pregnancy Tips (2016 Update)		
	Vegetarian Diet	Vegetarian Pregnancy Nutrition		

		Therapy		
Oncology		Head and Neck Cancer Prevention (Large Print)	Spanish (new 2016)	
		Head and Neck Cancer Nutrition Therapy (Large Print)	Spanish (new 2016)	
		Nutrition During and After Cancer Treatment		
		Oncology: Cooking Tips (Large Print)	Spanish (new 2016)	
		Oncology: Nutrition Tips for Well-Being (Large Print)	Spanish (new 2016)	
Oral Health		Dentures Nutrition Therapy (Large Print)	Spanish, Large Print	
		Difficulty Eating for People with Diabetes Nutrition Therapy (Large Print)	Spanish, Large Print	
		Difficulty Eating Nutrition Therapy (Large Print)	Spanish, Large Print	
		Dry Mouth (Large Print)	Spanish	
		Nutrition Recommendations After Oral Surgery (Large Print)	Spanish, Large Print	
		Nutrition Recommendations After Oral Surgery for People with Diabetes (Large Print)	Spanish, Large Print	
		Nutritional Recommendations for Orofacial Pain (Large Print)		
		Nutritional Recommendations When Wearing Partial Dentures (Large Print)	Spanish, Large Print	
Organ Transplant		Food Safety Nutrition Therapy	Spanish (new 2016)	
	~~Low Microbial Diet~~Neutropenic Diet	Low-Microbial Nutrition Therapy: Foods		
		Nutrition Therapy for Individuals with Lowered Immunity		
		Organ Transplant Nutrition Therapy: Foods; Menu; Tips		
Osteoporosis		Osteoperosis Nutrition Therapy: Foods; Menu		
Overweight & Obesity	Calorie Controlled Diet	1,200-Calorie 5-Day Menus	Spanish	
	Calorie Count Diet	1,500-Calorie 5-Day Menus		
		1,600-Calorie 5-Day Menu	Spanish	
		1,800-Calorie 5-Day Menus	Spanish	
		1,200-Calorie Sample Meal Plan		
		1,300-Calorie Sample Meal Plan		
		1,400-Calorie Sample Meal Plan		

		1,500-Calorie Sample Meal Plan		
		1,600-Calorie Sample Meal Plan		
		1,700-Calorie Sample Meal Plan		
		1,800-Calorie Sample Meal Plan		
		1,900-Calorie Sample Meal Plan		
		2,000-Calorie Sample Meal Plan		
		2,200-Calorie Sample Meal Plan		
		Roux-En-Y Gastric Bypass Sleeve Gastrectomy Discharge Nutrition Therapy	Spanish	
		Weight Loss Tips	Spanish	
		Weight Management Cooking Tips		
Pulmonary		Chronic Obstructive Pulmonary Disease (COPD) Nutrition Therapy: Menu		
		Pulmonary Nutrition Therapy: Menu	Spanish	
Renal		Acute Kidney Injury Nutrition Therapy: Foods; Menu	Spanish	
	Renal Diet	Chronic Kidney Disease Stage 5 Nutrition Therapy (Large Print): Foods; Menu	Spanish	
		Chronic Kidney Disease Stage 5 Tips for People Not on Dialysis	Spanish	
		Chronic Kidney Disease Stage 5 Tips for People on Dialysis	Spanish	
	Carbohydrate Controlled diet / Renal Diet	Diabetes and Chronic Kidney Disease Stages 1 through 4: Nutrition Guidelines		
		Diabetes and Chronic Kidney Disease Stages 1 through 4 Meal Planning Appendix for RDs		
		Kidney Stones Nutrition Therapy	Spanish	
		Kidney Stones Nutrition Strategies		
	~~Low-Purine Diet~~	Low-Purine/Purine-Restricted Nutrition Therapy: Foods; Menu	Spanish	
		Nephrotic Syndrome Nutrition Therapy: Foods; Menu	Spanish	
		Urinary Tract Infection (UTI) Nutrition Therapy: Menu		
Underweight		Underweight Nutrition Therapy: Foods; Menu		
	High-Calorie, High Protein Diet	High-Calorie, High-Protein Nutrition Therapy (Large	Spanish	

		Print);		
		High-Calorie, High-Protein Recipes		
		Suggestions for Increasing Calories and Protein	Spanish	
Vegetarian Nutrition	Vegetarian Diet	General, Healthful Vegetarian Nutrition Therapy		
		Lacto-Ovo Vegetarian Menu		
		Red Meat Avoidance Menu		
	Vegan Diet	Vegan Menu		
Surgical and Chronic Wounds		Pressure Ulcers Nutrition Therapy	Spanish	

Tri-City Health Care District
Oceanside, California

INFECTION CONTROL

ISSUE DATE:	**09/95**	**SUBJECT:**	**Aerosol Transmissible Diseases and Tuberculosis Control Plan IC 11**
REVISION DATE(S):	**09/01, 09/02, 10/03, 10/06, 10/08, 07/09, 10/09, 07/11, 08/14, 01/16 01/17~~, 5/18~~**		

Infection Control Department Approval:	**~~09/17~~05/18**
Infection Control Committee Approval:	**~~10/17~~07/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~01/18~~08/18**
Administration Approval:	**09/18**
Professional Affairs Committee Approval:	**~~02/18~~ n/a**
Board of Directors Approval:	**02/18**

A. **TUBERCULOSIS AND AEROSOL TRANSMISSIBLE EXPOSURE CONTROL PLAN INTRODUCTION:**

1. Legal mandates and regulatory agencies such as California Code of Regulation Title 8, Occupational Safety and Health Administration (OSHA) and the Centers for Disease Control and Prevention (CDC) have set the standards for the implementation of an Aerosol Transmissible Diseases (ATD) including Tuberculosis Exposure Control Plan.

B. **PURPOSE AND POLICY:**

1. It is the policy of Tri-City Healthcare District (TCHD) to provide care to patients with ATD's with a minimum risk of transmission to others. The Infection Control Committee will provide assistance in ensuring compliance with the policy. The plan includes:
   a. Source Control Procedures including cough etiquette / respiratory hygiene.
   b. Implementation of an effective triage system and early identification of suspects and active cases
   c. Engineering control measures
   d. Respiratory protection programs
   e. Education and training of employees
   f. Evaluation and treatment of employees exposed to ATD's
   g. Protection of patients, employees and visitors from exposure to ATD's. These include:
      i. Pathogens requiring Airborne Precautions;
         1) Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g. Anthrax/Bacillus anthracis
         2) Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)
         3) Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient. Localized disease in immunocompromised patient until disseminated infection ruled out
         4) Measles (rubeola)/Measles virus
         5) Monkeypox/Monkeypox virus
         6) Novel or unknown pathogens
         7) Severe acute respiratory syndrome (SARS)/SARS-associated coronavirus (SARS-CoV)

8) Smallpox (variola)/Varioloa virus (see vaccinia for management of vaccinated persons)
9) Tuberculosis (TB)/Mycobacterium tuberculosis -- Extrapulmonary, draining lesion; Pulmonary or laryngeal disease, confirmed; Pulmonary or laryngeal disease, suspected
   a) Any other disease for which the CDC or CDPH (California Department of Public Health) recommends airborne infection isolation

ii. Diseases requiring Droplet Precautions;
1) Diphtheria/Corynebacterium diphtheriae – pharyngeal
2) Epiglottitis, due to Haemophilus influenza type b
3) Group A Streptococcal (GAS) disease (strep throat, necrotizing fasciitis, impetigo)/Group A streptococcus
4) Haemophilus influenza Serotype b (Hib) disease/Haemophilus influenza serotype b -- infants and children
5) Influenza, human (typical seasonal variations)/influenza viruses
6) Meningitis caused by the following organisms:
   a) Haemophilus influenza, type b known or suspected
   b) Neisseria meningitidis (meningococcal) known or suspected
7) Meningococcal disease/Neisseria meningitidis: sepsis, pneumonia (see also meningitis)
8) Mumps (infectious parotitis)/Mumps virus
9) Mycoplasmal pneumonia/Mycoplasma pneumoniae
10) Parvovirus B19 infection (erythema infectiosum, fifth disease)/Parvovirus B19
11) Pertussis (whooping cough)/Bordetella pertussis
12) Pharyngitis in infants and young children/Adenovirus, Orthomyxoviridae, Epstein-Barr virus, Herpes simplex virus
13) Pneumonia caused by the following organisms:
   a) Adenovirus
   b) Chlamydia pneumoniae
   c) Mycoplasma pneumoniae
      i) Neisseria meningitidis
   d) Streptococcus pneumoniae (use droplet precautions if evidence of transmission within a patient care unit or facility)
14) Pneumonic plague/Yersinia pestis
15) Rubella virus infection (German measles) (also see congenital rubella)/Rubella virus
16) Scarlet fever in infants and young children/Group A streptococcus
17) Serious invasive disease
18) Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses, and Hantaviruses

iii. Ebola disease: Special considerations: Please refer to Tri City Medical Center Infection Control Ebola Plan Policy for management of a patient with confirmed or suspected Ebola.
1) Patients are screened at Triage and/or admission to the facility
2) Place patient in negative pressure room C26
3) Patients without symptoms of bleeding, vomiting, diarrhea or clinical condition that may warrant invasive or aerosol-generating procedures must wear extended personal protective equipment (PPE) (Covers all surfaces of the body including head and neck, coverings for the eyes, mouth, nose and skin). The hair must be completely enclosed. Full face shield with N95 respirator or higher.

4) Patients with symptoms of bleeding, vomiting, diarrhea or clinical condition that may warrant invasive or aerosol-generating procedures or overall worsening of symptoms: must wear Extended PPE (Covers all surfaces of the body including head and neck, coverings for the eyes, mouth, nose and skin). The hair must be completely enclosed. PAPR with full cowl or hood.
5) PAPR with extended PPE must be used prior to entering a patient's room with suspected or confirmed Ebola.

C. **SCOPE:**

1. The Tuberculosis Control and Aerosol Transmissible Diseases Plan applies to all inpatient and outpatient services

D. **RESPONSIBILITY:**

1. The Tuberculosis Control and Aerosol Transmissible Disease Program will require the participation of the following personnel:
   a. The Infection Control Officer and the Infection Preventionist are responsible for overseeing the plan. This includes, but is not limited to implementation of the plan for the facility; development of policies and procedures to support the implementation of the plan; reporting of suspected and diagnosed cases of ATD's and Tuberculosis as defined in under CA title 22 to the Infection Control Committee and county department of health. It is also the responsibility of the Infection Preventionist to evaluate the risk assessment at least annually.
   b. The Environment of Care Officer is responsible for implementation and maintenance of current standards to meet the requirements of the California Code of Regulation Title 8, Title 24 and the guidelines from the Centers for Disease Control and Prevention.
   c. Employee Health Services is responsible for employee TB skin testing and interpretations; conducting investigation regarding employee exposure to ATD's and TB; maintaining employee TB skin test conversion data; reporting employee conversion and diagnosed cases to the Infection Control and Safety committees annually; and managing and counseling staff who have active ATD's. Employee Health is responsible for developing and implementing policies and procedures related to the respiratory protection program. Employee Health is also responsible for screening, testing, and provision of immunizations as indicated and seasonal influenza vaccination administration and declination statement documentation.
   d. Department Directors are responsible for implementation of the TB and ATD Control Plan in their respective areas, providing educational training to all employees before exposure to a source case; maintaining documentation of personnel training; notification of the Infection Preventionist and Facilities Management when active TB patients or patients with other ATD's are admitted to their area.
   e. Administrative Supervisor is responsible for implementation of the TB control plan in the hospital during the hours of 1600-0800 and on weekends and holidays; and overseeing the reporting and discharge of suspected or confirmed cases of ATD or Tuberculosis on weekends and holidays.
   f. The Director of Education is responsible for including TB and ATD control plan in orientation of new employees and annual OSHA required training related to ATD's.
   g. The Director of Environmental Services is responsible for developing, implementing and monitoring procedures for cleaning rooms occupied by a patient with ATD's.
   h. The Facilities Director is responsible for monitoring and verifying air pressures daily on Airborne Infection Isolation Rooms (AIIR), when in use, and reporting of air changes and air pressures to the Infection control and Safety committees annually.
   i. The Director of Pulmonary Services is responsible for training, implementing and monitoring respiratory staffs' adherence to the ATD and TB Control plan including

protection for high-hazard procedures.

j. The Facilities Director is responsible for maintaining and cleaning of portable HEPA recirculators and providing portable HEPA recirculators to units as needed.

k. Microbiology Supervisor is responsible for the notification of the local health authority according to California and Federal regulations of ATD's and TB.

l. The Employees are responsible for early identification of suspects and active cases of ATD's and TB; early implementation of Airborne Precautions; knowledge of Tuberculosis and ATD control plan; reporting of cases to the Infection Preventionist and/or the Public Health Nurse; compliance with all protective practices; attendance of New Employee Orientation Program and annual OSHA required education; and reporting noncompliance and unusual occurrences using a quality review report.

m. The Physicians play an important part in TB and ATD Control by maintaining a high index of clinical suspicion.

i. Physicians should place all HIV positive patients with infiltrates in Airborne Precautions until three sputum concentrated smears are negative for AFB or until a diagnosis other than tuberculosis is clearly established.

ii. Place all new admits with a history of fever, weight loss and cough or pneumonia greater than 2-3 weeks in Airborne Precautions if no clear etiologic agent is identified.

iii. Treat all highly suspected tuberculosis cases with anti-tuberculosis medications pending sputum results.

iv. Consider ATD in patients with temperature greater than 100 degrees F and cough. ATD may also be considered in the presence of rash with fever.

v. Implement control measures when ATD is suspected.

E. AVAILABILITY OF THE PLAN:

1. The Tuberculosis and ATD Control Plan will be available via the Intranet in the Infection Control Manual in every department. OSHA required education will be conducted at the new employee orientation program and all other employees are required to complete an annual review. The written plan will be reviewed and updated annually and as indicated by regulations.

F. FUNDAMENTALS OF TUBERCULOSIS INFECTION CONTROL:

1. Some segments of the U.S. population have a higher risk for TB because they are more likely to have been exposed or because their infection is more likely to progress to active TB after infection. TB is carried in the air after being generated when persons with pulmonary or laryngeal TB sneeze, cough, speak or sing. These particles are carried on air currents and stay afloat for a long time. Infection occurs when a person inhales the germs into their lungs. Usually within 2-10 weeks after infection, the immune response limits further multiplication and spread but some bacteria can remain dormant for years (latent infection). People with normal immune systems have a 5-10% lifetime risk of the latent infection progressing to active disease. Factors that influence infection include the concentration (number) of the bacteria in the air and duration of exposure. Exposure in a relatively small space with inadequate ventilation can increase the risk of infection. Persons who are immunocompromised are more likely to become infected and to also develop active disease. The transmission, epidemiology and pathogenesis of TB were all considered in our plan. An effective program requires early identification, isolation and effective treatment of persons who have active disease.

a. The most effective control measure is to ensure rapid identification, isolation, diagnostic evaluation and treatment of persons likely to have TB.

b. The next level of effective control is the use of engineering controls (i.e. airflow, dilution, filtration and exhaust of air)

c. The final and least effective control is the use of respiratory protection.

G. TUBERCULOSIS RISK ASSESSMENT:

1. Risks assessment will be performed annually by the Infection Preventionist and reviewed by the Infection Control and Environment of Care Committees. The purpose of this assessment is to evaluate the risk of transmission of Tuberculosis so that appropriate interventions can be developed. The assessment will include:
   a. Community TB profile from public health department data
   b. Number of infectious TB patients treated in outpatient and inpatient areas.
   c. Drug susceptibility patterns of TB patients
   d. Analysis of staff PPD test results by area
   e. Review medical records for appropriate precautions, timing of specimens, duration of precautions and timely communication with public health.
   f. Observation of practice and review of engineering controls.
2. Considerations for determining the hospital's risk classification will be based on the following:

VERY LOW RISK	There are no TB patients admitted to the facility during the preceding year
LOW RISK	The employee PPD conversion rate in an area is not higher than in areas with increased occupation exposure to Tuberculosis Fewer than 6 patients were admitted to area during the preceding year There is no evidence of person-to-person transmission No clusters of staff PPD conversion
INTERMEDIATE RISK	Same as Low Risk with the addition of six or more TB patients admitted to the area during the preceding year.
HIGH RISK	PPD conversion rate is higher in areas without occupational exposure to Tuberculosis. Clusters of staff PPD conversion. Evidence of person-to-person transmission. More than 6 patients admitted to an area.

3. Early identification of suspected and active TB patients can initiate prompt treatment and prevent transmission of the disease. This is the most effective method for controlling the spread of tuberculosis, an Administrative Control. A suspected case of TB is defined as:
   a. A patient with unexplained cough, cough with bloody sputum, and/or a cough lasting longer than 3 weeks
   b. A patient with unexplained fever, night sweats, weight loss and anorexia
   c. Readmission of patients recently diagnosed with Tuberculosis
4. A high index of suspicion for Tuberculosis should be maintained for the following
   a. Patients requiring high-risk procedures such as aerosolized pentamidine and sputum induction for Acid Fast Bacilli (AFB)
   b. Patients who belong to a group with a higher prevalence of TB infection: medically under-served, foreign born from a developing country, homeless, current or past justice involved , alcoholic, injecting drug-user, elderly, or extended contact with an active TB case.
   c. Patients who belong to a group with a higher risk to progress from latent TB to active disease: immunocompromised (HIV, organ transplant, or on high dose steroids), silicosis, status post gastrectomy or jejunoileal bypass surgery, >10% below body weight, chronic renal failure, diabetes mellitus, infected within past two years, or child >5 years old.
5. In outpatient areas where patients with undiagnosed Tuberculosis may be present, precautions must be taken to minimize the risk of transmission.
   a. Instruct patients to cover their mouths with a handkerchief or tissue, and give them a surgical mask to wear. Tissues and masks must be readily available in the waiting areas.
   b. Questionnaires will be utilized in all outpatient areas and Emergency Department to assist in the early identification of suspected cases.
   c. Patients with symptoms suggestive of Tuberculosis will be removed from the common area and placed in a designated waiting area.

d. Patients unable to wear a mask can be placed outside with appropriate supervision until an appropriate room is available.

6. For departments in main hospital building without a built in negative pressure room, staff shall obtain HEPA recirculator from the Engineering department to enhance circulation in the exam or treatment room to be used by the patient. Contact Engineering for placement assistance. Please note: The patient must be placed in an AIIR room within 5 hours of identification.
   a. Staff wear N95 particulate respirators and visitors wear surgical masks when entering this area.
   b. If the patient is suspected or known to have infectious TB, the room must remain vacant for one hour after the patient leaves. The door is to remain closed and the filter running.
   c. Personnel may enter the area but must continue to wear respiratory protection until the time has lapsed.
7. For off-site areas, the patient will be asked to wear a surgical mask while inside the building.
8. Any possibility of TB as a diagnosis should be communicated by telephone to other departments, prior transporting the patient to those areas.
9. Patients seen in the ED with confirmed or suspected Pulmonary or Laryngeal TB might require hospitalization to control the spread of infection.
   a. Emergency Department rooms should remain closed for 30 minutes after the patient leaves to ensure 99.9% removal of contaminants. Personnel may enter the room before this time has lapsed but must wear an appropriate respirator.

H. **MANAGEMENT OF HOSPITALIZED PATIENTS WHO MAY HAVE ACTIVE TB:**

1. Staff who are the first points of contact should ask questions that will facilitate identification of patients with signs and symptoms suggestive of TB. See the Admission Assessment Patient History form>TB Screening form>to assess for TB risk factors and symptoms.
2. Upon identification of a patient with active or suspected Tuberculosis, the nurse must place the patient in an Airborne Infection Isolation Room (AIIR) (i.e. negative pressure room: C-26, 143, 243, 287, 387, 443, 487, Maternal Child room 200 and Progressive Care Unit (PCU) Rooms 301, 312 and 326. The door must be closed and the HEPA filter running. Post the Airborne Precautions sign outside the room.
   a. If a designated room is not available, notify the charge nurse and the bed coordinator of the need for an Airborne Precautions room. Remove any roommates and call Engineering for the HEPA filter. Keep the door closed and post the Airborne Precautions sign. Staff wear N95 particulate respirators and visitors wear surgical masks when entering this room.
   b. Patients with TB must not be placed together in the same room unless they have culture- confirmed TB, have drug susceptibility test available on current specimens obtained during the present hospitalization, have identical drug susceptibility patterns on these specimens and are on effective therapy.
3. Reporting:
   a. The Unit Secretary notifies Engineering (by placing a worker order) ~~and the Infection Control office~~ that an Airborne Precautions room is in use for tuberculosis.
   b. On weekends and holidays, the charge nurse or the primary nurse will notify the Public Health Nurse by calling cell phone number (619) 540-0194. Go to http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/TB-216TBSuspectCaseReport.pdf for a copy of the report.
   c. Laboratory Results: Hospitals and staff are required by law to report TB to protect the public. This must be done within one day of identification of the case or suspected case.
   d. The Microbiology department will notify the nursing unit and the Infection Preventionist of a positive AFB smear or culture results. A fax report of all positive AFB smears and cultures is sent to the Public Health.
   e. The Infection Preventionist (x 7410 or x 5696) or designee is responsible for reporting to public health. Tuberculosis (TB) Program Nurses are available 8:00am to 5:00pm, 7

days a week and all holidays on cell phone number (619) 540-0194 TB control does not have personnel available between the hours of 5:00 pm and 8:00 am Persons with routine questions or questions about TB exposure should call phone number (619) 692-8610 after 8:00am on the following day.

f. Person wanting to report a case of TB after 5:00pm should do one of the following:
   i. Call pager (619) 540-0194 after 8:00 am the following day to report directly to TB RN if they feel there is urgency about reporting; or
   ii. Leave a message on the Tuberculosis RN voice mail (619) 692-8610 and their call will be returned on the next working week day. Message should include patient's name, date of birth, facility name, reporter's name and phone number, and contact person at facility who will be available for more patient information.

g. Persons requesting Discharge Approval should:
   i. Contact TB RN between 8:00am and 5:00pm

h. Physicians from emergency rooms requesting recommendations regarding patients they suspect may be infectious after 5:00pm, should do the following:
   i. If patient is homeless or from congregate setting (SNF, school dormitory, etc.) and has clinical picture consistent with TB, we recommend to admit and rule out infectiousness.
   ii. If patient has a home and is otherwise medically stable (not in need of admission) patient can be sent home, obtain one sputum for AFB smear and culture prior to release, start on medication if indicated. Direct caller to contact TB RN on phone number (619) 692-8610 after 8:00am on the following day.

i. Persons calling about patients who are leaving against medical advice (AMA):
   i. Have facility get as much locating information as possible on patient (including address/phone of relatives or friends)
   ii. Call intake RN between 8:00am and 5:00pm; after hours call 8:00am the next day
      1) Go to http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/TB-216TBSuspectCaseReport.pdf for the report form.

4. Staff (fit-tested and approved for use) will wear an N95 respirator when entering the patient's room. See the Respiratory Protection Program under the Employee Health & Wellness Policy Manual.
5. Pediatric patients with suspected or confirmed TB must be evaluated for potential TB according to the same criteria, as adults. Parents and other visitors of pediatric patients must be evaluated for TB as soon as possible. Until they are evaluated, they must wear surgical masks when in areas of the facility outside of the child's room.
6. Diagnostic and treatment procedures must be performed in the Airborne Precautions rooms to prevent transporting to other areas of the facility. If the procedure cannot be done in the isolation room, the patient must wear a surgical mask during transport. Procedures should be scheduled at times when they can be performed rapidly and when the areas are less crowded.
7. Limit the number of persons entering an isolation room to a minimum. All visitors (except staff who have been fit-tested for an N95 respiratory) wear a surgical mask when entering an Airborne Precautions room.
8. Facilities will verify airflow rates and negative pressures at the time the negative pressure room is established. Negative pressures will be verified daily and a log maintained by Facilities department.
9. Cough-inducing procedures will not be performed on patients who have or may have active Tuberculosis unless the procedures are absolutely necessary and can be performed with appropriate precautions.
   a. The patient is in an Airborne Precautions room.
   b. The portable air filtration system has been set-up in a regular room.
10. Staff must wear respiratory protection (**N95 respiratory or** Powered Air Purifying Respirator-PAPR) when present in rooms or enclosures in which cough-inducing procedures are being

performed on patients who are being ruled out for Tuberculosis. See High Hazard Procedures.

11. After completion of the cough-inducing procedures, patients who may have infectious Tuberculosis will remain in the Airborne Precautions room until the coughing subsides. (If transport is necessary, patient will be provided with a surgical mask to wear.) Outpatients will wear surgical masks until they are outside of the hospital.
12. Before the Pulmonary Function Testing room is used again, after the booth has been in use, the HEPA filter is kept on and the door to the room closed for 1.5 hours. Staff entering the room before the 1.5 hours are over will wear an N95 respirator. See High Hazard Procedures.
13. Bronchoscopy considerations
    a. The bronchoscopy room for all inpatient and outpatient procedures will be a negative pressure room. The air filtration system will remain in use whenever performed on a suspect TB patient.. Respiratory protection must be worn. **An N95 Respirator or** Powered Air Purifying Respirator-PAPR must be worn by staff performing a Bronchoscopy on a suspect TB patient. The patient waiting for bronchoscopy will be provided a surgical mask and escorted to a non-communal waiting room.

I. ADDITIONAL CONSIDERATIONS FOR SELECTED AREAS:

1. Surgery/Peri-Anesthesia Nursing Services
    a. Postpone non-urgent or elective procedures on suspected/confirmed TB patients until the patient is no longer infectious.
    b. If procedures must be performed, they should be done in OR rooms with door closed and traffic at a minimum.
    c. Procedures should be done when other patients are not present in the operating suite e.g., end of day) and when minimum number of personnel are present. This applies to pulmonary and non-pulmonary surgical sites.
    d. Utilize the portable HEPA unit in the operating room during intubation and extubation. Turn off the HEPA unit during the procedure.
    e. For patients with known or suspected Airborne Infectious diseases staff must wear a **N95 Respirator or** Positive Air Purifying Respirator (PAPR). Order PAPR's from SPD (xt 7728)
        ~~i. Powered Air Purifying Respirator (PAPR) required to be worn by staff near the patient's head during intubation and extubation. Once the patient is intubated, all staff should wear N95 mask until the procedure is complete.~~
        ~~ii.~~i. PAPRs cannot be used near the sterile field, wear N95 mask in place of PAPR.
    f. For additional information see Surgery Protocol for Active/Rule Out Tuberculosis (TB).
    g. Airborne precautions are maintained in the Post Anesthesia Care Unit. Post-operative patients are placed in a private recovery room with a portable HEPA unit.
2. Autopsy Room
    a. Due to the probability of the presence of infectious aerosols, autopsy rooms should be at negative pressure with respect to adjacent areas, with room air exhausted directly to the outside of the building. ASHRAE recommends that autopsy rooms have ventilation that provides 12 total air changes per hour (ACH).
    b. Personnel performing autopsies on patients who may have had tuberculosis should wear respiratory protection (see high hazard procedures)
    c. In-duct HEPA filtered air re-circulation or UVGI may be used as a supplement to the recommended ventilation.
    d. The autopsy room should remain closed for one hour after the patient leaves to ensure 99.9% removal of contaminants. Personnel may enter the room before this time has lapsed but must wear an appropriate respirator.
    e. Deaths caused by a known or suspected contagious disease constituting a public health hazard are reportable to the Medical Examiner's Office. Autopsy performed on these cases will be performed by the Medical Examiner.
3. Home Health Services

a. Staff entering the home of a patient with confirmed or suspected TB or aerosol transmissible disease (ATD) should wear appropriate respiratory protection.
b. The patient should be taught to cover mouth and nose with a tissue when coughing or sneezing.
c. Educate patient regarding importance of taking medication (and administering directly observed therapy).
d. Immunocompromised persons or young children living in home with TB patient should be temporarily relocated until patient is no longer infectious.
e. Cough-inducing procedures should be performed on patients with infectious tuberculosis only if absolutely necessary. If their performance is required a well-ventilated area away from other household members should be used (for example, go outside or open a window). Staff will wear respiratory protection during the procedure
f. Specific processes and procedures pertaining to ATD's in the home are found in the Home Health Care policy manual.

J. **DIAGNOSTIC EVALUATION:**

1. Diagnostic evaluation should include the following:
   a. Medical history and evaluation - The probability of TB is greater among patients who have positive PPD test results or a history of positive PPD results, who have previously had TB or who have been exposed to someone with TB, or who belong to a group at high risk for TB.
   b. Mantoux skin test (PPD skin test) – is placed by the specially trained staff and read at 48- 72 hours after injection. Results are to be documented in the Medical Record.
   c. QuantiFERON-TB Gold (QFT-G) test can be used in any situation a Mantoux PPD skin test is indicated. A positive result has the same significance as a positive PPD skin test, and neither a positive PPD nor a positive QFT-G by itself warrants Airborne Precautions.
   d. Chest radiograph - radiographic abnormalities that strongly suggest active TB include upper lobe infiltrates, particularly if the cavitations are seen, and patchy or nodular infiltrates in the apical or sub apical posterior upper lobes or the superior segment of the lower lobe. The MD may include the words "cavitary lesion", "granuloma disease" or "suspected tuberculosis" in the results.
   e. Microscopic examination and culture of sputum or other appropriate specimen. Three sputum specimens should be collected 8–24 hours apart, and at least one should be an early morning specimen, induced, or bronchoalveolar lavage (BAL).Although direct AFB smears are available in house, concentrated smears performed by our reference laboratory are preferred and are included with orders for a TB culture. Since neither a direct nor a concentrated smear has sufficient sensitivity to exclude a diagnosis of tuberculosis, cultures must also be ordered.
   f. Initiating Treatment: Patients who have confirmed active TB or who are considered highly likely to have active TB should be started promptly on appropriate treatment in accordance with the current guidelines.
   g. Drug susceptibility should be performed on all initial isolates from patients with TB.
   h. Contact Infection Control at Ext. 5696 or 7410 for the latest recommendations.

K. **AIRBORNE PRECAUTIONS:**

1. Airborne Precautions can be discontinued as soon as the diagnosis of TB has been ruled out, when another diagnosis is confirmed, or when the patient is no longer infectious.
   a. Airborne Precautions can be discontinued:
      i. In a patient with active tuberculosis when the patient is on effective therapy, improving clinically, and has had three consecutive negative concentrate sputum AFB smears
      ii. In a patient with suspect tuberculosis as soon as the diagnosis of TB has been excluded by three negative AFB sputum smears taken 8-24 hours apart with at

least one from an early morning specimen, induced specimen, or BAL or when another diagnosis is confirmed

2. Continued isolation throughout the hospitalization should be considered for patients who have multi-drug resistant tuberculosis (MDR-TB) because of the tendency for treatment failure or relapse.

L. **DISCHARGE:**

1. Before leaving the hospital, TB patients must be approved for discharge by the Public Health Department. A discharge plan must include all of the following prior to approval from the TB Control Officer. TB Control can be contacted at: 619-692-8610 or 619-540-0194. The Tuberculosis Discharge Care Plan form can be accessed at: http://www.sandiegocounty.gov/hhsa/programs/phs/documents/TB-273TuberculosisDischargeCarePlan2014.pdf

   a. Patients in the Progressive Care Unit (PCU): Specific notification(s) must be obtained prior to discharging justice involved patients:
      i. The Department of Health TB Control to the specific county in which the justice involved patient is residing
      ii. The Public Health Department of the prison.
   b. For all other inpatient units:
      i. Three consecutive negative sputum smears from concentrate or approved living arrangements so that TB isolation can be maintained. For example, the accepting facility has an airborne precautions room available or the house and household contacts have been evaluated and cleared by the TB County public health nurse.
      ii. A confirmed outpatient appointment (date/time/place) with a provider (name and phone number) who will manage the patient's care until cured.
      iii. Sufficient medication to take until the outpatient appointment. Contact Pharmacy for assistance with take-home medications.
      iv. Placement into case management (e.g. DOT) or outreach programs of the public health department.
      v. The charge nurse, patients nurse or Case Manager, will notify the Public Health Department at (619) 692-8610 prior to the anticipated discharge and obtain approval.
      vi. Public Health requires at least two days prior to discharge to review the case. On weekends and holidays, obtain approval from the on-call TB County public health nurse at cell phone number (619) 540-0194

2. Cleaning of the room after a known or suspected TB patient is moved or discharged:
   a. If the suspected or confirmed TB patient was NOT in a negative pressure and HEPA filtered room:
      i. Post the Airborne Precautions sign and keep the door closed.
      ii. Call Engineering for a HEPA filter. To enter the room staff must wear an appropriate respirator (i.e. N95 or PAPR). Plug in the filter, turn it on and close the door. Post a sign that specifies the appropriate time period from the table below. Staff may enter the room during this time (i.e. to clean) but must wear an N95 respirator until the time period has elapsed. After the time period has ended, discontinue Airborne Precautions and return the HEPA filter to Engineering.

M. **ROOM SHUT DOWN TIME:**

Area	Length of Time Room is Closed
Orthopedics/Rehab (1N/S)	Two hours
Maternal/Child	Two Hours
South	Two hours
3 N/S	Two hours

Pavilion	One hour
E/W Tower	One hour
Surgery	One hour
Radiology	One hour
Emergency Department	30 minutes
Bronchoscopy area	30 minutes

a. If the patient is still infectious and was in a negative pressure room:
   i. Keep the Airborne Precautions sign posted, leave the HEPA filter running and close the door for one more hour. Post a sign that specifies this time period. Staff may enter the room during this time (i.e. to clean) but must wear an N95 respirator until the time period has elapsed. After the one-hour period has ended, discontinue Airborne Precautions.

b. If the patient is no longer infectious or TB has been ruled out:
   i. No special precautions needed. The door may be immediately opened and the room cleaned as usual.

N. **ANNUAL TUBERCULOSIS SCREENING:**

1. Auxiliary and Employees: See the Employee Health & Wellness Policy Manual: TB Surveillance and Respiratory Protection policies.
2. Physicians: the Medical Staff Office sends an annual screening survey to each physician on staff. PPD testing for physicians is required and available in Work Partners. The following medical staff departments are required to be fit-tested upon hire and annually: Emergency Department, Operating Room, Interventional Radiology, Cath Lab, Pulmonary, and Infectious Disease.

O. **AEROSOL TRANSMISSIBLE DISEASE CONTROL EXPOSURE DETERMINATION:**

1. A list of all job classifications in which employees have occupational exposure is available in the Employee Health & Wellness Policy Manual: Respiratory Protection Program (see Appendix C).

P. **ISOLATION PRECAUTIONS:**

1. Standard Precautions and Transmission based precautions including cough etiquette, Airborne Precautions, Droplet Precautions and Contact Precautions are outlined in the Infection Control Manual: Standard and Transmission based Precautions (IC.5), Type and Duration of Precautions for Selected Infections and Conditions (IC.5.1); Pregnant staff (IC.5.2).

Q. **HIGH HAZARD PROCEDURES:**

1. High hazard procedures include but not limited to
   a. Intubation and Extubation
   b. Sputum Induction
   c. Endotracheal & Tracheostomy Tube Care
   d. Bronchoscopy
   e. Pulmonary Function Tests
   f. Aerosolized administration of pentamidine or other medication
   g. Autopsy
2. For patients with known or suspected Droplet infectious diseases staff must wear an N95 respirator.
3. For patients with known or suspected Airborne Infectious diseases staff must wear a **N95 Respirator or** Positive Air Purifying Respirator (PAPR) except in an Operating Room or procedure room during an invasive procedure where there is a sterile field wear a N95 mask.
   a. Order PAPR's from SPD (x7728)

~~a.~~**4. Although Cal OSHA requires PAPRs for high hazard procedures on suspect/confirmed airborne disease patients, CDPH does allow the use of N95 Respirators instead of PAPRs if it interferes with the successful performance of the task or the procedure is performed**

with the patient in a ventilated enclosure.

R. **SOURCE CONTROLS AND ENGINEERING CONTROLS IN SPECIFIC HOSPITAL AREAS:**

1. Throughout the facility cough etiquette is used in waiting areas. Signs with instructions are posted in these areas in Spanish and English. Patients are provided tissues and are asked to wear surgical masks to prevent droplets from disseminating into the environment. Alcohol hand hygiene solutions are made available for patient use. Bilingual signs are posted in waiting areas instructing patients to "Cover your cough."
2. Emergency Department
   a. Engineering Controls during a surge of patients with ATD is addressed in the TCHD Infection Control Policy IC15.0 Influx of Infectious Patients: *Epidemic Influenza or other respiratory transmitted disease.*
   b. At the point of triage, ED staff shall screen and identify patients with symptoms of ATD and implement source control by placing a surgical mask on the patient and asking the patient to keep the mask on during their visit. If the patient cannot tolerate a surgical mask, tissues shall be provided and patients shall be instructed to cover their cough.
   c. Staff wears PAPR's during high hazard procedures (listed above) for disease spread by the airborne route.
   d. N95 respirators or PAPR's are used during patient contact for diseases spread by airborne route.
   e. Surgical masks are used during patient contact for diseases spread by the droplet route. N95 mask is used by staff during high hazard procedures for disease spread by the droplet route.
   f. Patients with diseases known to be transmitted by the airborne route, including novel viral infections, will be prioritized for Airborne Infection Isolation Room (AIIR) C-26.
   g. When room C-26 is not available a private room is used.
   h. When there are no private rooms available, patients are asked to keep their mask in place and use tissues to prevent droplet aerosolization.
   i. Patients may be cohorted in designated rooms or bays when indicated.
   j. Patients suspected of having ATD's are provided with disposable nebulizer units with expiratory filters or multi-dose inhalers as clinically indicated.
   k. There are no special environmental cleaning recommendations for TB or r/o TB patients.
   l. Rooms shall be cleaned between patients using the hospital approved disinfectant.
   m. When used for a patient with ATD, room C-26 shall remain empty with Airborne Precautions sign posted and door closed for 30 minutes prior to being used by another patient.
3. Nursing Units
   a. Patients who are admitted with airborne transmissible diseases are admitted to AIIR's on nursing units.
   b. Airborne Precautions are initiated and followed in accordance with CDC recommendations for Transmission Based Precautions. A TB quicklook is posted outside each AIIR for step by step instructions on initiating and maintaining proper airflow.
   c. Doors are kept closed.
   d. Patients in Droplet precautions do not need AIIR's for routine care. However, high hazard and cough inducing procedures performed as part of the clinical care of patients in both Airborne and Droplet Precautions will be done in AIIR. See chart above for selection on type of respirator.
   e. Portable HEPA filtration units can be used to facilitate AIIR. Engineering installs and maintains these devices. Place a work order for installation and monitoring.
   f. Airborne Infection Isolation rooms shall remain empty with Airborne Precautions sign posted and door closed for designated time when a patient with Airborne transmissible disease has occupied the room. (See Room Shut Down Time)

4. Pulmonary Services
   a. Bronchoscopy for patients in Airborne or Droplet Precautions will be performed in an AIIR.
   b. N95 respirators or PAPR's are used during Bronchoscopy.
   c. In areas where AIIR is not available, aerosolized medications are administered using disposable nebulizer units with expiratory filters or multi-dose inhalers as clinically indicated.
   d. Aerosolized medications may be administered using traditional routes while the patient is in an AIIR. The staff should wear an N95 or PAPR during this treatment (see High Hazard Procedures).
   e. Bronchoscopy suite will remain closed for the designated time when procedure is performed on a patient with known or suspected ATD.
   f. Expiratory filters are used for intubated patients with known or suspected ATD during transport.
5. Maternal Child Health Services (MCH)
   a. Neonatal Intensive Care Unit (NICU)
      i. The NICU has a dedicated AIIR.
      ii. Neonates born to mothers with diseases known to be spread by Airborne Route are placed in the AIIR until the neonate is found to be non-infectious.
      iii. Prior to entering the unit, visitors are screened for signs of ADT and immunization history. Visitors are asked not to visit for duration of illness.
   b. Labor and Delivery and Maternal Child Health
      i. Labor rooms may have portable HEPA units installed for mothers who have suspected ATD.
      ii. Staff follow Standard and Transmission based Precautions as indicated using the appropriate N-95 respirators or PAPR's for Airborne Precautions.
      iii. Rooms 200 and 201 are an AIIR and are used for MCH patients who require Airborne Precautions or need high hazard procedures.
6. Behavioral Health
      i. Patients who develop symptoms of ATD will be assessed by the physician to determine the need for medical intervention.
      ii. Source control will be implemented including masking the patient, use of tissues and hand hygiene.
      iii. If ATD illness is suspected (see list above) the patient will be asked to remain in their room and wear a surgical mask while awaiting admission to the hospital for further treatment.
      iv. If the patient is unable to wear a mask and non-compliant with containing respiratory secretions with tissues.Staff will wear appropriate PPE based on the transmission of the suspected illness (Droplet or Airborne transmission).
      v. If droplet precautions are indicated (see list above) and the patient is medically stable, the patient may remain on the BHU and Droplet precautions will be instituted and maintained for the duration of illness.
      vi. Airborne precautions cannot be implemented in the BHU. The need for admission to the hospital will be assessed on a case by case basis.
      vii. Patients who are identified as needing and AIIR will be transferred within <u>five hours of identification</u>.
7. Laboratory Services
   a. Methods of implementation for ATD exposure control in are found in the Laboratory Medicine Biosafety Plan.
   b. For respiratory protection in Laboratory Services: See Employee Health & Wellness Policy: Respiratory Protection Program Policy
8. Facilities Management Staff
   a. Facilities Management staff will wear N-95 respirators when entering an AIIR housing

patient(s) with known or suspected ATD.

b. N95 respirators are required when repairing, replacing, or maintaining air systems or equipment that may contain or generate aerosolized pathogens.

9. Personal Protective Equipment
   a. The respiratory protection program policy (Employee Health and Wellness Manual) describes requirements of PPE used for ATD protection in accordance with 29CFR1910.134 and CCR Title 8, section 5144.
   b. Respiratory Protection including N95 respirators or PAPR's is required in any hospital location in the following circumstances:
      i. Entering an Airborne Isolation Room occupied by a patient with an airborne transmitted ATD
      ii. Entering an Airborne Precautions room that is occupied or has been occupied within the past hour by a patient with active untreated airborne illness including pulmonary or laryngeal TB.
      iii. Entering a regular room where a patient with active or untreated pulmonary or laryngeal TB is undergoing or has undergone within the past 8 hours any high-hazard medical procedure.
      iv. Providing services that involve the need to be in close prolonged contact with a patient with active untreated airborne transmissible illness including pulmonary or laryngeal TB.
      v. Attending high hazard procedures.
   c. Respirator Shortages
      i. In the event of reported shortages of N95 respirators the following is recommended (notification received from supplier but still able to meet historic usage):
         1) TCHD will maintain a cache of N95 respirators in accordance with the disaster plan.
         2) Materials Distribution staff will perform in-house inventory to determine available stock and develop a timeline for inventory depletion.
         3) According to available stock, N95 respirators will be prioritized for distribution to Pulmonary Services, ICU, and Emergency Department for use in high hazard procedures.
         4) Re-use of N95 respirators for known or suspected Tuberculosis patients over a 12 hour shift unless the respirator is contaminated (e.g. visibly soiled) or the integrity of the respirator is disrupted (e.g. torn, cracked nose piece).
         5) Reuse of N95 respirators is acceptable during the care of patients with other ATD's under the following circumstances:
            a) A protective face shield (no surgical mask) is donned over the respirator to protect the respirator from contamination of ATD .
            b) The respirator integrity remains intact
            c) During the care of intubated and ventilated patients (closed circuit suction systems).
      ii. In severe respirator shortages (less than 30 days of stock available in house, when supplier cannot meet the demand or can only supply an alternative N95) the following steps may be considered:
         1) Prioritize available N95 for high hazard procedures.
         2) Provide surgical grade masks for employees who are not provided a respirator due to the implementation of prioritized respirator use.
         3) Contact Local Public Health Officer for possible acquisition of N95 respirators from local or state stockpiles.
         4) Alternate manufacturer's respirators may be used in cases of tuberculosis and other airborne illnesses. Fit testing will be waived in a declared state

of emergency.

5) Except during high hazard procedures, surgical masks may be used for H1N1 influenza.
6) PAPR's may be used.
7) The Infection Control Officer, Infection Preventionist, and the Safety Officer will determine if Internal Disaster Code Orange is warranted based on patient surge, physical and staffing resources.
8) When there is no option for providing N95 respirators, surgical masks will be provide to the employee.

iii. Positive Air Purifying Respirators (PAPR's)

1) PAPR's used for bronchoscopy are maintained in Respiratory Care Department.
2) SPD stores and maintains all other PAPR's.
3) Units are cleaned; disinfected using a hospital approved disinfectant and tested after each use.
4) Disposable hoods are used.

10. Admissions and transfers of patients with known or suspected Airborne transmissible ATD.
    a. Airborne transmissible ATD suspect cases shall be identified, and the individuals shall be given disposable tissues, hand hygiene materials and the patient will be masked until an AIIR is available. Transfer to an AIIR shall be facilitated within five (5) hours of identification.
    b. If an AIIR is not available, patients shall be transferred to a facility with AIIR availability.
    c. If the physician determines that transfer to another facility AIIR would be detrimental to the patient's condition the patient need not be transferred. In this case, employees will use N95 respirators when entering the room or area housing the individual. The patient's condition will be reassessed every 24 hours to determine if transfer is safe and the determination shall be documented.
11. Influenza Season
    a. From November 1 to March 31, all employees, volunteers, contract workers or others covered under the ATD standard must wear a standard surgical mask while on duty in the hospital. This requirement does not apply to anyone who has received the current influenza vaccine as recommended by the County of San Diego Public Health and Centers for Disease Control and Prevention.
    b. The enforcement dates are subject to change based on the recommendations of the hospital's Infection Control Committee.
    c. Non-compliance with this requirement is subject to discipline as outlined in the hospital's Human Resources policy.

S. **MEDICAL SERVICES:**

1. Vaccinations are offered to employees free of charge (Employee Health and Wellness Manual: Immunization Policy).
2. Medical Services shall be provided to employees who have occupational exposure to ATD's.
3. Medical Services may include vaccinations, tests, examinations, evaluations, determinations, procedures and medical management and follow-up.
4. Medical Services shall be conducted in accordance with EHS policies.

T. **TRAINING:**

1. Training is provided during the New Employee Orientation Process and annually through computer based education modules.
2. Opportunity is provided for questions to be answered by an infection control professional.
3. Respirator Fit testing
    a. Medical screening and training is performed in accordance with Employee Health and Wellness Manual: Respiratory Protection Program.

U. **REVIEW SCHEDULE:**

1. The ATD plan will be reviewed annually by the Infection Control Committee.
2. Employees will assess the effectiveness of the program in their respective areas annually during the Annual Work Survey and deficiencies will be corrected

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

1. Active/Rule Out Tuberculosis (TB) Surgery Protocol
2. Criteria for Infectiousness and Placement In High Risk Setting Table (PCU Unit Only)
3. Infection Control **Policy~~Manual~~**: Risk Assessment and Surveillance Plan
4. Infection Control **Policy~~Manual~~**: Epidemiologic Investigation of a Suspected Outbreak
5. Infection Control **Policy~~Manual~~**: Healthcare Associated Infections, Defined
6. Employee Health and Wellness **Policy ~~Manual~~**: Immunization
7. Employee Health and Wellness **Policy ~~Manual: Employee Health~~**: Respiratory Protection

W. **REFERENCE(S):**

1. Centers for Disease Control & Prevention, Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis In Health Care Settings, 2005. MMWR 2005; 54 (No RR-17). .
2. Centers for Disease Control & Prevention, Guideline for Environmental Infection Control in Health Care Facilities, 2003 (last updated 02/15/2017)
3. Centers for Disease Control & Prevention H1N1 guidance, Seasonal Influenza and vaccine Guidance www.cdc.gov
4. California Department of Public Health, Occupational Health Branch. (2015, August). Respirator Selection Guide for Aerosol Transmissible Disease. https://archive.cdph.ca.gov/programs/ohb/Documents/HCResp-ATD-RespSelectGuide.pdf
5. California Department of Public Health: January 20, 2015 Interim Guidance on Personal Protective Equipment (PPE) to be used by Healthcare Workers in the Inpatient Hospital Setting during Management of Patients with Suspected or Confirmed Ebola Virus Disease in California.
6. Respiratory Hygiene/Cough Etiquette in Healthcare Settings www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm
7. OSHA Directive CPL 02-02-078 dated June 30, 2015: Enforcement Procedures & Scheduling for Occupational Exposure to Tuberculosis. https://www.osha.gov/SLTC/tuberculosis/
8. CDPH: Cal-OSHA Aerosol Transmissible Diseases Standard, August 5, 2009
9. https://archive.cdph.ca.gov/programs/ohb/Pages/ATDStd.aspx
10. CDC: Tuberculin Skin Testing for TB dated May 11, 2016. https://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm
11. Cadena, J. (2014) Tuberculosis and other Mycobacteria. In P. Grota (Ed.), *APIC Text of Infection Control and Epidemiology 4th Ed.*, 95:1-20.
12. Hospital Respiratory Protection Program Toolkit: U.S. Dept of Labor/CDC/OSHA/NIOSH. Dated May 2015. https://www.osha.gov/Publications/OSHA3767.pdf
13. CDPH/CTCA: California Tuberculosis Risk Assessment: Adults June 2017 https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-TB-Risk-Assessment-and-Fact-Sheet.pdf

~~13.~~**14. CDPH Respirator Toolkit August 2015 (CDC, OSHA, NIOSH May 2015) page 16 https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/CDPH%20Document%20Library/HCResp-CARPPGuide.pdf**

ACTIVE/RULE OUT TUBERCULOSIS (TB)

Surgery Protocol

ADMINISTRATIVE CONTROLS	ENVIRONMENTAL CONTROLS	RESPIRATORY PROTECTION
• Postpone non-urgent procedures on suspected/confirmed TB patients until known to be non-infectious. • If necessary to proceed, schedule procedure as last case of the day, at low traffic times, whenever possible. **WHEN THE CASE IS SCHEDULED NOTIFY:** • Infection Control- (Lisa Mattia x5696) • POH (x5452) • PACU (x7264) • Engineering (x7148) of date/time of procedure to set up HEPA filters in OR and PACU • Anesthesia Charge to assure anesthesiologist has been fit tested and knows N95 size • Notify SPD to have five (5) PAPR units available • Notify pathology lab if TB specimens will be sent to lab. ***DAY BEFORE PROCEDURE, IF POSSIBLE:*** Assign staff and assure fit testing is completed and individuals know their N95 mask size. **DAY OF SURGERY:** • Obtain 3 Airborne Precaution Signs • Obtain five PAPR Units **or N95** • Prior to transporting the patient to the OR, send OR RN to the patient's unit to pre-op patient and complete handoff report.	**PRE-OP:** • Admit patient directly to the OR from the floor/unit. Do not stop in POH. **OR:** • Notify Engineering (x7148) to place portable HEPA unit in OR, positioned near the patient's head. • Utilize the portable HEPA unit in the OR during intubation and extubation. Turn the unit OFF during the procedure. • Keep OR doors closed, minimize traffic in/out of room and in surrounding areas. • Display Airborne Precautions signs on all doors to OR. • Close all doors after leaving the OR and keep room vacant with HEPA filter running for **ONE (1) HOUR** after patient leaves room, then perform normal room turnover. • Notify Engineering (x7148) to remove HEPA unit. **POST-OP:** • Notify Engineering (x7148) to place portable HEPA unit in PACU cubicle. • Post Airborne Precautions signs on cubicle door. • Place patient in cubicle post-Op and keep cubicle door closed. • Close cubicle door after patient leaves and keep room vacant with HEPA filter running for **ONE (1) HOUR,** then perform normal room turnover. • Notify Engineering (x7148) to remove HEPA unit.	**PATIENT:** • Provide surgical mask for patient during transport. • Intubated patients: Anesthesiologist to place expiratory filter (from Anesthesia Workroom) on the ambu bag (at PEEP valve) during transport. **HEALTH CARE PROVIDERS:** • **N95 Respirator or** Powered Air Purifying Respirator (PAPR) required during intubation and extubation for the anesthesiologist and anyone assisting anesthesia at the head of the table. Order PAPR's from SPD (x7728). • *PAPR's are not to be used near the sterile field.* • Once the patient is intubated, all staff should wear N95 mask until the procedure is complete. • Fit testing for N95 mask must be completed each year. Healthcare providers who failed fit testing may not be scheduled in a sterile procedure with Airborne Precautions.

Criteria for Infectiousness and Placement in High Risk Setting Table (PCU Unit Only)

CATEGORY	SETTING	CRITERIA
TB suspect - Not on treatment for suspect active TB	PCU	3 consecutive respiratory specimens, including one early AM or induced sputum, or BAL, collected at least 8 hours apart, are AFB smear negative
TB case or suspect on treatment for active TB -AFB smear positive -No risk factor for MDR-TB	PCU	1. 3 consecutive respiratory specimens, including one early AM or induced sputum, or BAL, collected at least 8 hours apart, are AFB smear negative 2. At least 14 daily doses of treatment for TB, preferably by directly observed therapy (DOT), taken and tolerated; and 3. Clinical improvement
TB case or suspect on treatment for TB -AFB smear negative X3 -No risk factor for MDR-TB	PCU	At least 5 daily doses of treatment for TB taken and tolerated
TB case or suspect on treatment for TB -At increased risk for MDR-TB	PCU	1. Obtain direct genetic test, if available, for Rifampin resistance 2. If direct genetic test not available, while phenotypic DST for Rifampin is pending, other criteria for patients with known MDR-TB, or criteria for patients not at increased risk of MDR-TB, or criteria for patients not at increased risk of MRD-TB may be applied, at the discretion of the local TB controller
Known MDR-TB case	PCU	1. 3 consecutive respiratory specimens, including one early AM or induced sputum, or BAL, collected at least 8 hours apart, are AFB smear negative 2. At least 14 daily doses of treatment for TB, preferably by directly observed therapy (DOT), taken and tolerated; and 3. Clinical improvement 4. At least 2 consecutive negative sputum cultures without a subsequent positive culture

Reference: CDPH/CTCA (2005). Guidelines for the assessment of tuberculosis patient infectiousness and placement in high and low risk settings. California Department of Public Health and California Tuberculosis Controllers Association.

Patient has signs and symptoms or chest x-ray compatible with TB

AND

Unstable housing or resident in a group setting
OR
Acutely ill or needing invasive diagnostic or therapeutic procedure
OR
Strong likelihood that patient will **not** follow-up with outpatient work-up

↓

Admit to Medicine and place on Airborne Precautions
For assistance
contact the TB Control Program or Infection Control at the numbers below.

AND

Stable, non-group housing
AND
Not acutely ill or needing invasive diagnostic or therapeutic procedure
AND
Strong likelihood that patient will follow-up with outpatient work-up

↓

Discharge the patient with a written plan for outpatient care & surgical masks to wear
AND
Instruct the patient to remain on home isolation[1] until infectiousness is ruled out
AND
Alert the TB Control Program ASAP, but no longer than 24 hours.

[1]Home isolation: Stay alone in a separate room with the door closed, as much as possible. Keep a window slightly open at all times. When alone in this room, you do not need to wear a mask. Please be sure to sleep and eat while alone in this room. Persons entering this room need to wear a mask. If you leave the room, you need to wear a mask. For example, when you use a shared bathroom or go to the doctor's office wear a mask.

TB Control in San Diego County is available 7 days a week from 0800 to 1700 only. Weekdays call TB Control at (619) 692-8610 and on Weekends and holidays call cell phone number (619) 540-0194 OR Leave a message on the Tuberculosis RN voice mail (619) 692-8610 and your call will be returned on the next working week day. Messages should include patient's name, date of birth, facility name, reporter's name and phone number, and contact person at facility who will be available for more patient information. Also leave a message at TCHD Infection Control: call ext. 7410 or 5696

Tri-City Health Care District
Oceanside, California

INFECTION CONTROL

ISSUE DATE: 09/01 **SUBJECT:** Cleaning, Disinfection and Sterilization

REVISION DATE(S): 3/05, 3/06, 10/06, 4/09, 4/12, 9/15~~, 5/18~~

Infection Control Department Approval:	05/18
Infection Control Committee Approval:	~~07/15~~07/18
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~08/15~~08/18
Administration Approval:	09/18
Professional affairs committee Approval:	~~09/15~~ n/a
Board of Directors Approval:	09/15

A. **PURPOSE:**

1. To provide guidelines for uniform and complete cleaning and disinfection or sterilization of patient care items as indicated on the basis of each item's intended use. Using the Spaulding classification scheme instruments and items for patient care are categorized as critical, semi critical, and noncritical. Situations which may impact the choice of disinfection or sterilization method may include complicated medical equipment, heat sensitive devices, and inactivation of certain types of infectious agents. Manufacturer recommendations and FDA cleared instructions for chemical sterilants/high level disinfectants are considered in these cases.

B. **INTRODUCTION:**

1. Meticulous physical cleaning must precede disinfection and sterilization procedures. Agents used on items are called sterilants or disinfectants. Agents used on skin or tissue are called antiseptics.
2. Sterilization is the complete elimination or destruction of all forms of microbial life. Before use on each patient, critical medical and surgical devices and instruments that enter normally sterile tissue or the vascular system or through which a sterile body fluid flows are sterilized.
   a. Sterilization is accomplished by either physical or chemical processes. Steam under pressure, dry heat, or chemical sterilants such as plasma sterilization are used to process "critical" items.
3. High-level disinfection can be expected to destroy all microorganisms, with the exception of high numbers of bacterial spores.
   a. Items determined to be "semi-critical" touch mucous membranes or non-intact skin.
   b. High-level disinfection is accomplished by the preferred method of heat sterilization between patients when possible. Medical instruments that are not heat-stable (for example endoscopy and ultrasound probes) are processed using **high level** chemical disinfectants. ~~such as paracetic acid or Cidex OPA.~~
4. Intermediate-level disinfection can be expected to destroy vegetative bacteria, mycobacteria, most viruses, most fungi but not bacterial spores. An example would be a EPA- registered hospital disinfectant with label claim regarding tuberculocidal disinfectant. Appropriate for "noncritical" patient care items or surfaces with visible blood.
5. Low-level disinfection is appropriate for "noncritical" items that come in contact with intact skin. Some items that may come in contact with non-intact skin for a brief period of time are usually considered noncritical surfaces and are disinfected with intermediate-level disinfectants.

C. **POLICY**

1. Sterilization Process
   a. All patient care objects needing sterilization will be cleaned of gross contamination in the area used and sent to Sterile Processing Department for complete processing. Don protective gloves and other required PPE prior to touching patient care items potentially contaminated with blood or body fluids.
   b. Visually check for used sharps and safely dispose of in a sharps container.
   c. ~~Lightly rinse objects in warm water.~~ **Pre-clean at the point of use (OR suite, procedure room)** with water or a product recommended for pre-cleaning with manufacturer's instructions-for-use followed **to remove blood, body fluids, and bioburden from instruments.**
   d. ~~Use an enzyme cleaner to assist with the removal of proteinaceous material (tissue, blood and body fluids).~~**Keep items moist during transport to prevent hardening of bioburden (eg, foam/gel spray, moist towel, etc)**
   e. ~~After cleaning,~~ **Pplace items in a leak proof, puncture proof, biohazard labeled container** ~~them in a rigid container~~ for transport or pick-up.
   f. Refer to Sterile Processing Department policies and procedures.
2. High Level Disinfection
   a. High-level disinfection is provided for processing semi critical patient-care equipment that touches either mucous membranes or nonintact skin.
   b. Refer to Patient Care Services Procedures Manual "High Level Disinfection Procedure" for detailed instruction.
3. Low level disinfection
   a. Environmental services (EVS) cleans/disinfects surfaces (e.g., floors, tabletops) on a regular basis, when large spills occur, and when these surfaces are visibly soiled.
   b. EVS staff follows manufacturers' instructions for proper use of disinfecting products, such as recommended use-dilution, contact time, material compatibility, storage, shelf-life, and safe use and disposal.
   c. Walls, blinds, and window curtains in patient-care areas are cleaned when visibly contaminated or soiled.
   d. Privacy curtains in patient- care areas are cleaned on a routine schedule (most areas are quarterly), in addition they are cleaned when visibly contaminated or soiled.
   e. An EPA-registered hospital disinfectant designed for housekeeping purposes in patient care areas is used.
   f. Wet-dust horizontal surfaces regularly is accomplished using clean cloths moistened with an EPA-registered hospital disinfectant.
   g. An EPA-registered sodium hypochlorite product is used to clean rooms housing patients with *C. difficile* Infection
   h. Rolling stock and other equipment that is to remain on the unit or at the bedside will be low-level disinfected using an EPA registered hospital disinfectant between patients whenever possible and when visibly soiled. Some examples of equipment include blood pressure cuffs on portable machines, IV poles, ventilators or bedside commodes (cover with plastic bag); bed scales, wheelchairs, medication and supply carts.
4. Spills of blood and other potentially infectious materials are contained and cleaned as soon as possible.
   a. Promptly clean and decontaminate spills of blood and other potentially infectious materials. Disinfect areas contaminated with blood spills using an EPA-registered tuberculocidal agent, or products with specific label claims for HIV or HBV or freshly diluted hypochlorite solution. If the spill contains large amounts of blood or body fluids, clean the visible matter with disposable absorbent material, and discard the contaminated materials in appropriate, labeled containment.

b. Hospital-approved products (for example Sanicloth and Dispatch) are to be used by staff for cleaning of small spills.
c. Large spills (over 200cc) are cleaned by Environmental Services. A solidifying agent may be used for large spills.
d. Wear personal protective equipment to prevent exposure from touch or splashes. This should always include gloves and the addition of a plastic apron or gown and face protection as needed.
e. Contaminated glass or sharps are picked up with forceps or like instrument. Place in an emesis basin or other puncture proof container to carry to a sharps container for disposal.
f. If the paper towels are used to mop up the spill and they are saturated and/or dripping with blood, dispose of in red biohazard bag trash. Paper towels not saturated and/or dripping with blood are placed in a regular trash container. Cloth towels and linen used to clean spills are placed in the soiled linen containers.

5. Occupational Safety and Health Administration (OSHA) requires Environmental Protection Agency (EPA) approved products for cleaning of blood and other potentially infectious materials.
   a. These products are labeled as "tuberculocidal" or effective against Hepatitis B and HIV.
   b. Follow the manufacturer's instructions for how long the surface must stay wet to be effective (wet/contact time).

D. **REFERENCE(S)**:

1. Centers for Disease Control and Prevention. (2007). Guideline for Isolation Precautions in Hospitals.
2. BBP Standard, Title 8 California Code of Regulations, Updated 1999.
3. Centers for Disease Control and Prevention. Guidelines for environmental infection control in health-care facilities: recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). MMWR 2003;52 (No. RR-10)
4. Rutala, W., Weber, D., & the Healthcare Infection Control Practices Advisory Committee (HICPAC) (2008). Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008. Retrieved from http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html
5. Friedman, C. (2014). Infection Prevention and Control Programs. In P. Grota (Ed.), *APIC Text of Infection Control and Epidemiology* (4th ed). Washington DC; 2014.

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL ~~MANUAL~~

ISSUE DATE: 7/2002 **SUBJECT: Philosophy**

REVISION DATE(S): 7/02, 4/09, 05/12, 09/15, ~~4/18~~05/18

Infection Control Department Approval:	~~04/15~~05/18
Infection Control Committee Approval:	~~07/15~~07/18
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~08/15~~08/18
Administration Approval:	09/18
Professional Affairs Committee Approval:	~~09/15~~ n/a
Board of Directors Approval:	09/15

A. **MISSION:**

1. The Infection Prevention and Control Department has been established to address compliance with local, state, and federal regulations as well as standards set by accrediting agencies. The department is committed to reducing adverse outcomes such as health care associated infections (HAIs), improving patient care by supporting the staff in all areas of the facility, minimizing occupational hazards associated with the delivery of health care, and fostering scientific-based decision making
2. Prevention of HAIs is recognized as one of the most important priorities at Tri-City Healthcare District (TCHD) and The Centers of Disease Control and Prevention (CDC) estimates that in 2011, there were approximately 722, 0000 HAIs in Acute Care hospitals and about 75,000 hospital patients with HAIs died during their hospital stay. Hospital-acquired infections (HAIs) are estimated to cost $4.5 to $5.7 billion per year to treat and approximately 1/3 of HAIs could be prevented. Prevention of infection requires an integrated, responsive process involving collaborative efforts throughout the hospital. This includes the identification of risk as well as efforts directed toward risk-reduction for patients, staff, visitors, students and others in the facility.
3. Scope of Service – The Infection Control (IC) Program provides a district wide framework, using a coordinated process of sound epidemiological principles, to reduce disease transmission. Activities are consistent with principles of Continuous Quality Improvement and include a multidisciplinary, participative approach to quality care.
   a. The Medical Director of Infection Prevention and Control is the designated infection control officer who, in cooperation with the hospital infection control committee, shall ensure implementation of the Infection Control Program. ~~This includes oversight and coordination of the development, testing, and implementation of NPSG.7.~~
   b. Qualified staff with education and/or credentials that document knowledge and expertise in Infection Control manage the department.
   c. The Infection Prevention and Control Services utilizes experts and resources such as:
      i. The Occupational Safety and Health Administration (OSHA) and other pertinent federal, state, and local regulations.
      ii. Standards set by the Joint Commission (TJC) for the accreditation of Health Care Organizations
      iii. Guidelines, position statements, recommendations and studies published by recognized experts, such as, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Prevention and Control (CDC), and the California Healthcare Association (CHA).

d. In consultation with the Medical Staff and the Infection Control Committee, the Infection Preventionists (IP) shall implement a systematic process for monitoring and evaluating the quality and effectiveness of the infection prevention and control program. Results shall be forwarded to appropriate parties to exchange findings and/or for action.

4. Department Goals
   a. The department strives to improve the quality of health care and the work environment by enhancing infection prevention and control activities within the district. The IP participates in Council and Committee meetings as the infection prevention and control expert. Examples of actions include:
      i. Recognize and maintain awareness of requirements, guidelines and recommendations that affect infection prevention and control and disseminate the information.
      ii. Provide documentation related to compliance with federal, state, and local regulatory and accrediting agencies.
      iii. Evaluate risks and other adverse events that are present with HAIs and make recommendations for reduction that are fair, scientifically sound, and recognize resource limitations.
      iv. Provide sound information to those seeking advice on how to decrease the risk of disease and microorganism transmission.
      v. Review and revise clinical practice policies and procedures related to infection prevention and control.
      vi. Provide assistance and participate in staff education to facilitate the creation of an environment of consistent, optimal patient care practices.
         1) Annually evaluate and update the new employee orientation and the reorientation programs including notes, presentation materials, and handouts as needed.
         2) Conduct department specific education for areas involved in direct patient care, as requested. Presentations are most often at staff meetings and focused physician, nursing and CNA education classes are also utilized to increase participation.
         3) When specific problems are identified, there is an educational component to problem solving that may include small group education, one-on-one efforts, or committee presentations. A variety of adult learning techniques are used to educate staff.

5. Surveillance Program
   a. Institution surveillance for infection control activities is a systematic, active, and ongoing observation. The authority for the program rests with the Infection Control Committee as defined in the Medical Staff Bylaws.
      i. A literature review reveals that specific efforts directed toward urinary tract infection, surgical wound infection, and device related infections such as ventilator associated pneumonia and intravascular line infections are strongly associated with reduced infection rates and have been considered in the development of our plan.
         1) The plan is updated and approved annually by the Infection Control Committee. Please see Infection Prevention and Control Risk Assessment and Surveillance Plan
         2) The Infection Prevention and Control Department uses the results and interpretations of the surveillance activities as a basis for modification of the surveillance plan during the course of the year if it becomes apparent that this would improve services to patients, staff, students, visitors, or others.
      ii. The CDC guidelines (National Healthcare Safety Network- NHSN) for identifying HAIs are used at TCHD to define infections in acute care (Healthcare Associated Infections Plan). TCHD Home Health uses definitions published by APIC.

iii. Outbreak Investigations are included in our plan.
1) While a number of factors might be involved in transmission including healthcare workers, equipment, and environment, the most important objective is to control further transmission.
2) Should an outbreak be suspected, control measures would be guided by the Infection Preventionist in consultation with the Infection Control Officer and instituted by the department. Collaborative actions are taken with the affected department and/or medical service.
3) Outside resources and governing agencies will be contacted if appropriate and/or required.

b. Reporting Internally/Externally: ~~see Infection Control Internal and External Reporting Table.~~
i. Results and interpretations of surveillance activities are reviewed on a regular basis and reported internally to Infection Control Committee and others as appropriate.
1) Findings, recommendations, actions, and evaluations are documented in meeting minutes..
2) Results shall be forwarded to appropriate parties to exchange findings and/or for action.
ii. External reporting of communicable diseases as required by law.
1) Diseases in the California Title 17 Code of Regulations to the local health authority.
2) Suspected or known active tuberculosis cases to San Diego County TB Control department.
3) Assist with determining infectious disease exposure of emergency response personnel (local police, ambulance and fire departments).
4) NHSN enrollment is maintained. HAIs are entered in this national database in compliance with California Department of Public Health and Centers for Medicare and Medicaid Services (CMS) requirements.

6. Employee Health Services
a. Infection Prevention and Control works closely with Employee Health on issues related to infectious diseases and district staff. Employee Health, plays an important role in the program and responsibilities include the following.
i. Writes, revises and updates Employee Health policies including restrictions for work related in infectious diseases, OSHA required reporting, and programs to decrease infectious risk
ii. Conducts initial hire screening and annual assessments and offers vaccinations.
1) Screens new employee for infectious diseases and immunity.
2) Encourages and/or offers appropriate vaccinations to employees and volunteers
3) Performs annual screening for symptoms of active tuberculosis and PPD conversions.
iii. Infection Control Department assists in notifying Employee Health of potential employee exposures based upon lab findings for pathogens requiring droplet/airborne isolation.
iv. Follows and treats employee exposures, using the latest department of health and CDC guidelines for:
1) Blood and body fluids.
2) Other infectious diseases (for example chickenpox and meningitis)
v. Reports on worker injury and illness
1) As required by federal, state and local regulations.
2) To the Environment of Care and Infection Control Committees at least quarterly and Managers and Directors as appropriate.

B. **REFERENCE LIST**

1. Centers for Disease Control and Prevention, Public Health Focus: Surveillance, Prevention, and Control of Nosocomial Infections MMWR October 23, 1992 / 41(42); 783-787.
2. Centers for Control and Prevention. (2015, January). Healthcare-associated Infections (HAIs). Retrieved from http://www.cdc.gov/HAI/surveillance/index.html
3. Pugliese G, Lamberto, B & Kroc, K. Development and Implementation of Infection Control Policies and Procedures In: Mayhall G. ed. Hospital Epidemiology and Infection Control. 2nd ed. Philadelphia: Lippincott, Williams & Wilkins; 1999:1357 - 1366.
4. Friedman, C. (2014). Infection Prevention and Control Programs. In P. Grota (Ed.), APIC Text of Infection Control and Epidemiology (4th ed). Washington DC; 2014.

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

~~1. IC Internal and External Reporting Table~~
~~2.~~1. **Infection Control Policy:**~~IC Manual~~ **Risk Assessment and** Surveillance **Plan**~~Program~~
~~3.~~2. **Infection Control Policy:**~~IC Manual~~ Epidemiologic Investigation of a Suspected Outbreak
~~4.~~3. **Infection Control Policy:**~~IC Manual~~ Healthcare Associated Infections, Defined
~~5. IC Manual Reducing Facility Acquired Infections~~
~~6. IC Manual Participation of Staff in the Infection Control Program~~

Appendix A - Internal and External Reporting

Infection / Problem	Rationale	Data Sources	Reported To
Bacteremia related to Central Lines (BSI) on all inpatient units	Associated with high mortality & morbidity.	• Positive cultures • Chart review	• Infection Control Committee • Critical Care Services • Affected Units
Ventilator Associated Events in Intensive Care settings	Associated with high mortality & morbidity.	• Ventilator Settings (PI weekly report) • Chart Review	• Infection Control Committee • Critical Care Services • Affected Units
Specific Surgical Site Infections (SSI) • HPRO & KPRO • Cardiac • Colon • All 29 Surgeries required by CDPH	Potential for high risk and repeat problems. To compare with NHSN data and identify opportunities for improvement.	• Positive cultures • Coding Reports • Chart review • RL Solutions	• Infection Control Committee • Surgical Services • Other Medical Staff and hospital committees as appropriate.
Multidrug Resistant Organisms • Methicillin Resistant *Staph. aureus* • Vancomycin resistant enterococcus • C. difficile • ESBL • MDR - other	Potential for high risk and repeat problems. Monitor effectiveness of Standard & Contact Precautions. Prevent secondary cases. Antibiotic use implications.	• Positive cultures • Chart review	• Infection Control Committee • Managers Council, Clinical Practice Committee, other Medical Staff and hospital committees as appropriate
Reportable Diseases (CMR) • Inpatients • Outpatients	Required by California Administrative Code (Title 17).	• Laboratory results • Staff reports • Requests from Public Health Services	• San Diego County Department of Public Health Serives (Health and Human Services Agency)
Severe *Staphylococcus aureus* infection in previously healthy person	Required by California Administrative Code (Title 17).	• Laboratory results • Staff reports	• San Diego County Department of Public Health Services (Health and Human Services Agency)
Tuberculosis • Inpatients • ED & Clinic patients • Outpatients • Employees • Volunteers	Monitor effectiveness of Aerosol Transmissible Disease plan (TB Exposure Control Plan). Potential for high risk and repeat problems. Required by OHSA, the Gotch Bill and California Codes.	• Laboratory results • Employee PPD screening • Reports from other facilities or public health.	• San Diego County TB Control • Infection Control Committee • Environment of Care Committee • Special Subcommittees
Outbreak Investigations	Early identification and control of clusters of infections. Potential for high risk and repeat problems.	• Positive cultures • Laboratory logs • Staff/QR reports	• Infection Control Committee • Other Medical Staff and hospital committees as appropriate. • Outside agencies as appropriate
Exposure Investigations • EH Sharps Injuries • Internal requests • External requests	Identification of HCW exposures. Early identification and treatment of contacts to communicable diseases. Potential for high risk and repeat problems. Required by OHSA and California Codes	• Employee Health • Positive cultures • Unit rounds • Assist with EMS Requests (Ryan White Act Health and Safety Code)	• Infection Control Committee • Environment of Care Committee • First Responders • San Diego County Bureau of AIDS and Communicable Diseases

nual Reviews • OSHA TB, ATD, & BBP Exposure Control Plans • Surveillance Program and Risk Assessment • QI Projects • MDRO Risk Assessments	Compliance with state and federal OSHA standards. Assist with hospital initiatives and goals. Active participation of Infection Control at all levels of the organization.	• National and state regulations • Recognized experts in the field of IC (APIC, CDC, and JCAHO) • Identified areas for improvements	• Interdisciplinary Education Council, Infection Control and EOC Committees • Quality Assurance Committee, Managers Council, Patient Care Coordinating Council, Clinical Practice Council, Professional Practice and Research Council, Interdisciplinary Education Council, Infection Control Committee and special work groups or taskforces, as requested

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: ~~2~~001	**SUBJECT:** Audit Criteria for Blood Utilization Review (BUR)
REVISION DATE(S): 05/08, 09/12	**POLICY NUMBER:** 8710 – 540

Medical Staff Department Approval:	12/17
Blood Utilization Review Committee Approval:	07/18
Medical Executive Committee Approval:	~~09/12~~08/18
Administration Approval:	09/18
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	09/12

A. **AUDIT CRITERIA FOR RED BLOOD CELL (RBC)TRANSFUSIONS:**

1. **Red blood cell** (RBC) transfusions are given to improve oxygen delivery.
2. Only transfuse in presence of compelling clinical indication in individual patients. Symptomatic anemia in a normovolemia patient, regardless of hemoglobin concentration may be indicated.
3. From the American Society of Anesthesiologist Task Force on blood Component Therapy the following recommendations are adopted:
   a. Hemoglobin greater than or equal to 10-g/dL transfusion is rarely indicated.
   b. Hemoglobin 6-~~8~~10 g/dL indications for transfusion should be based on the patient's risk of inadequate oxygenation from ongoing bleeding and/or high-risk factors.
   c. Hemoglobin less than 6 g/dL transfusion is almost always indicated.
   d. Preoperative Transfusion: aim should be to identify and correct anemia with non-transfusion methods.
   e. Patients with asymptomatic anemia and hemoglobin less than or equal to ~~8~~7 g/dL may need to be transfused if scheduled surgery is expected to produce significant blood loss (with or without cell saver use). The risks associated with general anesthesia are high.
4. In most healthy patients, oxygen delivery is thought be adequate even at hemoglobin of 7-8 g/dL
   a. Chronic anemia: cause of anemia should be established. See 2 above.
   b. RBC transfusion is contraindicated if specific replacement therapy is possible (e.g., iron, vitamin B12, folic acid). Transfuse only in case of emergency surgery, acute blood loss or trauma.
   c. RBC transfusion may be indicated in anemia secondary to aplasia or bone marrow suppression. In patients with no symptoms of anemia and no high risk factors, hemoglobin of 6-7 g/dL may be sufficient.
   d. Evidence of cardiovascular, pulmonary or cerebrovascular disease may need to be transfused with hemoglobin greater than or equal to 7 g/dL.
   e. Special situations such as severe Thalassemia or other Congenital Anemias: ~~The~~ **the** aim of transfusion in these cases is to prevent symptoms and suppress endogenous Erythropoiesis by maintaining hemoglobin at a minimum of **10**~~9~~–~~11~~ g/dL
   f. Sickle Cell Disease: Patients with a history of or at high risk for stroke or other severe complications who are not **on** a chronic transfusion protocol or who require acute RBC exchange, may be transfused to reduce Hb S to below 30-50%.
5. Acute Blood Loss (ABL): blood volume loss of 15-30% should be treated with crystalloids colloids, not RBC in young, healthy patients.
   a. ABL 30-40% blood volume loss requires rapid volume replacement and RBC transfusion is probably necessary.

b. ABL greater than 40% is life threatening and volume replacement including RBC transfusion is required.

6. Burn patients: depending on clinical symptoms transfusion trigger should be 6-~~8~~10 g/dL. At **Tri-City Healthcare District** (TCM~~C~~HD) these patients have probably been transferred post-burn unit confinement.

~~6.~~7. **All RBC transfused at TCM~~C~~HD are leukoreduced.**

B. PLATELETS:

1. Platelet count less than 10,000/uL in a non-bleeding patient with failure of platelet production.
   ~~1.~~a. **Note: all platelets given at TCMC are leukoreduced platelet pheresis products each containing greater than or equal to 3.0 x 10^{11} platelets.**
2. Platelet count less than 50,000/uL and impending surgery or invasive procedure or in a patient experiencing hemorrhage.
3. Diffuse micro-vascular bleeding following cardiopulmonary bypass or during use of an intra-aortic balloon pump with no significantly abnormal coagulation parameters.
4. Diffuse micro-vascular bleeding in a patient with massive blood loss (one blood volume) in whom platelet counts are not yet available.
5. Bleeding associated with a qualitative platelet defect, regardless of platelet count.
6. Comment: A platelet count should be obtained before and ~~10~~60 minutes after transfusion **to evaluate refractory status.**

C. FRESH FROZEN PLASMA:

1. **Plasma is administered to correct bleeding due to single or, much more commonly, multiple coagulation factor abnormalities when specific therapy is unavailable.**

~~C.~~2. **Standard audit criteria for plasma transfusion may include but are not limited to the following:**

   ~~1.~~a. PT or PTT greater than 1.5 times the mean reference range in a non-bleeding patient scheduled for or undergoing surgery or invasive procedure.
   ~~2.~~b. Diffuse micro-vascular bleeding in a patient transfused more than one blood volume and coagulation test results not yet available.
   ~~3.~~c. Microangiopathic hemolytic anemia (e.g., TTP) being treated with plasma exchange.
   ~~4.~~d. Emergency reversal of Coumadin effect.
   ~~5.~~e. Specific coagulation factor deficiency when appropriate concentrates are not available (e.g. Antithrombin III).
   ~~6.~~f. Comment: PT and PTT should be obtained pre and post transfusion to determine the need for and the effect of transfusion.

D. CRYOPRECIPITATED ANTIHEMOPHELIC FACTOR (CRYOPRECIPITALE):

1. **Cryoprecipitate is administered for prevention or treatment of bleeding due to hypofibrinogenemia, dysfibinogenemia, Von Willebrand Disease (in some circumstances) and very rarely Factor VIII and IX deficiency.**

~~D.~~2. **Standard audit criteria for cryoprecipitate transfusion may include but are not limited to the following:**

   ~~1.~~a. Fibrinogen less than 80 to 100 mg/dL.
   ~~2.~~b. Diffuse micro-vascular bleeding and fibrinogen less than 100 to 120 mg/dL.
   ~~3.~~c. Von Willebrand Disease unresponsive to DDAVP and no appropriate concentrates available.
   ~~4.~~d. Hemophilia A with no appropriate factor concentrates available.
   ~~5.~~e. Uremic bleeding if DDAVP is ineffective
   ~~6.~~f. Factor XIII deficiency

E. WHOLE BLOOD:

1. Whole blood is generally not available at any time except for autologous units.

F. **GRANULOCYTES:**

1. Neutrophil count less than 500/uL in patients with life-threatening infection who have recoverable marrow hypoplasia.
2. Severe neutrophil dysfunction (e.g.; chronic granulomatous disease).

G. **IRRADIATED BLOOD COMPONENTS:**

1. **Cellular blood components are irradiated to reduce the risk of graft versus host disease (GVHD) in individuals with severely suppressed immune system.**

~~G.~~**2. Patients with the following conditions and some others on a case-by-case evaluation should receive washed blood components.**

~~1. Intrauterine transfusions~~
~~2.~~**a.** Congenital immunodeficiencies
~~3.~~**b.** Progenitor cell transplantation, either allogeneic or autologous
~~4.~~**c.** Patients receiving HLA-matched cellular components
~~5.~~**d.** Patients receiving directed donor units (directed units are automatically radiated at collection site)
~~6.~~**e.** Patients with Hodgkin's Disease
~~7.~~**f.** Less well established indications
~~a.~~**g.** Marrow-toxic chemotherapy/radiation
h. Solid organ and hematologic malignancies
~~b.~~**i. Outside Facility Protocols that require participants to have irradiated blood components, when notified by the physician.**

~~H.~~ **WASHED BLOOD COMPONENTS:**

1. **Washing blood components removes the suspending plasma or the cryo-protectant from frozen cellular products. These products should be given when exposure to donor plasma can be dangerous to the recipient.**

~~H.~~**2. Patients with the following conditions and some others on a case-by-case evaluation should receive washed blood components.**

~~1.~~**a.** History of anaphylactic reaction to blood components
~~2.~~**b.** IGA deficiency with documented IGA antibodies.
~~3.~~**c.** Severe allergic reactions not made tolerable by pre-medication.
~~4.~~**d.** Recurrent febrile reactions not prevented by leukocyte reduction and premedication.
~~5.~~**e.** Comment: Plasma volume reduction without washing can sometimes be effective in cases 3 and 4.

I. **FROZEN RED CELLS (DEGLYCEROLIZED):**

1. Rare blood types
2. Antibodies to high incidence antigens
3. Multiple and complex antibody patterns

J. ~~**HLA-MATCHED AND CROSS MATCHED AND/OR HLA MATCHED PLATELETS:**~~

1. Patients demonstrating documented immune refractoriness to platelet transfusion **may require crossmatched or HLA-matched platelets to ensure increased numbers and functionality of transfused platelets (same criteria as above B).**
   - **a. Platelet Crossmatch compatibility is first line to find out if antibody (HLA or platelet antibodies) are causing refractoriness.**
   - **b. If there is a documented refractoriness due to a. then determination of the type of antibody interfering is done.**
   - **c. Depending on the outcome of b. Platelets will be obtained from supplier to best meet conditions within the given donor population.**
   - ~~1.~~**d. Sometimes a biologic increment is seen with random donors. In these cases the donors may be recalled to provide platelets for the identified patient.**
2. Criteria for refractoriness

a. Poor **1-hour**-post-transfusion increase in platelet count **(less than 50K increase)** or poor calculated platelet increment on at least two occasions in the absence of:
   i. Sepsis
   ii. DIC
   iii. ITP
   iv. TTP
   v. Splenomegaly
   vi. Active bleeding
   vii. Other conditions of accelerated platelet destruction

K. CYTOMEGALOVIRUS (CMV) RISK REDUCTION:

1. Methods:
   - **a. Leukoreduction: RBC and platelets provided by TC~~MC~~HD are leukoreduced. These products are considered to be CMV negative equivalent per current standards of practice.**
   - **~~a.~~b.** CMV seronegative blood donors
   - **~~b.~~c.** ~~Leukoreduction~~
2. Consider CMV – reduced Risk units in the following situations:
   - a. CMV seronegative recipients of allogeneic progenitor cell transplants
   - ~~b. Intrauterine transfusions~~
   - **~~c.~~b.** CMV-seronegative pregnant women
   - **c.** ~~Low birth weight infants (less than 1200g)~~**All routine neonatal transfusions including exchange transfusion**
     - **~~d.~~i. All neonatal RBC and platelets are CMV seronegative**
   - ~~e. Exchange transfusions in newborn~~
   - **~~f.~~d.** Congenital immunodeficiencies
   - **~~g.~~e.** CMV-seronegative patients with HIV infection
   - **~~h.~~f.** CMV-seronegative recipient of a solid organ transplant from a seronegative donor
   - **~~i.~~g.** CMV-seronegative patients undergoing chemotherapy that results in severe neutropenia

L. REFERENCE(S):

1. ~~Guidelines for Blood Utilization Review American Association of Blood Banks Technical Manual, Seventeenth Ed., 2011 (current edition)~~**Standards for Blood Banks and Transfusion Services, Current Ed., 31st – 2018. AABB Bethesda, MD 20814-3304**
2. **Technical Manual, Current Ed., 19th – 2017. AABB Bethesda, MD 20814-3304**
3. ~~**M.** American Society of Anesthesiologist Task Force on Blood Component Therapy~~**Practice Guidelines for Perioperative Blood Management. the American Society of Anesthesiologists, Inc. Wolters Kluwer Health, Inc. All Rights Reserved. Anesthesiology 2015; 122:241–00**

~~**Approvals:**~~
~~**Blood Utilization Review Committee: 09/12**~~
~~**Medical Executive Committee Approval: 09/12**~~
~~**Board of Directors Approval: 05/08; 09/12**~~

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

ISSUE DATE:	**NEW**	**SUBJECT:**	**Local Anesthesia In ~~Or~~Operating Room**

REVISION DATE(S):

Surgical Services Department Approval:	**~~12/15~~01/18**
Department of Anesthesiology Approval:	**03/18**
Operating Room Committee Approval:	**07/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**08/18**
Administration Approval:	**09/18**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**
1. To define the patient selection criteria and monitoring requirements for patients receiving local anesthesia without sedation in the Operating Room (OR).

B. **DEFINITIONS:**
1. Local anesthesia: the administration of a local anesthetic agent to one part of the body by local infiltration or topical application, usually administered by the surgeon.
2. ASA Physical Status Classification: American Society of Anesthesiologists Patient Physical Status Profile, classifying patients as:
   a. ASA I: Normal, healthy patient.
   b. ASA II: Patient with mild systemic disease.
   c. ASA III: Patient with severe systemic disease.
   d. ASA IV: Patient with a severe systemic disease that is a constant threat to life.
   e. ASA V: Moribund patient not expected to survive without the operation.
   f. ASA VI: A declared brain-dead patient whose organs are being removed for donor purposes.
3. Local anesthetic systemic toxicity (LAST): An uncommon, potentially fatal, toxic reaction that occurs when the threshold blood levels of a local anesthetic are exceeded by an inadvertent, intravascular injection or slow systemic absorption of a large, extravascular volume of local anesthetic. Symptoms of toxicity include, but are not limited to:
   a. Metallic taste
   b. Tinnitus
   c. Syncope
   d. Visual disturbances
   e. Numbness of tongue and lips
   f. Confusion
   g. Tremors
   h. Shivering
   i. Generalized seizures
   j. Initial tachycardia/hypertension
   k. Bradycardia/hypotension with increased toxicity
   l. Respiratory arrest
   m. Ventricular arrhythmias/cardiac arrest

C. **POLICY:**

1. Patients receiving local anesthesia in the OR are monitored by the Perioperative Registered Nurse (RN).
   a. Patients requiring sedation in addition to local anesthesia are not eligible for nurse monitored care.
2. Patient selection criteria for local anesthesia:
   a. ASA I or II.
   b. Patient must be NPO prior to procedure time for:
      i. **Two (2)**~~Three (3)~~ hours after clear liquids
      ii. Eight (8) hours after solids
   c. Patients must have a functioning IV.
3. Case selection for local anesthesia:
   a. Minor procedures less than 60 minutes in duration.
   b. The patient's cooperation is necessary for the procedure.
4. Cases performed under local anesthesia with nurse monitored care shall have "under local anesthesia" included on the consent form.
5. Staffing requirements:
   a. The RN monitoring the patient receiving local anesthesia shall have no other duties or responsibilities during the case.
   b. RN's shall have documented competency on monitoring patients receiving local anesthesia and signs and symptoms of local anesthetic systemic toxicity.
6. The RN shall monitor/assess the patient continuously during the procedure and document every five (5) minutes or more often if significant changes in the patient's condition occurs during the procedure:
   a. Blood Pressure
   b. Heart Rate
   c. Respiratory Rate
   d. O_2 saturation
   e. Level of sedation for adults using the RASS Scale:

4	Combative	Overly combative or violent, immediate danger to staff
3	Very Agitated	Pulls on or removes tubes or catheters or has aggressive behavior toward staff
2	Agitated	Frequent non-purposeful movement or patient-ventilator dyssynchrony
1	Restless	Anxious or apprehensive but movements not aggressive or vigorous
0	Alert and Calm	
-1	Drowsy	Not fully alert, but has sustained, more than 10 seconds, awakening with eye contact to voice
-2	Light Sedation	Briefly, less than 10 seconds, awakening with eye contact to voice
-3	Moderate Sedation	Any movement, but no eye contact to voice
-4	Deep Sedation	No response to voice, but any movement to physical stimulation
-5	Unresponsive	No response to voice or physical stimulation

   f. Pain level
7. Document on the Sedation Flow Sheet.
8. Supplemental oxygen, suction apparatus, and emergency crash cart shall be readily available for use.
9. Monitor the patient for the desired response and adverse reactions to local anesthetic medications. Toxicity may occur if large amounts of anesthetics are absorbed rapidly.
10. Medications shall be dispensed under the physician's order.
11. Post-procedure:

a. Inpatients receiving local only anesthesia for surgery will be returned to their room upon completion of their procedure, unless there is a physician order for PACU recovery/observation.
b. Same Day Surgery (outpatients) will be transferred to PACU post-procedure for discharge.

12. The circulating RN shall provide hand-off report to the post-procedure RN, including procedure performed, medications administered, IV's in place, and how the patient tolerated the procedure.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

ISSUE DATE: 06/15

SUBJECT: Surgical Supply Stocking, Rotation and Outdate

REVISION DATE(S): ~~01/18~~

Surgical Services Department Approval:	**01/18**
Department of Anesthesiology Approval:	**n/a**
Operating Room Committee Approval:	**07/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**09/18**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**
1. To ensure rotation of sterile supplies so items with the earliest expiration date are used first.
2. To remove items from stock before the expiration date is reached.

B. **POLICY:**
1. All supplies located in the Surgery department shall be checked monthly for package integrity and expiration date.
   a. Materials Management is responsible for checking outdates on all supplies located in Pyxis machines, including Tissue Pyxis.
   b. **Operating Room (OR)** staff is responsible for checking outdates on items stored in the Surgery department outside Pyxis machines.
   c. OR staff is responsible for checking outdates on all medications stored outside of Medication Pyxis machines.
2. Sterile packages are to be arranged to allow stock rotation on a first in, first out system.
   a. New Items shall be placed in the back, left hand side of the shelf.
   b. Rotate supplies such that items to expire first will be located in the front, right hand side of the shelf.
3. All outdates are to be completed by the last day of each month.
4. Remove items that will expire in the following month.
5. Expired items are to be returned to Materials Management department.
6. Document completion of outdates in the Surgery Outdate Log.
7. Items are to be checked for package integrity and expiration date before being used.
   a. If there is no day listed in the expiration date, the item expires the last day of the month (eg, expiration date 7-2015, the item expires 7-31-2015).

~~a.~~**8. Expired items will be reviewed for usage and necessity before reordering. Items which are no longer used or necessary will be removed from inventory.**

C. **FORM(S):**
1. **Operating Room** Outdate Log

Operating Room Outdate Log

Store Room 1 /Supply Room

Outdates Checklist

Month:_____

	Date Checked:	Print Name/Initials:
Covidien Staples		
Endovascular Unicell		
ENT traveling Bronch		
ENT Unicell		
Ethicon Staples		
Hand Cart		
Laparoscopic Unicell		
Thoracic Unicell		
Vascular Unicell		
Vnus Cart		
GYN Supply Rack		
GYN Laparoscopic Unicell		
Endo ERCP Cart		
Wound VAC Cart		
Glass Cab A,B,C		
Glass Cab D,E		
Pyxis Door 1-4		
Pyxis Door 5-8		

Store Room 2 /Robot Supply

Outdates Checklist:

Month: _____

	Date Checked:	Printed Name/Initials:
Eye Cabinets		

Case Cart/Equipment Room

Outdates Checklist:

Month: _____

Berkeley D&C Suction		
GYN Novasure		
Hysteroscopy/Myosure		
Nervana X2		
Neuro Power #1		
Neuro Power #2		
Peak		
Stryker Core #1		
Stryker Core #2		
Tori Cart(s)		
Sonopet		
Malis		
Laser Cart		

Central Core / Misc

Outdates Checklist:

Month: _____

Arthroscopy shaver bins		
Troch Nail Cart		
Ortho Cabinets		
Heart cabinets		
Shoulder Scope Cart		
Neuro between Rm3-Rm4		
Neuro Cabinets		
Specimen Room: Blood Tubes		

OR ROOM OUTDATES

Month: _____

OR	Date Checked:	Printed Name/Initials
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

**Includes wall suture, prep carts, anesthesia prep, anesthesia stocks

Practice Change Evaluation: Conversion from gadoversetamide (Optimark®) to gadobutrol (Gadavist®)

Requestor: Tori Hong, PharmD, Gloria Cheng, PharmD

Declared conflicts of interest: None

Situation: Optimark will be removed from the market in September 2018.

Background: Optimark (gadoversetamide) and Gadavist (gadobutrol) are both gadolinium-based contrast agents used for magnetic resonance imaging (MRI).

Assessment:

- Optimark® was deleted from the formulary through P&T Committee in September 2016 but has remained in use.
- Gadavist® was approved as a formulary addition through P&T Committee in September 2016.
- Radiologists have selected Gadavist® as their agent of choice.

Recommendation(s):

- The Pharmacy Service recommends full conversion to Gadavist® once remaining Optimark® supply is depleted.

Nitroglycerin 0.4mg Spray: Review of formulary removal

Requestor: David Spiegel, MD

Declared conflicts of interest: None

Situation: Due to increased cost and availability of sublingual nitroglycerin 0.4mg tablet as the formulary alternative, nitroglycerin spray was removed from the formulary in January 2018. There is now a request to add nitroglycerin spray back to the formulary.

Background: Nitroglycerin spray is no longer a formulary item, but was previous stocked in STEMI kits, ED, and cath lab.

Assessment:

- Nitroglycerin when administered as a spray has no documented clinical advantage when compared to the sublingual tablet.
- Pharmacokinetics are similar in terms of onset of action, duration of action, volume of distribution, metabolism and elimination. The only difference is that the peak effect of the sublingual tablet is approximately 5 minutes, whereas the translingual spray is 4 to 15 minutes.
- The use of sublingual tablets is the gold standard in ambulatory and emergency settings. It is often the only formulation carried by most hospitals.
- Nitroglycerin spray costs approximately $100 per bottle, whereas sublingual nitroglycerin 0.4mg costs approximately $0.28 per tablet.
- Due to regulatory and patient safety issues, bottles cannot be shared between patients.

Recommendation(s):

- The Pharmacy Service recommends that nitroglycerin 0.4mg spray continue to remain a non-formulary item.

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

Tri-City Medical Center
Finance, Operations and [illegible]ning Committee Minutes
September 18, 2018

Members Present	Director Julie Nygaard, Director Cyril Kellett, Director Leigh Anne Grass, Dr. Marcus Contardo, Dr. Mark Yamanaka, Dr. Jeffrey Ferber, Wayne Lingenfelter, Jack Cumming
Non-Voting Members Present:	Steve Dietlin, CEO, Ray Rivas, CFO, Scott Livingstone, COO, Sharon Schultz, CNE, Carlos Cruz, CCO, Susan Bond, General Counsel
Others:	Director Jim Dagostino, Jeremy Raimo, Jane Dunmeyer, Cristina Barrera, Kelly Mourning, Glen Newhart, Maria Carapia, Eve England, Sherry Miller, Barbara Hainsworth
Members Absent:	Dr. Gene Ma

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Nygaard called the meeting to order at 12:32 pm.		
2. Approval of Agenda	Before the vote, Director Nygaard announced that the following items are being pulled from the agenda, as they are not ready to move forward at this time: • 7.e. Physician Recruitment Proposal – General Surgery-Eleazar Lawson, M.D. • 7.h. Medical Directorship Agreement for Employee Health Services Department-Jeffrey M. Ferber M.D. She also mentioned that a correction is necessary to the following write-up: • 7.a. Physician Agreement for Cardiovascular Health Institute – Quality Committee-Dr. Ashish Kabra.	**MOTION** **It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved to accept the agenda of September 18, 2018 with the modifications as outlined by Director Nygaard.** **Members:** **AYES: Nygaard, Kellett, Grass, Contardo, Yamanaka, Ferber, Lingenfelter, Cumming** **NOES: None** **ABSTAIN: None** **ABSENT: Ma**	

Topic	Discussions, Conclusic Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
	The write-up reflects 20 hours per year. This number should be corrected to be 18 hours per year.	**Barbara Hainsworth to edit write-up 7.a. to reflect the quantity change in the annual hours.**	
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Nygaard read the paragraph regarding comments from members of the public.		Director Nygaard
4. Ratification of minutes of August 21, 2018	Minutes were ratified.	Minutes were ratified. **MOTION** **It was moved by Mr. Lingenfelter, Dr. Ferber seconded, that the minutes of August 21, 2018 are unanimously approved with Directors Kellett and Grass, abstaining from the vote.**	
5. Old Business	None		
6. New Business	None		
7. Consideration of Consent Calendar:	Mr. Lingenfelter requested that the following items be pulled for discussion: • 7.f. Comprehensive Coverage / Directorship Agreement for ARU, Stroke, Neurology, Epilepsy, ARU (mid-level) • 7.g. Physician Agreement for ED On-Call Coverage – OB/GYN Director Grass requested that the following item be pulled for discussion: • 7.b. Campus Medical Office Building Traffic Improvements – Budget Closeout	**MOTION** **It was moved by Dr. Contardo to approve the Consent Calendar, Mr. Cumming seconded.** **Members:** **AYES: Nygaard, Kellett, Grass, Contardo, Ma, Yamanaka, Lingenfelter, Cumming** **NOES: None** **ABSTAIN:** **ABSENT: Ma**	Chair
a. Physician Agreement for Cardiovascular Health Institute – Quality Committee • Dr. Ashish Kabra		**Approved via Consent Calendar**	Eva England

Topic	Discussions, Conclusio Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
b. Campus Medical Office Building Traffic Improvements – Budget Closeout • Dick Miller, Inc. (DMI)	Director Grass questioned the source of the additional "change order" costs. Scott Livingstone conveyed that much of the additional expenses had been absorbed by the vendor. He explained that when a change order exceeds a 5% overage, it is District policy that any requests for additional funds, be approved by the Board of Directors.	**MOTION** **It was moved by Director Grass, seconded by Director Kellett to authorize the a Change Order to Dick Miller, Inc. for $96,634 for additional traffic control costs due to unfore-seen storm drain relocation delays and the additional project budget of $64,000, to cover the change order costs.** **Members:** **AYES: Nygaard, Kellett, Grass, Contardo, Yamanaka, Ferber, Lingenfelter, Cumming** **NOES: None** **ABSTAIN: None** **ABSENT: Ma**	Chris Miechowski
c. Physician Agreement for Antibiotic Stewardship Chair • Dr. Richard Smith		**Approved via Consent Calendar**	Sherry Miller / Scott Livingstone
d. Medical Directorship Agreement for Plastic Surgery – Consultative & Procedural Services • Geehan D'Souza, M.D.		**Approved via Consent Calendar**	Susan Hadley / Sharon Schultz
e. Physician Recruitment Proposal • Eleazar Lawson, M.D.		PULLED	
f. Comprehensive Coverage / Directorship Agreement for ARU, Stroke, Neurology, Epilepsy, ARU (Mid-Level)	Mr. Lingenfelter inquired about the number of agreements included within this one write-up. Jeremy Raimo explained that they had previously been submitted as separate	**MOTION** **It was moved by Mr. Lingenfelter, seconded by Director Kellett to authorize the agreement with The Neurology Center to provide**	

Topic	Discussions, Conclusio Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
• The Neurology Center	agreements, however, with physicians associated with the same medical group. They were simply consolidated into a single agreement, under The Neurology Center, as a physicians' group practice.	**comprehensive coverage/directorship for ARU, Stroke, Neurology, Epilepsy, ARU (mid-level) for a term of 12 months beginning October 1, 2018 and ending September 30, 2019, for a total cost for the term of $561,130.** **Members:** **AYES: Nygaard, Kellett, Grass, Contardo, Yamanaka, Ferber, Lingenfelter, Cumming** **NOES: None** **ABSTAIN: None** **ABSENT: Ma**	
g. Physician Agreement for ED On-Call Coverage – OB/GYN • Tina Dhillon-Ashley, M.D. • Marlene Pountney-Levesque, M.D.	Mr. Lingenfelter inquired about the response time for and on-call OB/GYN physician. Scott Livingstone conveyed that the TCMC by-laws reflect a response time of 30 minutes. The majority of on call OB/GYN physicians spend the night on-site in the physician's sleeping quarters.	**MOTION** **It was moved by Mr. Lingenfelter, seconded by Director Kellett to add Drs. Tina Dhillon-Ashley and Marlene Pountney-Levesque to the currently existing ED On-Call Coverage Panel for OB/GYN for a term of 21 months, beginning October 1, 2018 and ending June 30, 2020.** **Members:** **AYES: Nygaard, Kellett, Grass, Contardo, Yamanaka, Ferber, Lingenfelter, Cumming** **NOES: None** **ABSTAIN: None** **ABSENT: Ma**	
h. Medical Directorship Agreement for Employee Health Services Department • Jeffrey M. Ferber, M.D.		PULLED	

Topic	Discussions, Conclusio Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
8. Financials:	Ray Rivas presented the financials ending August 31, 2018 (dollars in thousands) **TCHD – Financial Summary Fiscal Year to Date** Operating Revenue $ 59,759 Operating Expense $ 61,354 EBITDA $ 1,963 EROE $ (598) **TCMC – Key Indicators Fiscal Year to Date** Avg. Daily Census 158 Adjusted Patient Days 17,744 Surgery Cases 1,119 Deliveries 388 ED Visits 9,813 **TCHD – Financial Summary Current Month** Operating Revenue $ 30,614 Operating Expense $ 31,229 EBITDA $ 1,168 EROE $ (121) **TCMC – Key Indicators Current Month** Avg. Daily Census 156 Adjusted Patient Days 8,868 Surgery Cases 599 Deliveries 202 ED Visits 4,838 **TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year** Net Patient A/R Avg. (in millions) $ 42.8 Days in Net A/R Avg. 44.0 **Graphs:** • TCMC-Net Days in Patient Accounts Receivable		Ray Rivas

Topic	Discussions, Conclusio Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
	• TCMC-Average Daily Census, Total Hospital-Excluding Newborns • TCMC-Acute Average Length of Stay		
9. Work Plan:			
a. Wellness Center *(bi-monthly)*	Scott Livingstone gave a brief overview of the PowerPoint Presentation for the Wellness Center, which had been included in the packet. <u>Membership:</u> • Growth-Increase of 17%, between August 2017 – June 2018 <u>Medically Integrated Program:</u> • FY2018: 74 Members • FYTD2019 (August): 102 Members • As of September 2018: 117 Members Brief discussion ensued.		Scott Livingstone
b. Meaningful use *(semi-annual)*	Scott Livingstone conveyed that CMS is undertaking a number of changes to the Meaningful Use program. One specific change is that the name is being changed to "Promoting Interoperability". He further conveyed that work continues to move toward simplifying the exchange of electronic health information between providers and patients. Brief discussion ensued.		Mark Albright
c. Crisis Stabilization Unit (CSU) *(bi-monthly)*	CSU Services were suspended on 8/3/18 – No Report		Sharon Schultz
d. Dashboard	No discussion		Ray Rivas
10. Comments by committee			

Topic	Discussions, Conclusic Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
members			
11. Date of next meeting	Tuesday, October 16, 2018		Chair
12. Community Openings (0)			
13. Adjournment	Meeting adjourned 1:05 p.m.		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 18, 2018
Physician Agreement for Cardiovascular Health Institute – Quality Committee

Type of Agreement		Medical Directors		Panel	X	Other: Quality Committee
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Vendor's Name: Dr. Ashish Kabra

Area of Service: Cardiovascular Health Institute – Quality Committee

Term of Agreement: 9 months, Beginning, October 1, 2018 – Ending, June 30, 2019

Maximum Totals:

Rate/Hour	Hours Per Month	Hours per Year	Monthly Cost	Annual Cost	Total Term Cost
$210	2	18	$420	$3,780	$3,780

Description of Services/Supplies:

- Physician shall serve as a Quality Committee Member and shall be responsible for the services as outlined in the previously approved Co-Management Agreement for the Institute.

Document Submitted to Legal:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Eva England, Cardiovascular Service Line Director / Scott Livingstone, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Dr. Kabra, as Cardiovascular Health Institute – Quality Committee member for a term of 9 months, beginning October 1, 2018 and ending June 30, 2019. Not to exceed 2 hours per month at an hourly rate of $210 for an annual cost of $3,780 and a total cost for the term of $3,780.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 18, 2018
Campus Medical Office Building Traffic Improvements - Budget Closeout

Type of Agreement		Medical Directors		Panel	X	Other: Budget Closeout
Status of Agreement		New Agreement		Renewal – New Rates		Renewal – Same Rates

Vendor's Name: Dick Miller, Inc. (DMI)

Area of Service: Campus Medical Office Building (MOB)

Term of Agreement: Completion of work

Maximum Totals:

Detail:	Amount:
Final Project Budget	$1,033,723
Previously Approved Budget	$969,723
Remaining Budget	$32,634
Storm Drain Change Order to DMI	$96,634
Additional Expenses Incurred	**$64,000**

Description of Services/Supplies:
Unforeseen conditions encountered by DMI (contractor) during traffic improvement work associated with the Campus MOB:

- Existing storm drain piping possessed a higher elevation than was reflected on the "as-built plans", provided by the City of Oceanside.
- Higher storm drain elevation required relocation in order to permit the right hand turn lane from College onto Vista Way.
- Storm-drain relocation required approval by Caltrans; project delayed approximately three months.
- Delay resulted in additional traffic control equipment costs.

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:		Yes	N/A	No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Chris Miechowski, Director, Facilities / Scott Livingstone, Chief Operating Officer

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Change Order to Dick Miller, Inc. for $96,634 for additional traffic control costs due to unforeseen storm drain relocation delays and the additional project budget of $64,000 to cover the change order costs.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 18, 2018
PHYSICIAN AGREEMENT for Antibiotic Stewardship Chair

Type of Agreement		Medical Directors		Panel	X	Other: Chair, Antibiotic Stewardship Program
Status of Agreement		New Agreement		Renewal – New Rates	X	Renewal – Same Rates

Physician's Name: Dr. Richard Smith

Area of Service: Hospital Oversight of Antibiotic Stewardship Program

Term of Agreement: 24 months, Beginning, October 1, 2018 – Ending, September 30, 2020

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

Hourly Rate	Hours per Year (Not to Exceed)	Annual Cost (Not to Exceed)	Total Cost (Not to Exceed)
$175	300	$52,500	$105,000

Position Responsibilities:

- Chair of Antibiotic Stewardship Program
- Supervise and provide direction on program activities
- Review antibiotic orders for appropriateness

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Tori Hong, Director, Pharmacy / Scott Livingstone, Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Richard Smith, M.D. as Chair of Antibiotic Stewardship for a term of 24 months, beginning October 1, 2018 and ending September 30, 2020, at an hourly rate of $175, not to exceed 300 hours per year, for an annual rate not to exceed $52,500 and a term cost of $105,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 18, 2018
MEDICAL DIRECTORSHIP AGREEMENT FOR PLASTIC SURGERY - CONSULTATIVE & PROCEDURAL SERVICES

Type of Agreement	X	Medical Directors		Panel	X	Other: Consulting & Procedural Services
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Physician's Name: Geehan D'Souza, M.D.

Area of Service: Hospital Inpatient, Observation and Outpatient Units

Term of Agreement: 12 months, Beginning, October 1, 2018 – Ending, September 30, 2019

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	12 month (Term) Cost
$210	18	216	$3,780	$45,360

Position Responsibilities:

- Physician to provide Plastic Surgery Services (Consultative and Procedural) for registered TCMC Hospital patients (inpatient, observation, and outpatient units)
- Provide medical direction and services for plastic, wound care and reconstructive surgery
- Recommend to the medical staff that patients receive evidence-based plastic, wound and reconstructive care
- Participate in in-service training, ulitization review, and service as a liaison for the community

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director Business Development / Scott Livingstone, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Geehan D'Souza as the Medical Director for Plastic Surgery Consultative and Procedural Services for a term of 12 months beginning October 1, 2018 and ending September 30, 2019, for a total cost for the term of $45,360.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 18, 2018
COMPREHENSIVE COVERAGE/DIRECTORSHIP AGREEMENT FOR
ARU, STROKE, NEUROLOGY, EPILEPSY, ARU (MID-LEVEL)

Type of Agreement	X	Medical Directors		Panel	X	Other: Call Coverage
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Name: The Neurology Center
Area of Service: Call coverage: (Epilepsy, ARU-Mid-level)
Medical Directorships: (ARU, Stroke, Neurology)
Term of Agreement: 12 months, Beginning, October 1, 2018 – Ending, September 30, 2019
Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	12 Month (Term) Cost
$740/day – ED Neurology Call (24 hr. rate)	N/A	N/A	$22,508	$270,100
$200 - Stroke	12	144	$2,400	$28,800
$200 - Neurology	8	96	$1,600	$19,200
$200 – Epilepsy	4	48	$800	$9,600
$165 – ARU Medical Director	80	960	$13,200	$158,400
$61 – ARU Mid-Level	102	1230	$6,252	$75,030
		TOTAL		**$561,130**

Position Responsibilities:

- The Neurology Center to provide comprehensive coverage & directorship services for all areas of service requiring clinical neurological care and oversight.

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director Business Development / Scott Livingstone, Chief Operating Officer

Motion:
Move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize an agreement with The Neurology Center to provide comprehensive coverage/directorship for ARU, Stroke, Neurology, Epilepsy, ARU (mid-level) for a term of 12 months beginning October 1, 2018 and ending September 30, 2019, for a total cost for the term of $561,130.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 18, 2018
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – OB/GYN

Type of Agreement		Medical Directors	X	Panel		Other:
Status of Agreement		New Agreement		Renewal – New Rates	X	Renewal – Same Rates

Physician's Names: Tina Dhillon-Ashley, M.D.; Marlene Pountney-Levesque, M.D.

Area of Service: Emergency Department On-Call: OB/GYN

Term of Agreement: 21 months, Beginning, October 1, 2018 – Ending, June 30, 2020

Within Hourly and/or Annualized Fair Market Value: YES

Maximum Totals: For entire Current ED On-Call Area of Service Coverage: OB-GYN
Adding physicians to existing panel, no increase in expense

Rate/Day	Annual Panel Days	Annual Panel Cost	Term Cost
Mon-Fri / $800	FY18: 253 FY20: 255	$202,400 $204,000	$406,400
Sat-Sun / TCMC Recognized Holidays: $1,000	FY18: 112 FY20: 111	$112,000 $111,000	$223,000
	Total Term Cost		**$629,400**

Position Responsibilities:

- Provide 24/7 patient coverage for all OB/GYN specialty services in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Complete related medical records in accordance with all Medical Staff, accreditation, and regulatory requirements.

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff Services / Scott Livingstone, Chief Operating Officer

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors add Drs. Tina Dhillon-Ashley and Marlene Pountney-Levesque to the currently existing ED On-Call Coverage Panel for OB/GYN for a term of 21 months, beginning October 1, 2018 and ending June 30, 2020.

Professional Affairs Committee
(No meeting held in September, 2018)

Tri-City M[illegible]ical Center
Audit, Compliance & Ethics Committee
September 20, 2018
Assembly Room 1
8:30 a.m-10:00 a. m.

Members Present:	Director Larry W. Schallock(Chair); Director James Dagostino; Director Julie Nygaard; Faith Devine, Community Member; Kathryn Leslie Schwartz, Community Member; Dr. Cary Mells, Physician Member
Non-Voting Members:	Steve Dietlin (CEO); Ray Rivas, CFO; Scott Livingstone, COO; Carlos Cruz, CCO; Susan Bond, General Counsel
Others Present:,	Stacy Stelzriede, Partner, Moss Adams; Annie Norviel, Senior Manager, Moss Adams; Anh Nguyen, Controller; Kristy Larkin, Director of Compliance, Audit & Monitoring; Maria Carapia, Compliance Manager; Teri Donnellan, Executive Assistant
Absent:	Katheryn Fitzwilliam, Community Member

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to Order	The meeting was called to order at 8:30 a.m. in Assembly Room 1 at Tri-City Medical Center by Chairman Schallock.		
2. Approval of Agenda	Chairman Schallock requested the Closed Session minutes be deferred to next month's meeting. **It was moved by Mr. Leslie Schwartz and seconded by Director Dagostino to approve the agenda as amended. The motion passed unanimously.**	**Amended Agenda approved.**	
3. Comments by members of the public and committee members on any item of interest to the public before Committee's consideration of the item	There were no public comments.		
4. Ratification of minutes – July 26, 2018	**It was moved by Director Dagostino and seconded by Mr. Leslie Schwartz to approve the minutes as presented. The motion passed unanimously.**	**Minutes ratified.**	
5. Old Business	None		

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
6. New Business A) Fiscal 2018 Financial Statement Audit Status – Moss Adams	Chairman Schallock stated Ms. Stacy Stelzriede, Engagement Reviewer and Ms. Annie Norviel are here today to present the results of the FY2018 Financial Audit. He explained the auditors will give their presentation and management will review the financials. The committee will have the opportunity to ask questions of the auditors in the absence of staff. Ms. Stelzriede stated today's presentation will include the following: ➢ Auditor Opinions and Reports ➢ Communication with Those Charged with Governance ➢ Management Representation Letter ➢ Other Information Ms. Stelzriede stated the auditors also performed the following non-attest services which included completion of the Auditee portion of the Data Collection. Ms. Stelzriede stated they will issue an unmodified opinion which reflects the Financial Statements are presented fairly and in accordance with US Generally Accepted Accounting Principles. Ms. Stelzriede stated the GAGAS Report on Internal Control over Financial Reporting and on Compliance and Other Matters reflected that there were no financial reporting findings to communicate or compliance findings to communicate. The Report on Compliance Requirements that could have a Direct and Material Effect on Each Major Federal Program an on Internal Control Compliance required by the Uniform Guidance reflected no control findings to communicate and no compliance findings to communicate.	**Recommendation to be sent to the Board of Directors to accept the FY2018 Financial Statement Audit and the Single Audit in accordance with the Uniform Guidance and Consolidated Financial Statements as presented; item to appear on Board agenda and included in agenda packet.**	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
	Ms. Stelzriede stated the auditor's responsibility is to ensure the financials are free of material misstatement however that does not relieve management of their responsibilities. Ms. Stelzriede stated the auditors believe management has selected and applied significant accounting policies appropriately and consistent with those of the prior year. Ms. Norviel reported on the areas of audit emphasis which are subject to management's judgments and accounting estimates and included the following: ➢ Patient Revenue Receivables ➢ Cost Report Settlements, including Supplemental Funding ➢ Self-Insured Liabilities ➢ Line of Credit and Long-Term Debt (HUD Financing, Covenant Compliance) ➢ Single Audit ➢ MOB Legal Proceedings Ms. Norviel provided a detailed explanation on Patient Accounts Receivable – Lookback Analysis. Mr. Dietlin explained this is the highest risk area in every hospital as we provide estimates that are as accurate as possible. Ms. Stelzriede noted it is also important when estimating that we are not being too aggressive or too conservative. Ms. Norviel commented on the following notes: ➢ Note 6 – Goodwill ➢ Note 8 – Short term Debt ➢ Note 9 – Long-term Debt ➢ Note 14 – Commitments and Contingencies ➢ Note 15- Subsequent Events Ms. Stelzriede reported there no corrected or uncorrected audit adjustments. She stated this is unusual and it is a very		

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
	clean audit. Ms. Stelzriede commented that the focus on the audit changes from year to year. Lastly, Ms. Stelzriede reviewed the Financial Ratios and Metrics that included Cash on Hand (Days), Current Ratio, Days in Accounts Receivable, Debt to Capitalization and EBITDA% of Operating Income. Ms. Stelzriede stated we are still in the "green" and that is very difficult to do these days with the squeeze on reimbursement. Mr. Ray Rivas provided a report on the financials and answered questions from committee members. Discussion was held regarding the various Federal Matching Programs such as PRIME, IGT and 340B and their impact on the financials. Mr. Rivas also commented on the fact that ED visits are down as more patients are utilizing Urgent Care Centers. *Staff left the room at 9:30 a.m. to give the Committee the opportunity to ask questions of the auditors.* *Staff returned to the meeting at 9:40 a.m.* Ms. Stelzriede reported there were no negative comments by staff. Director Dagostino questioned the financial strength of the hospital compared to other District hospitals. Ms. Stelzriede stated the District is in a good position and the margin is much better than many of their other clients. Mr. Rivas expressed his appreciation to the auditors for a smooth collaborative process. **It was moved by Mr. Leslie Schwartz to recommend the**		

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
	Board accept the FY 2018 Financial Statement Audit and the Single Audit in accordance with the Uniform Guidance and Consolidated Financial Statements. Director Nygaard seconded the motion. The motion passed unanimously. *Ms. Stelzriede and Ms. Norviel left the meeting at 9:45 a.m.*		
8. Comments from Committee Members	There were no comments from Committee Members.	None.	
9. Committee Openings		Information only.	
10. Date of Next Meeting	Chairman Schallock stated the Committee's next meeting will be held on October 18, 2018.	**The committee's next meeting is scheduled for October 18, 2018.**	
11. Adjournment	Chairman Schallock adjourned the meeting at 9:45 a.m.		

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

August 21, 2018 – 4:15 o'clock p.m.
Classroom 5 – 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 4:15 p.m. on August 21, 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
Susan Bond, General Counsel
Ed Shaffer, Board Counsel
Dr. Victor Souza, Chief of Staff
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 4:15 p.m. in Classroom 5 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

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 Mitchell to approve the agenda as presented. Director Kellett 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 August 21, 2018 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter of Potential Litigation.

6. Motion to go into Closed Session

   It was moved by Director Kellett and seconded by Director Mitchell to go into Closed Session at 4:16 p.m. The motion passed (6-1) with Director Reno voting no.

8. At 4:25 p.m. the Board returned to open session with 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. There being no further business, Chairman Dagostino adjourned the meeting at 4:25 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

August 21, 2018 – 4:30 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 4:30 p.m. on August 21, 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
Susan Bond, General Counsel
Scott Livingston, Chief Operations Officer
Sharon Schultz, Chief Nurse Executive
Ray Rivas, Chief Financial Officer
Aaron Byzak, Chief External Government Affairs Officer
Ed Schaffer, Board Counsel
Dr. Victor Souza, Chief of Staff
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 4:30 p.m. in Assembly Rooms 2&3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2. Director Nygaard led the Pledge of Allegiance.

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the Board Agenda.

4. Approval of agenda.

   It was moved by Director Mitchell to approve the agenda as presented. Director Grass seconded the motion. The motion passed unanimously (7-0).

5. Oral Announcement of Items to be discussed during Closed Session

   Chairman Dagostino made an oral announcement of the item listed on the August 21, 2018 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter of Potential Litigation.

6. Motion to go into Closed Session

It was moved by Director Grass and seconded by Mitchell to go into Closed Session at 4:40 p.m. The motion passed (6-1) with Director Reno voting no.

7. At 5:05 p.m. the Board returned to open session in Assembly Rooms 1, 2 and 3 with attendance as previously noted.

8. Report from Chairperson on any action taken in Closed Session.

Chairman Dagostino reported no action was taken in closed session.

10. New Business

a) Reconsideration of Board decision on June 26, 2018, to suspend operations of Inpatient Behavioral Health Unit and Crisis Stabilization Unit and implementing actions.

Chairman Dagostino, Mr. Steve Dietlin, CEO and Dr. Victor Souza read statements on behalf of the Board, Administration and the Medical Staff respectively.

Chairman Dagostino opened the meeting for public comments.

The Board heard comments from various members of the community, elected officials, and members of the Police force, physicians and staff. *(The names of speakers are on file for reference.)*

At the conclusion of the public comments the Board had an opportunity to comment and ask questions of staff. Following an extensive discussion, Chairman questioned in any Board member would like to entertain a motion.

It was moved by Director Nygaard to extend the date to suspend operations in the Inpatient Behavioral Health Unit to October 2nd and suspend operations of the Crisis Stabilization Unit immediately. Director Kellett seconded the motion.

Discussion continued.

Direction Kellett called for the question.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Nygaard, and Schallock**
NOES:	**Directors:**	**Reno, Mitchell**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

10. There being no further business, Chairman Dagostino adjourned the meeting at 8:30 p.m.

James J. Dagostino
Chairman

ATTEST:

Leigh Anne Grass
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS

August 30, 2018 – 1:30 o'clock p.m.
Classroom 6 – 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 August 30, 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
Dr. Victor Souza, 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 Classroom 6 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 presented. Director Schallock seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the August 30, 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 August 30, 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; Conference with Legal Counsel regarding three (3) matters of Potential Litigation and approval of Closed Session Minutes.

5. Motion to go into Closed Session

It was moved by Director Mitchell and seconded by Director Kellett 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 Cyril F. Kellett, M.D.
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

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. Victor Souza, 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 Schallock 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. Chairman Dagostino explained there is a new Speaker Form for those interested in speaking. Speakers were asked to complete the Speaker Form and retain the copy until called to speak. Chairman Dagostino reported the room configuration has been adjusted to give speakers the full Board's attention.

12. Special Presentation:

a) National Hospital Organ Donation Campaign – Platinum Recognition

Mr. Sharon Schultz, CNE reported for the second year in a row Tri-City has won a Platinum award for Organ Donation. Ms. Schultz invited our partners from Lifesharing, Crystal Bui and Alex Ritch along with Merebeth Richins, Director for ICU and Pulmonary Services to the podium.

Ms. Alex Rich stated in early 2000, the U.S. Department of Health & Human Services launched an initiative called the Workplace Partnership for Life. This was designed to promote engagement amongst hospital partners in raising donation awareness. Lifesharing is the organization that is federally designated to provide donation services to the hospitals in San Diego and Imperial Counties.

Ms. Rich stated last year hundreds of people have received the gift of life through organ donation from Tri-City. Tri-City stands out in many ways, one of which is community engagement in terms of raising awareness about organ and tissue donation. She stated there have been a number of activities from October through April where Tri-City put on awareness events to increase enrollment in state registry as organ, eye and tissue donors. Ms. Rich stated it is a hospital wide effort that makes this possible and we would not be able to do this without service engagement from our hospital partners including the staff, physicians, Critical Care Units, Medical Records, Radiology, Health Information, to name a few. Ms. Rich also expressed her appreciation to Ms. Merebeth Richins and the Tri-City Donor Committee for their support.

On behalf of the Board of Directors, Chairman Dagostino expressed his appreciation to Ms. Richins and the Tri-City Donor Committee for their commitment to organ donation.

No action taken.

13. Report from TCHD Auxiliary – Jeff Marks, First Vice President

In Ms. Gleisberg's absence, Mr. Jeff Marks, First Vice President reported the following:

- There are currently 465 active volunteers; of those 177 are college "student volunteers.
- 15 volunteers have served more than 20 years or a minimum of 10,000 hours and one volunteer has served 34 years totaling 15,000 hours.

Mr. Marks introduced Ms. Bunny McElliott, Chairman of the JV's who provided a brief overview of the Junior Volunteer's Program and the history of the program which began in the 1960's. Ms. McElliott stated there are at least 14 high schools that are being represented here by our Junior Volunteers. These Junior Volunteers participate in an intensive training session and learn about the hospitals policies and procedures, HIPAA, hand-hygiene, chain of command and emergency procedures.

Ms. McElliott invited one of our Junior Volunteers to speak on what it means to be a Junior Volunteer. The young lady commented on her experience as a Junior Volunteer and what a privilege it is to assist patients in our community. She stated we need young leaders to lead the youth as generations continue and one of the aspects of being a leader is to support loved ones who are in need, especially those that are patients in our hospital.

In closing, Ms. McElliott commented on the fact that this year 17 of our high school seniors received a scholarship. McElliott expressed her appreciation for the support for the Scholarship program and encouraged everyone to continue to support our kids.

No action taken.

14. Report from Chief Executive Officer CEO

Mr. Steve Dietlin, CEO gave a brief report. He expressed his appreciation to Mr. Jeff Marks and the entire Auxiliary team who have donated over 60,000 hours and serve over 25 departments in the hospital. He commented on the fact that the Auxiliary has donated over a million dollars in scholarships over the years which have been invested in tomorrow's healthcare leaders. In addition, the Auxiliary partners with the Foundation and the hospital on investing in the newest technology. It is a great community effort and the Auxilians are an integral part of the Tri-City team. Mr. Dietlin stated the Auxilians really make Tri-City a different place and a different experience for patients and their families.

Mr. Dietlin stated Tri-City is very busy with over 60,000 Emergency Department visits a year and over 13,000 in-patient admissions. Excellent clinical outcomes are the norm and there are thousands of people working together to provide this 24/7 care every single day to this community and we intend to provide world class healthcare services to this community for years to come.

Mr. Dietlin stated Dr. Souza, Tri-City's Chief of Medical Staff has brought the theme of gratitude forward this year and he personally thanked each and every individual who contributes to bring the highest quality healthcare to this community each and every day.

No action taken.

15. Report from Chief Financial Officer

Mr. Rivas reported since this is the first month of the Fiscal Year the current month and year-end financials are the same. He reported the following:

- Operating Revenue – $29,146
- Operating Expense – $30,126
- EBITDA- $796
- EROE – ($478)

Other Key Indicators for the current month driving those results included the following:

- Average Daily Census – 160
- Adjusted Patient Days – 8,876
- Surgery Cases – 520
- Deliveries – 186
- ED Visits – 4,975

Mr. Rivas reported on the following indicators for FY18 Average:

- Net Patient Accounts Receivable - $43.6

- Days in Net Accounts Receivable – 44.9

Director Reno questioned if surgeries are down. Mr. Rivas responded that actually surgeries are way up.

Director Reno questioned the number of day's cash on hand. Mr. Rivas responded there is approximately 60 days cash on hand.

No action was taken.

16. Report from Chief Governmental & External Affairs Officer

Ms. Aaron Byzak, Chief Government External Affairs Officer provided a brief report on the following:

- September 30th is the last day for the California Legislature to pass bills.
- Marketing, Communications, Governmental Affairs and Community Engagement plans are in the process of being finalized.
- Outreach with elected officials continues to talk about issues that are important to our Medical Center.
- Partnerships with the community are done as much as possible and we sponsor a variety of organizations throughout the year. Those sponsorships are being realigned around not only the priorities of the Medical Center but also around the Community Healthcare Needs Assessment and data
- Employee Appreciation Month was launched and yesterday handed out gift cards and meal vouches to over 800 employees. In addition there will be events throughout the month of September to show appreciation for our staff.

  Chairman Dagostino stated it appears the hospital is mimicking Dr. Souza's theme of gratitude for staff. Mr. Byzak stated Marketing and Human Resources are working hand in hand in this regard.

No action taken.

17. New Business - None

18. Old Business - None

19. Chief of Staff

a. Consideration of August Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on August 27, 2018.

It was moved by Director Mitchell that the Tri-City Healthcare Board of Directors approve the August Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on August 27, 2018. Director Nygaard seconded the motion.

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**

b. Consideration of Pediatrics Privilege Card

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors approve the Pediatrics Privilege Card as presented and recommended by the Medical Executive on August 27, 2018. Director Schallock seconded the motion.

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**

20. Consideration of Consent Calendar

It was moved by Director Schallock to approve the Consent Calendar. Director Nygaard seconded the motion.

It was moved by Director Reno to pull item 20 1) Administrative & Board Committees. Director Kellett seconded the motion.

The vote on the main motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

The vote on the main motion, minus the item pulled was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell Nygaard, Reno and Schallock**
NOES:	**Directors:**	**Reno**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

21. Discussion of items pulled from Consent Agenda

Director Reno who pulled Administrative and Board Committees questioned why the policies did not go through the Professional Affairs Committee. Ms. Donnellan explained several months ago the Board voted to hold the Professional Affairs Committee on a quarterly basis or as needed and the policies would be reviewed by an Administrative Committee comprised of C-Suite members and the polices would

then move on to the Board for approval. Chairman Dagostino explained any Board member may pull a policy for discussion. Ms. Sharon Schultz, CNE explained any policies that the C-Suite feels warrant additional review and discussion by the Professional Affairs Committee will be placed on that agenda.

It was moved by Director Reno to approve Administrative and Board Committees. Director Nygaard seconded the motion.

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**

Director Reno stated she had intended to pull an additional item from the Consent Calendar. Board Counsel stated it is up to the Board's discretion as to whether an additional item can be pulled at this point on the agenda. Board members agreed to allow Director Reno to question an additional item.

Director Reno stated the FOP minutes reflect that Director Nygaard was the only Board member in attendance however Director Schallock substituted for Board members who were unable to attend. She stated she believes it is a conflict for Director Schallock to substitute on the FOP Committee due to the fact that he sits on the Audit, Compliance & Ethics Committee. Chairman Dagostino explained Director Schallock was "in house" and available at the last minute. Director Reno stated in the future she would like to be called as a substitute.

22. Reports

Director Nygaard requested an update on the Retail Pharmacy.

Mr. Scott Livingstone, COO provided a brief update.

24. Comments by Members of the Public

Chairman Dagostino recognized the following individuals who spoke on the suspension of the Behavioral Health Inpatient Unit and Crisis Stabilization Unit: Larry Kornic, George Coulter and Jeremy Raimo.

Chairman Dagostino recognized Jim Burley who commented on the hospital's financials.

Chairman Dagostino recognized Courtney Hayes, CNA Representative who read a letter on behalf of the RNs.

25. Additional Comments by Chief Executive Officer

Mr. Dietlin had no additional comments

26. Board Communications

Reports from Board Members

Director Mitchell and Nygaard wished everyone a safe holiday weekend.

Directors Grass, Reno, Kellett and Schallock had no comments.

27. Report from Chairperson

Chairman Dagostino stated he appreciated the decorum at today's meeting

31. There being no further business Chairman Dagostino adjourned the meeting at 4:26 p.m.

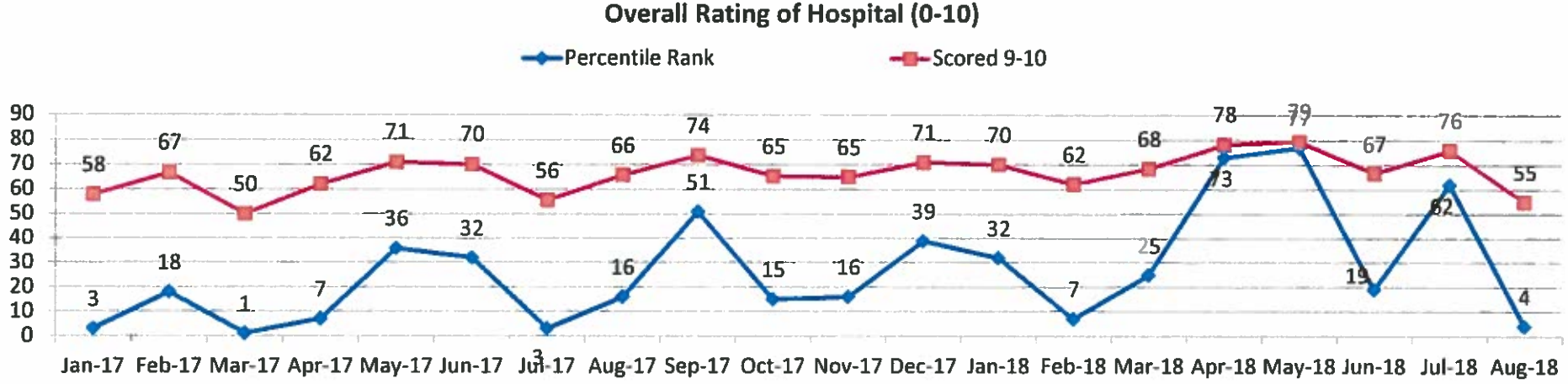
James J. Dagostino, DPT, PT
Chairman

ATTEST:

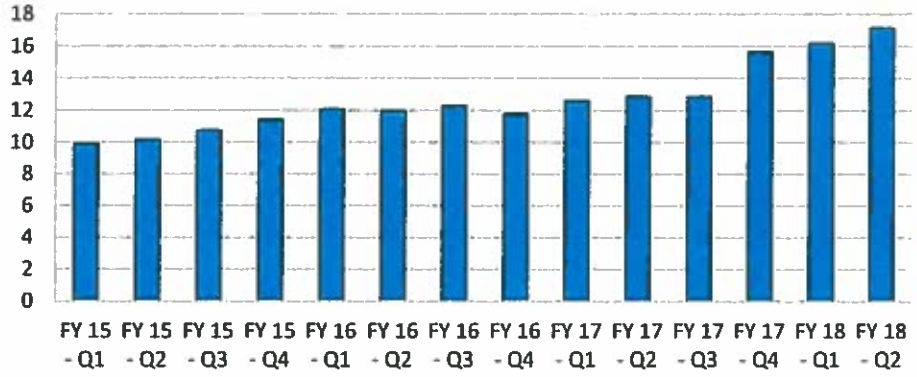
Leigh Anne Grass, Secretary

Stakeholder Experiences

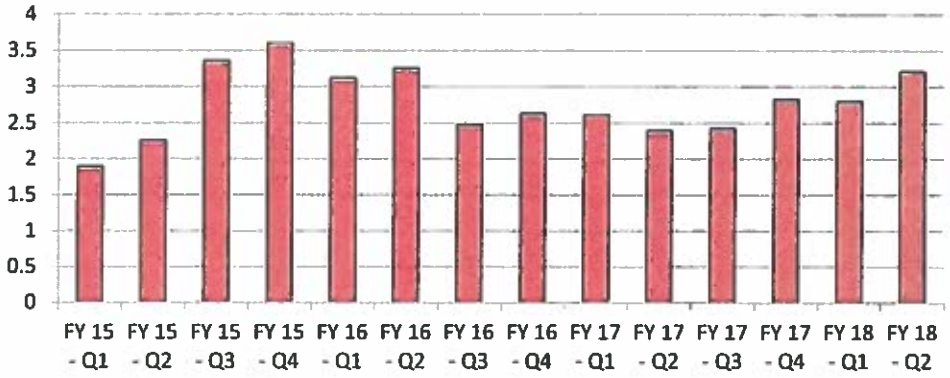
Overall Rating of Hospital (0-10)



Voluntary Employee Turnover Rate

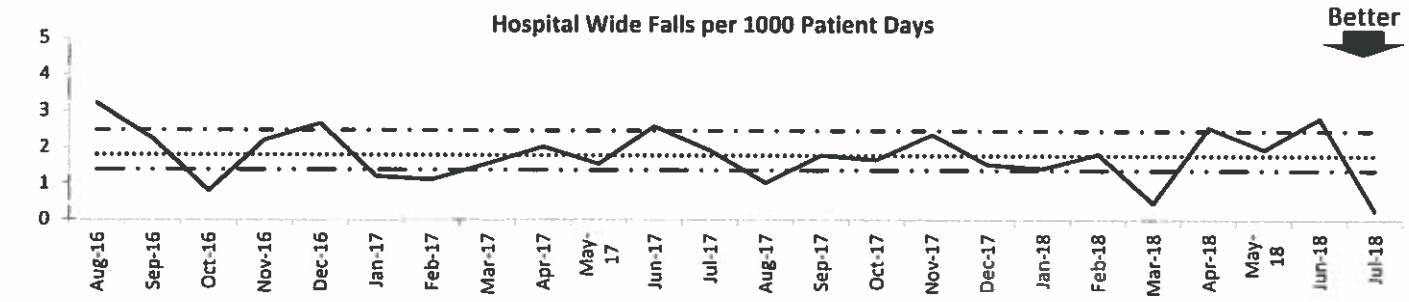


Involuntary Employee Turnover Rate



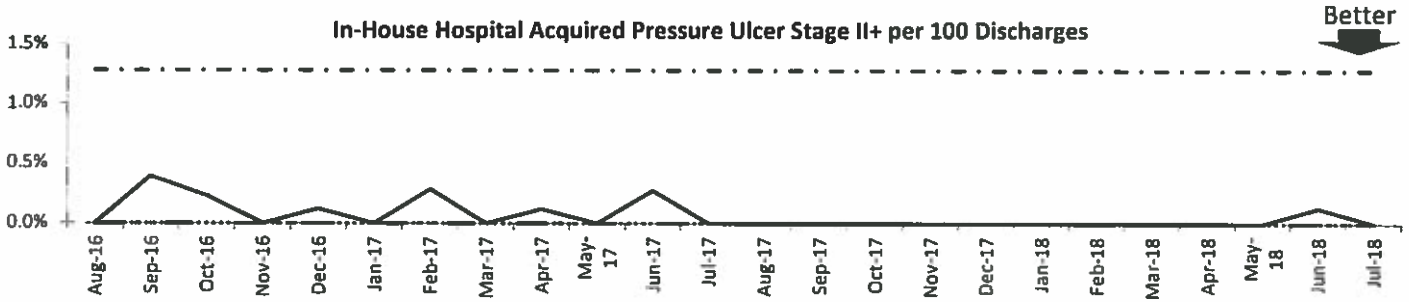
Current Trending Measures

TCMC Rate ····· Mean - · - · - CA Mean — · — · — TCMC Target



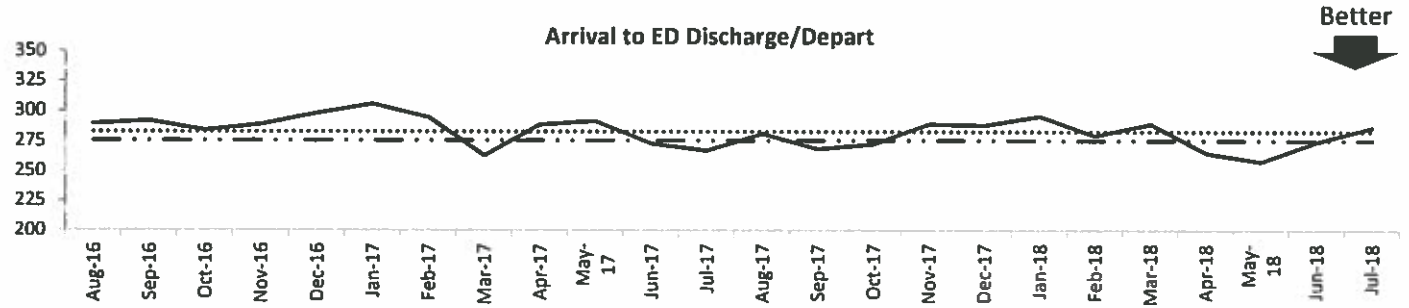
Action Plan

Continue to increase fall awareness and monitor hourly rounding compliance. Improvement noted. No action necessary at his time. Continue to monitor.



Action Plan

Performance below goal. No action plan necessary. Continue to monitor.

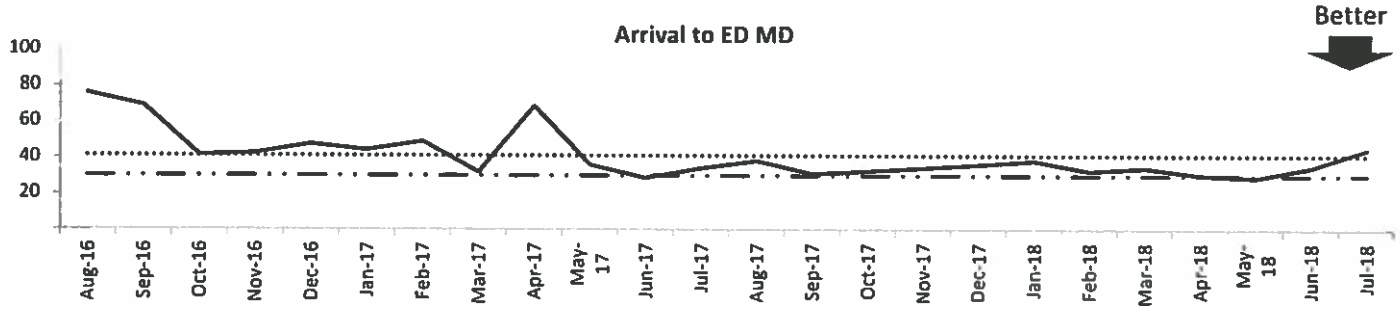


Action Plan

MD coverage reduced due to ED volume decrease. Admits and discharges taking longer as each provider has more patients. Adding doctor hours at peak times being assessed.

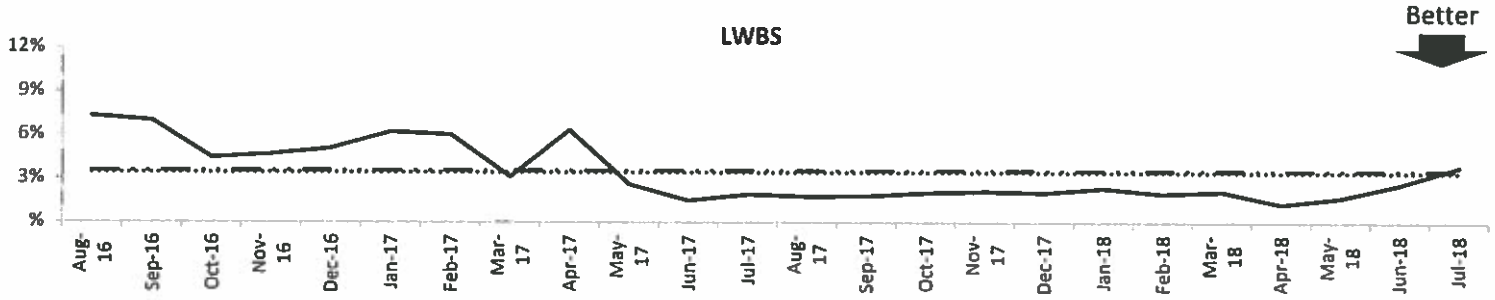
Current Trending Measures

TCMC Rate ····· Mean - · - · - CA Mean — · — · — TCMC Target



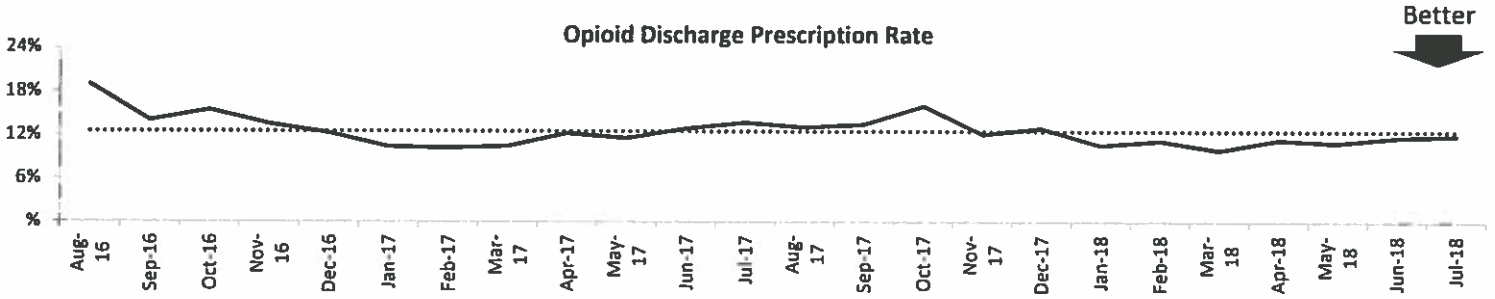
Action Plan

Triage MD hours reduced causing longer waiting times to be seen and in the main ED. Earlier MD coverage to be added by 10/1.



Action Plan

LWBS < due to longer waits and increase in ED Psych volume. Station F opened and more MD hrs.

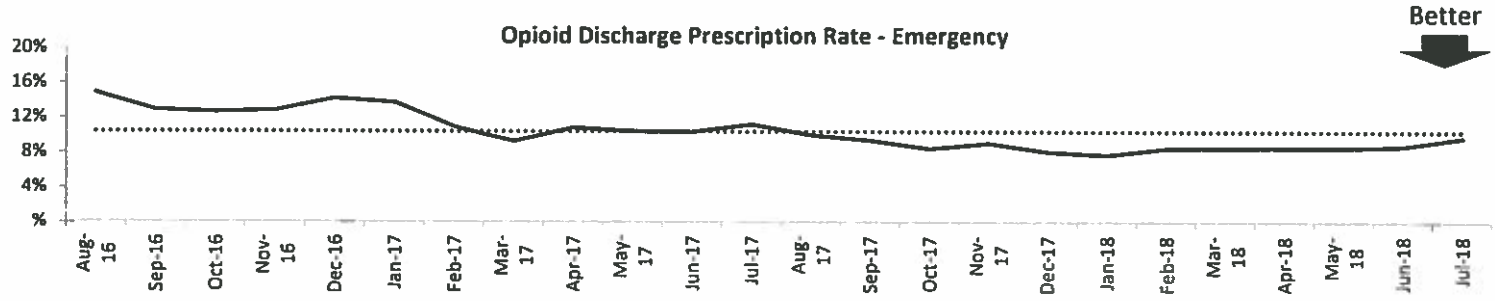


Action Plan

Performance continues to be better than the mean. No action necessary at this time. Continue to monitor.

Current Trending Measures

TCMC Rate Mean CA Mean TCMC Target



Action Plan

Performance continues to be better than the mean. No action necessary at this time. Continue to monitor.

Volume

Performance compared to prior year: Better | Same | Worse

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	18	29											47
FY18	26	23	23	20	27	27	22	23	24	20	20	28	49

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	10	14											24
FY17	14	6	7	13	7	15	14	8	12	7	10	6	20

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	19	16											35
FY18	11	12	12	14	16	18	23	12	15	15	16	20	23

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	20	23											43
FY18	15	20	20	16	23	15	15	19	23	11	20	17	35

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	31	31											62
FY18	48	37	33	32	26	38	29	24	30	38	33	38	85

Performance compared to prior year: Better | Same | Worse

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	10.8	11.3											11.1
FY18	15.7	14.5	16.2	16.3	9.9	14.2	16.7	12.5	13.7	13.8	13.0	11.9	15.1

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	7.4	9.1											8.2
FY18	9.0	6.7	6.2	9.5	8.3	7.3	7.2	8.7	7.5	7.1	6.6	4.8	7.9

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	11.4	9.8											10.6
FY18	11.3	16.4	12.4	13.9	13.5	10.5	12.5	12.7	12.4	11.5	12.2	13.5	13.9

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	160.3	155.9											158.1
FY18	169.7	181.9	163.4	173.4	160.9	172.5	210.7	185.8	186.4	163.2	161.9	165.9	175.8

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	186	202											388
FY18	210	222	194	206	184	166	209	169	186	156	163	188	432

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	8	10											18
FY18	12	11	11	11	11	18	16	5	7	16	15	20	23

Performance compared to prior year: Better Same Worse

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	3	4											7
FY18	4	7	7	3	4	3	2	4	8	2	7	8	11

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	8	8											16
FY18	8	7	7	11	3	14	11	10	4	10	8	5	15

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	1.79	1.83											1.81
FY18	1.75	1.80	1.81	1.80	1.83	1.72	1.64	1.77	1.78	1.85	1.86	1.79	1.77

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY19	44.9	43.1											44.0	48-52
FY18	47.7	47.8	48.9	50.8	49.6	49.5	49.8	47.2	46.8	47.0	46.6		47.8	

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY19	84.9	86.5											85.7	75-100
FY18	82.1	79.1	78.8	83.4	87.7	81.3	82.9	85.2	78.8	83.2	89.2		80.6	

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY19	($478)	($121)											($598)	$ (1,047)
FY18	($394)	($429)	($224)	($171)	($2,571)	($383)	($1,242)	($542)	($337)	($679)	($408)		($824)	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY19	-1.64%	-0.39%											-1.00%	-1.82%
FY18	-1.33%	-1.39%	-0.76%	-0.55%	-9.47%	-1.26%	-3.94%	-1.86%	-1.09%	-2.31%	-1.31%		-1.36%	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCHD EBITDA $ in Thousands (Earnings before Interest, Taxes, Depreciation and Amortization)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY19	$796	$1,168											$1,963	$1,559
FY18	$898	$864	$1,091	$1,146	($1,288)	$908	$81	$751	$963	$571	$900		$1,762	

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY19	2.73%	3.81%											3.29%	2.72%
FY18	3.03%	2.80%	3.69%	3.66%	-4.74%	2.99%	0.26%	2.57%	3.13%	1.95%	2.90%		2.91%	

TCMC Paid FTE (Full-Time Equivalent) per Adjusted Occupied Bed

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY19	6.73	6.70											6.72	6.36
FY18	6.51	5.92	6.90	6.26	6.50	6.43	5.95	5.99	5.86	6.29	6.43		6.20	

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
FY19	$50.0	$49.5											
FY18	$58.5	$49.8	$42.3	$48.2	$58.6	$54.5	$54.7	$53.1	$49.4	$42.7	$41.5		

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases

Month Ending August 31, 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	$3.59	(a)	45,637.80	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	$1.91	(a)	10,919.98	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	$2.58	(a)	26,711.35	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	$2.58	(a)	15,640.35	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	$2.62	(a)	9,867.81	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)	10,673.64	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				$ 186,303.61			

(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 August 2018

Cost Center	Description	Invoice #	Amount	Vendor #	Attendees
6150	PCCN REVIEW COURSE	83118	128.62	77699	EMMA HILBOURN
6150	PCCN CERTIFICATION COURSE	81718	185.00	77699	EMMA HILBOURN
6150	PCCN REVIEW COURSE	81418	250.00	77699	EMMA HILBOURN
7010	2018-19 SAN DIEGO COUNTY PROTOCOL BOOK	80218	189.64	82803	CHARA COTE
7010	MICN TRAINING COURSE	30918	400.00	62089	MARY ANN FABUNAN
7010	MICN TRAINING COURSE	30918	400.00	62089	MICHAEL RODRIGUEZ
7290	OASIS D DATA SET	72418BOATRIGHT	410.00	14369	CYNTHIA BOATRIGHT
7420	CMSRN RECERTIFICATION	70618	275.00	79011	MARIA CYNTHIA TESTMAN
7770	BOOTCAMP FOR SKILLED THERAPY	73118	479.88	83228	INPATIENT OT STAFF
7894	CRNI RENEWAL CERTIFICATION	73118	300.00	80734	RENATA MACIK
8390	ACLS TRAINING	81518	195.00	80073	TAMMY HSU
8390	CSHP SEMINAR	80818HONG	470.00	81003	TORI HONG
8450	MANUAL TRANSFER SWITCH TRAINING	1306959	450.00	9983	PLANT ENGINEERING STAFF
8450	BOILER OPERATOR TRAINING	262775	975.00	48073	STEVE CRAWFORD
8480	CERNER VISION CENTER FUNCTIONALITY	81318	1,145.24	82983	MARK JAMES ALBRIGHT
8480	CERNER VISION CENTER FUNCTIONALITY	80818	1,342.44	65505	KIMBERLY QUINN
8532	CERNER VISION CENTER FUNCTIONALITY	80818	367.28	80216	JONI PENIX
8532	CERNER PT ACCOUNTING SYSTEM	80218	689.96	80216	JONI PENIX
8610	VIZIENT BOARD MEETING - TRAVEL EXPENSE	80618	363.27	81508	STEVEN DIETLIN
8650	JANUS V AFSCME WEBINAR	80618	125.00	83103	SUSAN BOND
8740	BIRTH BONDING & NEUROSCIENCE	81718	100.00	78644	CYNDI OZBUN
8740	FUNDAMENTALS OF FLUOROSCOPY	80318	100.95	29219	CONNIE J. GEORGE
8740	ONS/ONCC CHEMOTHERAPHY BIOTHERAPY	80318	103.00	82125	MARIA AVILEZ
8740	CCRN RENEWAL	72018	120.00	80655	CHRISTA SETTLE
8740	7TH ED NRP INSTRUCTOR RENEWAL	81018	149.00	82703	DONNA WHEATON
8740	ACLS BLS	72018	150.00	80074	ARACELI MORALES
8740	CCRN ADULT RENEWAL	81718	198.00	82545	JESSICA SAGUIN
8740	IMPROVING CORE STRENGTH & STABILITY	72018	200.00	14165	JENNIFER PENNINGTON
8740	AACN CERTIFICATION	81718	200.00	83176	JONATHAN DEVERA
8740	IBCLC RECERTIFICATION	72018	200.00	83313	NICOLETTE HARRIDGE
8740	PALS RECERT COURSE	81718	200.00	83315	FERNANDA NEIL
8740	ADVANCE FETAL MONITORING	80318	200.00	83316	ROMINA TROESH
8740	RN - BSN	72018	2,500.00	81918	YAUHNET WOOLSEY
8740	RN - BSN	72018	2,500.00	83314	AGNES MCCREA
8758	CA HUMAN TRAFFICING POSTER INFO	72418	107.20	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.

August 29, 2018

Report to the Board

James J. Dagostino, Chairman of the Board TCHD

Governance Forum, California Hospital Association, August 29, 2018 San Diego, California

I attended the Governance Forum of CHA. The Governance Forum is a subcommittee of the CHA Board that allows Trustees input into the legislative agenda. This forum represents both public and private hospitals along with CHA staff and Board members.

A review of the Pathway for CHA behavior was presented Dr. Richard Afable Board Chair CHA. This was a confidential document that the CHA Board will vote on later this year. It outlines the priorities (philosophically) of what CHA stands for. This will be the guide in governing CHA's legislative behavior. Input was received by Dr. Afable from this group and will be shared with the Board before finalization of the document.

The remainder of the day followed up on legislative activity. Most notable was that CHA has changed its position on AB 1795(Gipson) a paramedic alternative destination bill. CHA is now opposed as the bill has changed radically and talks about limiting transportation to just sober houses mainly in the San Francisco area. Legislature finishes its debate on all bills Friday at 12 o'clock midnight.

2019 priority issues on public policy document were shared with this group. CHA will most likely use this document to help finalize the Pathway document.