TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
March 28, 2019 – 2:00 o'clock p.m.
Classroom 7 - 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 (1 Matter)		
	b. Conference with Legal Counsel – Existing Litigation (Authority: Government Code, Section 54956.9(d)1, (d)4 (1) Medical Acquisitions Company vs. TCHD Case No: 2014-00009108 (2) TCHD vs. Medical Acquisitions Company Case No: 2014-00022523		
	b. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	c. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: TBD		

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
	d. Conference with Labor Negotiators: (Authority: Government Code, Section 54957.6) Agency Negotiator: Steve Dietlin Employee organization: SEIU-UHW		
	e. 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
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	Report from TCHD Auxiliary – Mary Gleisberg, President	10 min.	Standard
13	February 2019 Financial Statement Results	10 min.	CFO
14	New Business a) Consideration to cast the ballot for Regular LAFCO Special District Member b) Consideration to cast the ballot for Alternate LAFCO Special District Member	 5 min. 5 min.	 Chair Chair
15	Old Business - None		
16	Chief of Staff a) Consideration of March 2019 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on March 25, 2019.	10 min.	Chief of Staff
17	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.*** ***(3) Requested items to be pulled require a second.***	5 min.	Standard

	Agenda Item	Time Allotted	Requestor

(1) Administrative Committee

a) Patient Care Policies & Procedures
1) Code STEMI Policy
2) Diluting IV Medication for IV Push Administration Procedure (DELETE)
3) D-Stat Rad-Band Topical Hemostat Procedure (DELETE)
4) Emergency Cart (Crash Cart) Cardiopulmonary Arrest Policy
5) Gowning & Gloving Procedure
6) Medication Administration Policy
7) Monitor Technicians (MTs): Communication Process Policy
8) Pre-Operative Education Medication Instructions to Surgical Patients Standardized Procedure
9) Pre-Operative Patient Preparation Procedure
10) Titrating Medications, Adult Patients Policy
11) Universal Protocol Procedure
12) Ventricular Assist Device: Impella Nursing Care of Patient
13) Wearable Defibrillator (LifeVest)

b) Administrative
1) Confidentiality Policy 455
2) Doctor Strong Policy 221
3) Patients Injured by Deadly Weapon or Criminal Act 315

c) Emergency Operations Procedure (EOP) Manual formerly Disaster Manual

1) Emergency Operations Plan Policy

d) Engineering
1) Emergency Generator Test and Failures Policy
2) Failure of Fire Alarm System 8015 Policy
3) Guidelines for Procedure for Failure of Essential Equipment 8017 Policy
4) System Record Drawings 8019 Policy
5) Utility Management Plan 4003 Policy

e) Environment of Care Manual
1) Fire Plan - Code Red Policy
2) Hazardous Material and Waste Management and Communication Plan
3) Life Safety Management Plan Policy
4) Medical Equipment Management Plan Policy
5) Safety Plan Policy
6) Security Management Plan Policy

f) Food & Nutrition
Scope of Nutrition Services for Oncology Patients Policy (DELETE)

g) Infection Control
1) Department Specific Infection Control Behavioral Health Services - IC 7 (DELETE)
2) Risk Assessment and Surveillance Plan

h) Mammography Women's Center
1) Diagnostic Mammography Policy

i) Medical Staff

	Agenda Item	Time Allotted	Requestor
	1) Appropriate Use of Commercial Support and Exhibits Policy 8710-603 2) CME Speaker & Honoraria Reimbursement Policy 8710 – 604 3) Conflict of Interest Resolution Policy 8710 – 605 4) CPOE Power Plan Revisions-Additions Policy 8710-568 5) Educational Planning; Needs Assessment; Objectives; and Evaluation of a Continuing Medical Education (CME) Activity Policy 8710 – 600 6) Joint Providership Co-Providership Policy 8710 – 602 7) Medical Staff Standards of Conduct Policy 8710-552 8) Regularly Scheduled Series (RSS) Policy 8710 – 606 9) Surgical Assistance Policy 8710-545 **j) Pharmacy** 1) Medication Management Program Policy **k) Rehabilitation** 1) NICU Scope & Qualifications Policy 505 **l) Surgical Services** 1) Second Witness Procedure for High Risk Medication Administration and Documentation in PACU, SPRA and Pre-Op Hold Policy (DELETE) **m) Women & Newborn Services** 1) Uterine Tamponade Devices Procedure **n) Behavioral Health Services (Suspended unless otherwise noted)** 1) Table of Contents 2) 14-Day Certification Review Hearings 3) 5250: 14-Day Involuntary Holds 4) 5270 30 Days of Additional Intensive Treatment 5) 72-Hour Hold Evaluation and Treatment of the Involuntary Patient 6) Abuse Reporting Forms 7) Administration of Antipsychotic Medication (move to PCS) 8) Administration of Zyprexa Relprevv 9) Approved Abbreviations, Behavioral Health Unit (BHU) and Crisis Stabilization (CSU) Specific 10) Assisting Medi-Cal Recipients with Grievance and Appeals Processes 11) Behavioral Health Unit / Crisis Stabilization Unit Departmental Disaster Implementation Plan 12) Conducting Searches Patient Room Patient Belongings 13) Confidentiality 14) Consent for Psychotropic Medications (move to PCS) 15) Consent related to Mental Health Treatment 16) Elopement Precautions (move to PCS) 17) Emergency Medication (move to PCS) 18) Cleaning and Changing Behavioral Health Unit (BHU) and Crisis Stabilization Unit (CSU) Bathroom Curtains 19) Family Involvement in Treatment 20) Food on the Unit 21) Freedom of Movement 22) Judicial Review Pursuant to a Writ of Habeas Corpus 23) Management of Aggressive and Assaultive Behavior (move to PCS) 24) Narrative of Organizational Chart		

	Agenda Item	Time Allotted	Requestor
	25) Notification of County Serious Incident of Unusual Occurrences 26) Notification of Responsible Persons 27) Pastoral Care 28) Patient Responsibilities 29) Patient Rights 30) Patient Satisfaction Surveys 31) Release of Information 32) Role of Medical Staff Leadership in Behavioral Health Services 33) Non-Smoking Environment 34) Solicitation of Patients, Referrals to self 35) Suicide Risk Assessment and Management 36) Telephone Use 37) Unit Staff Meetings 38) Visiting in Behavioral Health Unit 39) Washer Dryer Use Policy **o) Behavioral Health Unit – Inpatient (Suspended unless otherwise noted)** 1) BHU Multidisciplinary Treatment Plan 2) Clinical Assessment 3) Community Meeting 4) Conservatorship 5) Daily Environmental Safety Rounds 6) Daily Schedule 7) Direct Admissions to the BHU 8) Discharge Planning 9) Dress Code for Patients 10) Environmental Safety Standards in BHU 11) General Supervision of Patients, Patient Rounds 12) Hose Use During Garden Activity 13) Inpatient Unit Admission Criteria 14) Levels of Participation 15) Managing the Medical Record for BHU in the Emergency Department 16) Notice of Certification and Advisement of Rights (move to PCS) 17) Notification of MediCal Beneficiary of Denial of Benefits (move to PCS) 18) One to One Observation of Patients (move to PCS) 19) Orientation of New Patients 20) Patient Belongings 21) Patient Discharge Types 22) Patient Transport for Off Unit Diagnostic Testing 23) Psychiatric Advanced Directive 24) Reise Hearing Refusal to Consent to Psychotropic Medications 25) Report of Firearms Protection 26) Scope of Service – Behavioral Health Unit 27) Termination of Temporary Conservatorship 28) Treatment of Patients 29) Treatment Planning Policy 30) Utilization Management 31) Vital Signs **(2) Board Committees** **A. Community Healthcare Alliance Committee** Director Chavez, Committee Chair *(No meeting held in March, 2019)*		CHAC Comm.

	Agenda Item	Time Allotted	Requestor
	B. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 1 *(No meeting held in March, 2019)*		FO&P Comm.
	C. Professional Affairs Committee Director Reno, Committee Chair *(No meeting held in March, 2019)*		PAC
	D. Audit, Compliance & Ethics Committee Director Schallock, Committee Chair *(No meeting held in March, 2019)* Open Community Seats – 1		Audit, Comp. & Ethics Comm.
	(3) Minutes – Approval of: a) Regular Board of Directors Meeting – February 28, 2019 (4) Meetings and Conferences – None (5) Dues and Memberships - None		Standard
18	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
19	Reports (Discussion by exception only) (a) Dashboard – Included (b) Construction Report – None (c) Lease Report – (February, 2019) (d) Reimbursement Disclosure Report – February, 2019) (e) Seminar/Conference Reports – None	0-5 min.	Standard
20	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda.	5-10 minutes	Standard
21	Comments by Chief Executive Officer	5 min.	Standard
22	Board Communications (three minutes per Board member)	18 min.	Standard
23	Report from Chairperson	3 min.	Standard
24	Total Time Budgeted for Open Session	2 hours	
25	Adjournment		

2-27-19

San Diego County
Local Agency Formation Commission
Regional Service Planning | Subdivision of the State of California

BALLOT FORM

February 25, 2019

TO: Independent Special Districts of San Diego County

FROM: Keene Simonds, Executive Officer
Tamaron Luckett, Executive Assistant

SUBJECT: **Special District Ballot Form | San Diego Local Agency Formation Commission Regular and Alternate Member – Certified Mail**

On November 28, 2018, the San Diego Local Agency Formation Commission solicited nominations pursuant to Government Code Section 56332(1) for two special districts members – (a) one regular and (b) one alternate – to serve on the San Diego Local Agency Formation Commission (LAFCO). A total of eight nominations were received – five for the regular member and three for the alternate member – with terms both expiring May 2023.

As required by the Selection Committee Rules, all eligible nominations were forwarded to a Nominating Committee. The Nominating Committee comprise Gary Arant (Valley Center Municipal Water District), Tom Kennedy (Rainbow Municipal Water District), and Mark Robak (Otay Water District). After the candidate's forum held on February 20, 2019 in conjunction with the San Diego Chapter of the California Special District Association's Quarterly Dinner Meeting, the Nominating Committee met to discuss a recommended slate of nominees for the open positions.

Attached are the following election materials:

- Nominating Committee's Report and Recommendations. (Attachment A)
- Special District Election Ballot and Vote Certification Forms for Regular and Alternate Member. (Attachment B)

Administration
Keene Simonds, Executive Officer
County Operations Center
9335 Hazard Way, Suite 200
San Diego, California 92123
T 858.614.7755 F 858.614.7766
www.sdlafco.org

- Special District Summary of Nominations and Nomination Forms[1]. (Attachment C)

There is a separate special district election ballot and vote certification form to cast your vote for each position: (a) Regular Member and (b) Alternate Member. All nominees are listed on the ballot and vote certification form. An asterisk identifies the Nominating Committee recommendations, and incumbents have been italicized. Write-in candidates are permitted, and spaces have been provided for that purpose. **Only one cast vote is eligible for each category on the ballot and vote certification form; a ballot that is cast for more than indicated number of positions the vote will be disregarded.**

State Law and the Selection Committee Rules require a district's vote to be cast by its presiding officer, or an alternate member of the legislative body appointed by the other members. Therefore, the certification form has been incorporated with the ballot forms to be signed by the person who cast your district's votes. **A ballot received without a signed certification form will be voided.**

The Selection Committee Rules stipulate that most of the districts shall constitute a quorum for the conduct of committee business. There are 59 independent special districts in the county; therefore, a minimum of 30 ballots must be received to certify that a legal election was conducted. A candidate for a LAFCO member must receive at least a majority of the votes cast to be elected. The ballots will be kept on file in this office and will be made available upon request.

The deadline for receipts of the ballots by LAFCO is **Friday, April 12, 2019.** The Selection Committee Rules require that marked ballots be returned by certified mail – return receipt requested. Ballots and certification forms will be accepted by email to tamaron.luckett@sdcounty.ca.gov or Facsimile (FAX), if necessary, to meet the ballot deadline, but the originals must be submitted as soon as possible thereafter.

Should you have any questions, please contact me at (858) 614-7755.

Keene Simonds
Executive Officer

Attachments
a) Nominating Committee Report and Recommendations
b) Special District Election Vote Certification Form and Ballots
c) Special District Summary of Nominations and Nomination Forms

[1] LAFCO staff does not include any of the candidates' promotional materials with the election materials.

Attachment A

February 25, 2019

TO: Independent Special Districts in San Diego County

FROM: Special Districts Election Nominating Committee

SUBJECT: **Nominating Committee Report and Recommendations**

The Nominating Committee was appointed to review the nominations submitted, and to prepare a list of recommended candidates. According, to the Selection Committee Rules, the nominating committee is appointed by the Chairperson or Vice Chair of the Special Districts Advisory Committee.

The Nominating Committee members Gary Arant (Valley Center Municipal Water District), Tom Kennedy (Rainbow Municipal Water District), and Mark Robak (Otay Water District) met on February 22, 2019. In evaluating the nominations, the Committee considered special district experience, interest, and knowledge of LAFCO issues. The Committee further considered attendance records and meeting participation. The Committee also wanted to ensure representation from those types of districts that most often are involved in making recommendations to LAFCO. A summary of the nominations has been attached. (Attachment C)

The nominating committee's recommendation for each category follows:

Nominating Committee | Recommendations

LAFCO Regular Special District Member

- Edmund K. Sprague (Olivenhain Municipal Water District)

LAFCO Alternate Special District Member

- Erin Lump (Rincon del Diablo Municipal Water District)
- Steve Castaneda (South Bay Irrigation District)

Administration
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County Operations Center
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2018 SPECIAL DISTRICTS ELECTION
BALLOT and VOTE CERTIFICATION
FOR REGULAR LAFCO SPECIAL DISTRICT MEMBER

VOTE FOR ONLY ONE

William Haynor [ ]
(Whispering Palms Community Services District)

William Leach [ ]
(Fallbrook Regional Health District)

Hector Martinez [ ]
(South Bay Irrigation District)

* ***Edmund K. Sprague***[1] [ ]
(Olivenhain Municipal Water District)

Barry Willis [ ]
(Alpine Fire Protection District)

Write-Ins

_____ [ ]

_____ [ ]

As presiding officer or his/her delegated alternate as provided by the governing board, I hereby certify that I cast the votes of the

(Name of Independent Special District)

at the 2018 Special Districts Selection Committee Election.

_____
(Signature)

_____ _____
(Print Name) (Date)

_____
(Print Title)

Please note: The order in which the candidates' names are listed was determined by random selection.

* Nominating Committee's Recommendation

1 Incumbent member

2018 SPECIAL DISTRICTS ELECTION
BALLOT and VOTE CERTIFICATION
FOR ALTERNATE LAFCO SPECIAL DISTRICT MEMBER

VOTE FOR ONLY ONE

* **Steve Castaneda** [ ]
(South Bay Irrigation District)

Judy Hanson[2] [ ]
(Leucadia Wastewater District)

* **Erin Lump** [ ]
(Rincon del Diablo Municipal Water District)

Write-Ins

_____ [ ]

_____ [ ]

As presiding officer or his/her delegated alternate as provided by the governing board, I hereby certify that I cast the votes of the _____
(Name of Independent Special District)
at the 2018 Special Districts Selection Committee Election.

_____
(Signature)

_____ _____
(Print Name) (Date)

_____
(Print Title)

Please note: The order in which the candidates' names are listed was determined by random selection.

* Nominating Committee's Recommendation

2 Incumbent member

ATTACHMENT A

NOMINATION OF THE SPECIAL DISTRICT REPRESENTATIVES
LAFCO REGULAR AND ALTERNATE
FOR THE SAN DIEGO LOCAL AGENCY FORMATION COMMISSION

The Whispering Palms CSD is pleased to nominate William Haynor as a
(Name of Independent Special District) (Name of Candidate)

Candidate for the San Diego Local Agency Formation Commission as a regular or alternate special district member.

Please check one box.
Refer to the List of Incumbents.

[X] **Regular Special District Member** (Term expires 2023)
[ ] **Alternate Special District Member** (Term expires 2023)

As presiding officer or his/her delegated alternate as provided by the governing board, I hereby certify that:

- The nominee is a member of a legislative body of an independent special district whom resides in San Diego County.

(Signature)

William Haynor
(Print Name)

1/9/2018
(Date)

President
(Print Title)

PLEASE ATTACH RESUME FOR NOMINEE
- Limit two pages
- Must be submitted with Nomination Form

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LAFCO Special District Regular Member Candidate
William W. Haynor
Resume

Business Background

William W. Haynor has more than 30 years of banking and finance experience, with senior positions at Bank of America, Imperial Corporation of America, Great American Bank, and as Executive Vice President and Chief Administrative Officer of Bank of San Francisco. Mr. Haynor was a Founding Director of Selectquote Insurance Services, Inc. and is currently Founder, Chairman and CEO of Seniorquote Insurance Services Inc., a direct response distributor of senior life and health insurance. Mr. Haynor was also a Founding Director of the Star System and past Vice Chairman of the Board.

CSD Background

1. Past Board Chairman of the Marin Municipal Water District.
2. Past Board Chairman of The Strawberry Recreation District
3. Current Board Chairman of the Whispering Palms Community Services District

Appointment Background

1. Past Chairman of the Richardson Bay Development Committee Joint Powers with Marin County and Cities of Sausalito, Mill Valley, Tiburon, and Belvedere
2. Current SDCERS (San Diego City Pension Board) Board Member and Past Investment Committee Chairman

Personal Highlights

Education: Denison University B.S. Biology – USC, MBA Finance, USC, MS Aerospace Systems Management
Military: USAF, Strategic Air Command, Avionics/Intelligence – Captain – Viet Nam Combat Service Ribbon
Family: Married with three children and four grandchildren

ATTACHMENT A

NOMINATION OF THE SPECIAL DISTRICT REPRESENTATIVES
LAFCO REGULAR AND ALTERNATE
FOR THE SAN DIEGO LOCAL AGENCY FORMATION COMMISSION

The FALLBROOK REGIONAL HEALTH DISTRICT (Name of Independent Special District) is pleased to nominate William Leach (Name of Candidate) as a

Candidate for the San Diego Local Agency Formation Commission as a regular or alternate special district member.

Please check one box.
Refer to the List of Incumbents.

[X] **Regular Special District Member** (Term expires 2023)
[ ] **Alternate Special District Member** (Term expires 2023)

As presiding officer or his/her delegated alternate as provided by the governing board, I hereby certify that:

- The nominee is a member of a legislative body of an independent special district whom resides in San Diego County.

Howard Salmon (Signature)

Howard Salmon (Print Name)

1/9/2019 (Date)

Board President (Print Title)

PLEASE ATTACH RESUME FOR NOMINEE
- Limit two pages
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Bill Leach

Special District and Government Experience

EXPERIENCE

Fallbrook Regional Healthcare District, Fallbrook CA — *Governing Board Member*

December 2016 - PRESENT

Fallbrook Community Planning Group, Fallbrook CA- Governing Board Member

December 2016 - January 2019

Association of California Healthcare Districts, Sacramento CA- Advocacy Committee Member

September 2017- January 2019

Association of California Healthcare Districts, Sacramento CA- Education Committee Member

September 2017- January 2019

ATTACHMENT A

NOMINATION OF THE SPECIAL DISTRICT REPRESENTATIVES
LAFCO REGULAR AND ALTERNATE
FOR THE SAN DIEGO LOCAL AGENCY FORMATION COMMISSION

The SOUTH BAY IRRIGATION DISTRICT is pleased to nominate HECTOR MARTINEZ as a
(Name of Independent Special District) (Name of Candidate)

Candidate for the San Diego Local Agency Formation Commission as a regular or alternate special district member.

Please check one box.
Refer to the List of Incumbents.

[✓] **Regular Special District Member** (Term expires 2023)
[ ] **Alternate Special District Member** (Term expires 2023)

As presiding officer or his/her delegated alternate as provided by the governing board, I hereby certify that:

- The nominee is a member of a legislative body of an independent special district whom resides in San Diego County.

(Signature)

JOSE PRECIADO
(Print Name)

1-9-19
(Date)

BOARD PRESIDENT
(Print Title)

PLEASE ATTACH RESUME FOR NOMINEE
- Limit two pages
- Must be submitted with Nomination Form

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Hector M. Martinez, P.E.

Experience - **While at Sweetwater Authority, in the engineering department, I had the opportunity to prepare and process several annexations and detachments for the district. As a developer, I have considered on several occasions annexing land for development.**

March 2014 to present	Green Housing Development	Chula Vista, CA
Dec 1988 to March 2014	Sweetwater Authority (26 years)	Chula Vista, CA

Engineering Manager, 2004-2014
Deputy Chief Engineer, 2001-04
Principal Engineer, 1997-2001
Senior Engineer, 1994-97
Associate Engineer, 1993-94
Assistant Engineer, 1988-93

Prior to Dec1988 Various

Junior Civil Engineer, City of San Diego
Water Treatment Specialist - 77W, US Army, Fort Lee VA
Structures Teacher, New School of Architecture, Carlsbad and San Diego
Math Teacher, New School of Architecture, Chula Vista, Carlsbad and San Diego
Laborer, Welsh Construction, Chula Vista
Building Maintenance, New School of Architecture, Chula Vista

Education

2011	Masters in Public Administration, National University
1996	Masters in Management, National University
1987	BS in Civil Engineering, San Diego State University
1985	Associate Degree in Engineering, Southwestern College

Licenses Obtained

Department of Health Services Grade D4 Water Distribution System Operator, #4512
Licensed Registered Civil Engineer, C52560
Licensed building Contractor
AWWA Grade 3, 04512

Appointments

Water Agency Design Standards Committee Chair person, SEMS Committee, 2002 SWA Security Task Force, Sweetwater Authority Recreation Association Committee member, United Way Annual Contribution Campaign, Safety Committee member, SDG&E Major Customer Advisory Panel Member

Extra Curricular Activities (Past and Present)

South Bay Irrigation District Board Member
Child Development Associates Board Member
Chula Vista Rangers Soccer Club Board Member – Youth Sports Council Member
Chula Vista Growth Task Force Member
Eastlake Community Church Volunteer and MTB Club Leader
AWWA Water for People Committee Member and Treasurer
South Bay YMCA Management Board Member
Eastlake III Home Owners Association Board Member
Chula Vista Democratic Club Treasurer and President
Border Angels Board Member
South Bay Forum Member
San Diego Immigration Rights Consortium
Border Patrol Citizens Academy Graduate

Hobbies

Mountain and Road biking, jogging, general physical exercise and travel.

ATTACHMENT A

NOMINATION OF THE SPECIAL DISTRICT REPRESENTATIVES
LAFCO REGULAR AND ALTERNATE
FOR THE SAN DIEGO LOCAL AGENCY FORMATION COMMISSION

The Olivenhain Municipal Water District is pleased to nominate Edmund K. Sprague as a
(Name of Independent Special District) (Name of Candidate)

Candidate for the San Diego Local Agency Formation Commission as a regular or alternate special district member.

Please check one box.
Refer to the List of Incumbents.

[✓] **Regular Special District Member** (Term expires 2023)
[ ] **Alternate Special District Member** (Term expires 2023)

As presiding officer or his/her delegated alternate as provided by the governing board, I hereby certify that:

- The nominee is a member of a legislative body of an independent special district whom resides in San Diego County.

Kimberly A. Thorner
(Signature)

Kimberly A. Thorner
(Print Name)

1/16/19
(Date)

General Manager
(Print Title)

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- Limit two pages
- Must be submitted with Nomination Form

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2019 LOCAL AGENCY FORMATION COMMISSION
INDEPENDENT SPECIAL DISTRICT MEMBER
NOMINATION / RESUME

NOMINATED BY:	
District Name:	Olivenhain Municipal Water District
District Phone:	760-753-6466
NAME OF NOMINEE:	
Name:	Edmund K. Sprague
Address:	1966 Olivenhain Road Encinitas, CA 92024
Phone:	760-753-6466
NOMINATED FOR:	
Please check <u>one</u> box	**(X) Regular Special District Member** **( ) Alternate Special District Member**
DISTRICT EXPERIENCE:	Being appointed to OMWD Board in 2008 to represent Division 5 has provided him a great deal of experience governing water, wastewater, recycled water, hydroelectricity and parks and recreation services to over 86,000 customers. Served as President of the Board from 2009 to 2012, 2015-2016 and currently serves as President of the OMWD Board of Directors. Currently serves on OMWD's Finance, Personnel, and Public Policy and Public Outreach Committees. Served on the Board of Directors of the Special District Risk Management Authority in 2011. Earned the Recognition in Special District Governance certification from the Special District Leadership Foundation in 2010. Served on the California Special District Association's Education Committee.
LAFCO EXPERIENCE:	Currently serves as the incumbent Regular Special District Member on LAFCO since 2015.
ADDITIONAL INFORMATION:	As a lifetime resident of northern San Diego County, Mr. Sprague has dedicated his entire career to championing the needs of the public as well as serving his local community. Mr. Sprague has over 30 years of public service starting as a cadet firefighter for the City of Escondido in 1986. He ascended through the fire service ranks all the way up to Fire Battalion Chief for the Carlsbad Fire Department. He then transitioned into the role of Deputy Fire Chief for the North County Fire Protection District where he retired in 2015. After his successful firefighter career, Mr. Sprague has been able to dedicate considerably more time to his passion of teaching and leading others as a Fire Technology Assistant Professor at Palomar College. Worked with the City of Carlsbad as a Firefighter, Fire Engineer, Fire Captain, Battalion Chief – Training Officer, and Shift Battalion Chief. During this 26 year period, was a Public Education Officer, and was a Liaison Officer with North County Dispatch JPA. Holds bachelors and master's degrees in public administration from San Diego State University and an associate's degree in fire science from Palomar College.

ATTACHMENT A

NOMINATION OF THE SPECIAL DISTRICT REPRESENTATIVES
LAFCO REGULAR AND ALTERNATE
FOR THE SAN DIEGO LOCAL AGENCY FORMATION COMMISSION

The Alpine Fire Protection District (Name of Independent Special District) is pleased to nominate Barry Willis (Name of Candidate) as a

Candidate for the San Diego Local Agency Formation Commission as a regular or alternate special district member.

Please check one box.
Refer to the List of Incumbents.

[X] **Regular Special District Member** (Term expires 2023)
[ ] **Alternate Special District Member** (Term expires 2023)

As presiding officer or his/her delegated alternate as provided by the governing board, I hereby certify that:

- The nominee is a member of a legislative body of an independent special district whom resides in San Diego County.

(Signature)

Alicea Caccavo
(Print Name)

1/16/2019
(Date)

Clerk of the Board
(Print Title)

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- Limit two pages
- Must be submitted with Nomination Form

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SAN DIEGO LAFCO

Baron T. Willis

EDUCATION

U.C. Berkeley/ University of California, San Diego
Major: Pre-Law Program/Bachelor of Arts in Political Science
Minor: Psychology

College for Financial Planning
Chartered Retirement Planning Counselor Designation

Kaplan Financial Education
Series 7 Stock Broker License

Chelsea Financial Services Broker Training Programs
Life Insurance and Financial Planning, (Multi-State)

Relevant Skills and Strengths:

- Owner/Operator of successful insurance company
- Office Administrator of success Counseling Business in East County
- Over 25 years in Senior Management position
- Excellent Mediation and Negotiation Skills
- Active in Alpine and surrounding communities helping seniors, homeless and special needs groups
- Strong supporter of our military, public safety and homeless populations
- Advocate for disenfranchised persons
- Excellent Customer Service Skills
- Committed to the safety and future of our community and surrounding communities
- Actively involved in community organizations
- Working knowledge of vocational rehabilitation and clinical procedures in counseling office that specializes in Worker's Compensation and Expert Testimony.
- HIPAA trained and compliant; ensuring confidentiality of sensitive medical, mental health and personal information; reviewed confidential and sensitive med/legal files.
- Experience with Workers Compensation and assisting injured workers with re-employment/return to work benefits; identifying suitable employment opportunities after reviewing physical disabilities and permanent restrictions. Assisted government employees in return-to-work with suitable and gainful employment.
- Heavy interaction with injured workers, physicians, attorneys, insurance carriers and claims adjusters, psychologists, government entities, schools and employers.
- Performed client intake
- Conducted Labor Market research, and Labor Market reports
- Reviewed and analyzed Sub Rosa tapes
- Excellent Microsoft Office, PC and Mac experience; managed electronic client data files
- Exceptional interpersonal and organizational skills, reliable and personable

PROFESSIONAL EXPERIENCE

Hartley Cylke Pacific Insurance Agency, San Diego, CA
Insurance Broker - 2003 – Present - (FT)
Responsible for Group Medical, Life and Health Insurance and various Fix Annuities, Retirement Planning and assisting clients with their insurance needs.

Barry Willis Insurance & Financial Services Agency, San Diego, CA
Insurance Broker - 1997 - Present - (PT)
Owner/Operator of a successful Insurance company that specializes in Retirement Planning, Series 7 Stock Broker license. Life Insurance and Financial Planning with clients.

Jeannette S. Clark & Associates Inc.
Office Administrator 10/1/2009 - Present - (PT), El Cajon, CA
Office Administrator and Logistics Manager for Certified Department of Labor Counseling/Vocational Rehabilitation and Personal Counseling Office: Responsible for Drafting and editing legal documents and correspondence, assisted Worker's Compensation clientele (injured Department of Labor, veterans and other government workers) with re-employment/ return to work benefits. Working knowledge of clinical procedures in vocational rehabilitation in a Counseling office. Heavy interaction with physicians, attorneys, psychologists, government entities, insurance carriers and claims adjusters, schools and employers. Performed client intake. Review confidential and sensitive medical files and brief attorneys; conduct labor market research surveys; reviewed, analyzed Sub Rosa tapes; generate legal and general correspondence including drafting expert witness statements; cash handling experience. Troubleshooting of PC/Mac and software. Electronic data management and filing. Excellent client relations. Greet clients, provide assistance in person and via phone. Answer telephones, respond to e-mails, schedule client appointments, and coordinate travel arrangements.

Denny's Restaurants
Restaurant Manager - 1981 - 1983, Pacific Beach, CA
Responsible for managing, marketing, scheduling, interviewing, hiring and termination of employees, teaching employees how to maintain a safe work place, food orders, front and back staff, cost of sales, budgets, cash handling, working with vendors and customer service.

COMMUNITY INVOLVEMENT:

Alpine Fire Protection District Board
Board Member - 2018

Alpine Kiwanis
Member - 2018

Santee Chamber of Commerce
Executive Board Member - 1996-1998
Elected to handle budgetary and Administrative issues at the local Santee Chamber

ATTACHMENT A

NOMINATION OF THE SPECIAL DISTRICT REPRESENTATIVES
LAFCO REGULAR AND ALTERNATE
FOR THE SAN DIEGO LOCAL AGENCY FORMATION COMMISSION

The SOUTH BAY IRRIGATION DISTRICT is pleased to nominate STEVE CASTANEDA as a
(Name of Independent Special District) (Name of Candidate)

Candidate for the San Diego Local Agency Formation Commission as a regular or alternate special district member.

Please check one box.
Refer to the List of Incumbents.

[ ] **Regular Special District Member** (Term expires 2023)
[✓] **Alternate Special District Member** (Term expires 2023)

As presiding officer or his/her delegated alternate as provided by the governing board, I hereby certify that:

- The nominee is a member of a legislative body of an independent special district whom resides in San Diego County.

Jose Preciado
(Signature)

JOSE PRECIADO
(Print Name)

1-9-19
(Date)

BOARD PRESIDENT
(Print Title)

PLEASE ATTACH RESUME FOR NOMINEE
- Limit two pages
- Must be submitted with Nomination Form

RECEIVED
JAN 25 2019
SAN DIEGO LAFCO

Steve Castaneda

Steve@PRMConsult.com

POSITION

Current Private Position: President, PRM Consulting, Inc. (www.prmconsult.com)
Marketing & Research firm specializing in providing services to government and non-Government clients.

Past and Present Public Sector Positions: Chair, Sweetwater Authority Board of Directors (2014-present);
Councilman, Chula Vista City Council (2004-2012); Member, Metropolitan Transit System (2010-2012);
Chair, San Diego County Law Enforcement Review Board (1996-2004)

STATEMENT OF QUALIFICATIONS

General Qualifications: Experienced in market level research with an emphasis on transportation, land use and government programs. Abilities include: program management, survey development and execution, conducting focus groups, public/government relations, media, and special event organization. Additional experience in community relations involving business and civic groups, as well as organizing and gathering community support for specific projects.

Pertinent Experience:

Marketing, Research, Outreach & Government Relations (1996-current)

Recent Clients:
Southern California Gas Company, Aviation Systems Associates, Imperial County Transportation Commission, California Department of Public Health, Southern California Association of Governments, Land Developers and Associates Corporation.

Contract Outreach Administrator (1995)

Golden Turner, Convention Center Builders
Served as program administrator to assist small, local businesses obtain necessary qualifications. Duties included direct company contact, garnering public support, media production and distribution. Organized construction management courses and worked with various business organizations.

Legislative Specialist (1992-1995)

Department of Intergovernmental Relations
City of San Diego
Served as consultant on the City Council's Committee on Transportation and Land Use. Duties included developing and preparing committee agendas, coordinating staff reports, providing independent analysis and maintaining media relations on behalf of the committee. Other responsibilities include analyzing state and federal legislation and coordinating city's legislative program and oversight of all transportation issues including transit service on behalf of the City Council. In addition, responsible for overseeing San Diego's multi-million dollar Capital Improvements Program and revising City's contract qualification process.

City Council Representative (1987-1992)

Office of San Diego Councilmember Ron Roberts
Duties included representing Councilmember in a variety of situations and issues. Responsible for analyzing issues making recommendations, in addition to working with community and business organizations and press media. Particular emphasis on equal opportunity policies, housing, transportation, land use and redevelopment.

Education National University, San Diego California
Business Administration

ATTACHMENT A

NOMINATION OF THE SPECIAL DISTRICT REPRESENTATIVES
LAFCO REGULAR AND ALTERNATE
FOR THE SAN DIEGO LOCAL AGENCY FORMATION COMMISSION

The Leucadia Wastewater District (Name of Independent Special District) is pleased to nominate Judy Hanson (Name of Candidate) as a

Candidate for the San Diego Local Agency Formation Commission as a regular or alternate special district member.

Please check one box.
Refer to the List of Incumbents.

[ ] **Regular Special District Member** (Term expires 2023)
[X] **Alternate Special District Member** (Term expires 2023)

As presiding officer or his/her delegated alternate as provided by the governing board, I hereby certify that:

- The nominee is a member of a legislative body of an independent special district whom resides in San Diego County.

Elaine Sullivan
(Signature)

ELAINE SULLIVAN
(Print Name)

12/12/2018
(Date)

PRESIDENT
(Print Title)

PLEASE ATTACH RESUME FOR NOMINEE
- Limit two pages
- Must be submitted with Nomination Form

RECEIVED

JAN 07 2019

SAN DIEGO LAFCO

LEUCADIA WASTEWATER DISTRICT | LEADERS IN ENVIRONMENTAL PROTECTION

Judy Hanson

LAFCO SPECIAL DISTRICT BOARD ALTERNATE

Experience Summary

My name is Judy Hanson and I have been actively involved with San Diego Local Agency Formation Commission (LAFCO) for the past 23 years. I have also been actively involved with special districts in a variety of ways for well over 50 years now. I am very interested in continuing my service as a San Diego LAFCO Special District Board Alternate and I believe my background and experience make me well suited for this position. I would appreciate your support by nominating me. A brief background of my experience is as follows:

LAFCO Experience

- Special District Board Alternate – 2016 – Present
- Special District Advisory Committee – 1996 – 2016

Special District Experience

Leucadia Wastewater District:

- Board of Directors 1983 – Present (most recently re-elected in 2016)
  - Investment & Finance Committee
  - Human Resources Committee
  - Employee Recognition Committee
- Board President – 2003, 2007, 2012, 2017

San Dieguito Water District:

- 33 Year Employee (Retired in 2010)
  - Served in a variety of positions in area of finance

California Special District Association – San Diego Chapter:

- Board of Directors - 2000 – 2004
- Chapter President – 2004
- Scholarship Committee Member

Based on these experiences, I believe I have a unique perspective of the challenges and opportunities facing Special Districts, which will allow me to continue to make valuable contributions to LAFCO. If you will provide me the privilege of serving as the Board Alternate, I promise that I will continue to be a tireless advocate for Special Districts from a platform of local control and fiscal conservatism.

Again, I am very interested in continuing my service to LAFCO and I would really appreciate your support – Thank you.

ATTACHMENT A

NOMINATION OF THE SPECIAL DISTRICT REPRESENTATIVES
LAFCO REGULAR AND ALTERNATE
FOR THE SAN DIEGO LOCAL AGENCY FORMATION COMMISSION

The Rincon del Diablo Municipal Water Distict is pleased to nominate Erin R. Lump as a
(Name of Independent Special District) (Name of Candidate)

Candidate for the San Diego Local Agency Formation Commission as a regular or alternate special district member.

Please check one box.
Refer to the List of Incumbents.

[ ] **Regular Special District Member** (Term expires 2023)
[X] **Alternate Special District Member** (Term expires 2023)

As presiding officer or his/her delegated alternate as provided by the governing board, I hereby certify that:

- The nominee is a member of a legislative body of an independent special district whom resides in San Diego County.

(Signature)

James Murtland
(Print Name)

January 16, 2019
(Date)

Board President
(Print Title)

PLEASE ATTACH RESUME FOR NOMINEE
- Limit two pages
- Must be submitted with Nomination Form

RECEIVED

JAN 17 2019

SAN DIEGO LAFCO

ERIN R. LUMP

Director, Rincon del Diablo Municipal Water District

(760) 215-0601
erin@erinlump.com

EDUCATION

Bachelor of Arts, Political Science, CSUSM, 2011
- Research, Critical Analysis, Social Behavioral Science Courses

Current California Real Estate License
- Real Estate Principals, Finance, Appraisal

OBJECTIVE

To Represent Special Districts as the Alternate Seat on the LAFCO Commission

RELEVANT EXPERIENCE

Vice President of the Board of Directors
Rincon del Diablo Municipal Water District | November 2014 - Present
- Chair of the Emergency Preparedness & Fire Services committee
- Served on the Finance, Insurance & Personnel & Public Information & Intergovernmental Relations Committees
- LAFCO Special District Advisory Committee since 2016

Realtor
Real Estate Professionals Group | March 2016 - Present
- Residential Real Estate
- Property Management

Vice President
Pacific Political, Inc. | April 2011 - March 2016
- Staff Management
- Website Design; Dreamweaver and Wordpress
- Graphic Design Services; Print and Web
- Social Media Marketing
- Volunteer & Employee Management
- Contribution & Database Administration
- Campaign Treasury Services
- Client Assistance
- Event Planning

Events Manager
Congressman Darrell Issa | February 2011 - March 2016
- Coordinator of High Dollar Fundraising Events
- Donor Lead Generation
- Email Marketing

Event Planner & Educational Instructor
Escondido Children's Museum - January 2007 - July 2010
- Guest Services & Database Management
- California Curriculum Standards Lesson Planning
- Marketing and Promoting the Museum
- Social Media & Website Maintenance

QUALITIES

Organized
Self-Motivated
Welcoming
Innovative
Problem Solver
Critical Thinker
Friendly
Happy
Professional
Creative
Well Spoken
Team Player
Trustworthy

TECHNOLOGY

MS Office (Word, Excel, PowerPoint, Publisher), Wordpress, Adobe CS (Dream Weaver, Photoshop, InDesign, Illustrator)

INTERESTS

Politics, Graphic Design, Technology, Reading, Community Volunteer

www.erinlump.com

connect with me on in

HESPERIA
Recreation & Park District
... Serving the Community Since 1957

Post Office Box 401055 • Hesperia, California 92340-1055 • (760) 244-5488

February 26, 2019

Teri Donnellan
Tri-City Healthcare District
4002 Vista Way
Oceanside, CA 92056

Dear Teri:

I want to share my interest in serving you and your District as the Southern Network (Seat B) representative on the CSDA Board of Directors. In order to accomplish this I am asking for your consideration and hopefully your District's vote. Once the nominations close, April 17th, the ballots will be emailed to each district's CSDA contact person. The deadline for returning the ballot to CSDA's office is August 9th.

It has been a privilege and honor to be active with CSDA by serving at the committee level as a representative of the California Special Districts Association's Southern Network. I have served the Hesperia Recreation and Park District (HRPD) since 1987 in a variety of capacities which has given me a well-rounded foundation in the special district governance. HRPD was established in 1957 and now serves a diverse population of over 90,000. Our District provides a wide range of recreational, educational, social and other vital community services to our residents.

With your support I will serve you, your agency, and the other member districts of CSDA with the same high level of professionalism, dedication, service, and innovation that I have provided to the residents of Hesperia and HRPD. If elected, I will work cooperatively with the other CSDA Board of Directors to advance the work we do throughout the state as well as work with other organizations to protect our districts and the vital services we provide to our communities. We are all facing many of the same challenges and I want to be an active part of the future of CSDA as we work to educate, strengthen, and defend special districts both now and in the future. Lastly, I am committed to working hard to keep our Districts intact.

I would greatly appreciate your board of director's support in the coming election. Thank you for your consideration.

Sincerely,

HESPERIA RECREATION AND PARK DISTRICT

Lindsay Woods
General Manager

/ldw

LEUCADIA WASTEWATER DISTRICT

LEADERS IN ENVIRONMENTAL PROTECTION

March 1, 2019

Ref: 19-6576

3-11-19

Board of Directors
Tri-City Healthcare District
4002 Vista Way
Oceanside CA 92056

Subject: LAFCO Elections – Request Your Vote for Ms. Judy Hanson

Dear Board of Directors:

On behalf of the Leucadia Wastewater District (LWD) Board of Directors, I am writing to request your vote for Ms. Judy Hanson for the Special District's Board Alternate position in the upcoming LAFCO election. The LWD Board nominated Ms. Hanson for the Alternate Board position at its December 12, 2018 meeting.

Ms. Hanson has served as the Special District Board Alternate since 2016. She was also the Vice Chair of the LAFCO Special District Advisory Committee (SDAC) and served on the committee from 1996-2016. In addition to the SDAC, Ms. Hanson has an extensive professional background with special districts that has spanned over 50 years. She has been on the LWD Board of Directors since 1983, serving on various Board committees as well as Board president in 2003, 2007, 2012 and 2017.

Ms. Hanson has also held various officer positions on the Board of Directors of the San Diego Chapter of the California Special Districts Association (CSDA), serving as Chapter President in 2004. Furthermore, Ms. Hanson was a special district employee for virtually her entire professional career, which included over 33 years of service with the San Dieguito Water District and later the City of Encinitas.

As can be seen, Ms. Hanson's involvement with special districts has been extensive on a personal, professional and political level. Throughout her career, Judy has been a long-time and tireless advocate for special districts from the platform of local control and fiscal conservatism. We are confident that, if elected, Ms. Hanson will continue to make many valuable contributions to LAFCO and represent special districts in a very positive way.

For these reasons, we urge you to vote for Ms. Judy Hanson for the LAFCO Special Districts Board Alternate. Your support is greatly appreciated.

Best Regards,

David Kulchin
President, Board of Directors

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
March 13, 2019

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 04/01/2019 – 03/31/2021)

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 04/01/2019 through 03/31/2021:

- **BERMAN, Blake DO/Neurosurgery (Southern Ca. Institute of Neurosurgery)**
- **GHOSH, Tanushree DO/Pediatrics (Vista Community Clinic)**
- **KIM, I. Anna MD/Ophthalmology (Rady Children's Hospital San Diego)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
March 13, 2019

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 04/01/2019 -03/31/2021)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 04/01/2019 through 03/31/2021, 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:

- **ANSARI, Rashad, MD/Rheumatology/Active Affiliate**
- **ARGOUD, Georges, MD/Endocrinology, Diabetes & Metabolism/Active Affiliate**
- **BODDU, Navneet, MD/Anesthesiology/Active**
- **BUCKLEY, Michael, DO/Anesthesiology/Provisional**
- **DELGADO, George, MD/Hospice & Palliative Medicine/Active Affiliate**
- **GILBOA, Ruth, MD/Dermatology/Refer and Follow**
- **HARTMAN, Andrew, MD/Orthopedic Surgery/Active**
- **LEE, Margaret, MD/Diagnostic Radiology/Active**
- **NICPON, Gregory, MD/Diagnostic Radiology/Active**
- **RAMBUR, Tricia, MD/Obstetrics & Gynecology/Provisional**
- **RYPINS, Eric, MD/General Surgery/Active**
- **VANFLEET, Robert, MD/Teleradiology/Provisional**
- **VORA, Roshni, MD/Anesthesiology/Provisional**
- **WANG, Anchi, MD/Neurology/Active**

RESIGNATIONS: (Effective date 03/31/2019 unless otherwise noted)

Automatic:

- **MONGEON, Robert, MD/Internal Medicine**

Attachment B

Voluntary:

- **BALLAS, Ierasimos, MD/Maternal & Fetal Medicine**
- **BLASKO, Barbara, MD/Emergency Medicine**
- **BRADLEY, Joseph, DO/Emergency Medicine**
- **DZINDZIO, Barry, MD/Cardiology**
- **ESKANDER, Ramez, MD/GYN Oncology**
- **KATZMAN, Lee, MD/Ophthalmology**
- **KELLY, Thomas, MD/Maternal & Fetal Medicine**
- **LEVIEL/Linda CNM/Allied Health Professional**
- **LIU, Alice, MD/Dermatology**
- **RAMOS, Gladys, MD/Maternal & Fetal Medicine**
- **TARSA, Maryam, MD/Maternal & Fetal Medicine**
- **WOELKERS, Douglas, MD/Maternal & Fetal Medicine**
- **WOLF, Richard, DO/Maternal & Fetal Medicine**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
March 13, 2019

EXTENSION OF PROCTORING

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 **September 30, 2019** would result in these privileges automatically relinquishing.

- GOLTS, Eugene MD — Cardiothoracic Surgery
- GRAMINS, Daniel MD — Cardiothoracic Surgery
- HOWE, Steven MD — Cardiothoracic Surgery
- LOTAN, Roi MD — Teleradiology
- PERRIZO, Nathan DO — Pain Medicine
- POLLEMA, Travis DO — Cardiothoracic Surgery
- RIAD, Shareef MD — Teleradiology
- ROSENBERG, Jay MD — Neurology
- SEIDEN, Grant MD — Orthopedic Surgery

ADDITIONAL PRIVILEGE REQUEST (Effective 3/29/2019, unless otherwise specified)

The following practitioners requested the following privilege(s) and met the initial criteria for the privilege(s):

- FERBER, Jeffrey M.D. — Family Medicine
- WAKILY, Hussna M.D. — General/Vascular Surgery

STAFF STATUS CHANGE

- FERBER, Jeffrey MD — Family Medicine

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
March 13, 2019

PROCTORING RECOMMENDATIONS (Effective 3/29/2019, unless otherwise specified)

• MOUSSAVIAN, Mehran DO	Cardiology
• STENZEL, Alison PA	Allied Health Professional
• WAKILY, Hussna MD	General Surgery
• WERNEID, Kristian MD	Anesthesiology

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT
March 5, 2019

Attachment B

ADDITIONAL PRIVILEGE REQUEST (Effective 03/29/2019, unless otherwise specified)
The following practitioners requested the following privilege(s) and met the initial criteria for the privilege(s)

- **FISHER-GAMEZ, Lori NP, RNFA** — **Allied Health Professional**
- **KAUR, Manpreet PA-C** — **Allied Health Professional**

ADMINISTRATION REVIEW CONSENT AGENDA
March 18th, 2019

CONTACT: Scott Livingstone, COO

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Code STEMI Policy	Practice Change	Forward to BOD for Approval
2. Diluting IV Medication for IV Push Administration Procedure	DELETE	Forward to BOD for Approval
3. D-Stat Rad-Band Topical Hemostat Procedure	DELETE	Forward to BOD for Approval
4. Emergency Cart (Crash Cart) Cardiopulmonary Arrest Policy	3 Year Review, Practice Change	Forward to BOD for Approval
5. Gowning & Gloving Procedure	3 Year Review, Practice Change	Forward to BOD for Approval
6. Medication Administration Policy	Practice Change	Forward to BOD for Approval
7. Monitor Technicians (MTs): Communication Process Policy	Practice Change	Forward to BOD for Approval
8. Pre-Operative Education Medication Instructions to Surgical Patients Standardized Procedure	2 Year Review, Practice Change	Forward to BOD for Approval
9. Pre-Operative Patient Preparation Procedure	2 Year Review, Practice Change	Forward to BOD for Approval
10. Titrating Medications, Adult Patients Policy	Practice Change	Forward to BOD for Approval
11. Universal Protocol Procedure	Practice Change	Forward to BOD for Approval
12. Ventricular Assist Device: Impella Nursing Care of Patient	NEW	Forward to BOD for Approval
13. Wearable Defibrillator (LifeVest)	3 Year Review, Practice Change	Forward to BOD for Approval
Administrative		
1. Confidentiality Policy 455	Practice Change	Forward to BOD for Approval
2. Doctor Strong Policy 221	3 Year Review, Practice Change	Forward to BOD for Approval
3. Patients Injured by Deadly Weapon or Criminal Act 315	3 Year Review, Practice Change	Forward to BOD for Approval
Emergency Operations Procedure (EOP) Manual formerly Disaster Manual		
1. Emergency Operations Plan Policy	Annual Review	Forward to BOD for Approval
Engineering		
1. Emergency Generator Test and Failures Policy	NEW	Forward to BOD for Approval
2. Failure of Fire Alarm System 8015 Policy	3 Year Review, Practice Change	Forward to BOD for Approval
3. Guidelines for Procedure for Failure of Essential Equipment 8017 Policy	3 Year Review, Practice Change	Forward to BOD for Approval
4. System Record Drawings 8019 Policy	3 Year Review, Practice Change	Forward to BOD for Approval
5. Utility Management Plan 4003 Policy	Annual Review	Forward to BOD for Approval
Environment of Care Manual		
1. Fire Plan - Code Red Policy	3 Year Review, Practice Change	Forward to BOD for Approval
2. Hazardous Material and Waste Management and Communication Plan	Annual Review	Forward to BOD for Approval
3. Life Safety Management Plan Policy	Annual Review	Forward to BOD for Approval

ADMINISTRATION REVIEW CONSENT AGENDA
March 18th, 2019

CONTACT: Scott Livingstone, COO

Policies and Procedures	Reason	Recommendations
4. Medical Equipment Management Plan Policy	Annual Review	Forward to BOD for Approval
5. Safety Plan Policy	Annual Review	Forward to BOD for Approval
6. Security Management Plan Policy	Annual Review, Practice Change	Forward to BOD for Approval
Food & Nutrition		
1. Scope of Nutrition Services for Oncology Patients Policy	DELETE	Forward to BOD for Approval
Infection Control		
1. Department Specific Infection Control Behavioral Health Services - IC 7	DELETE	Forward to BOD for Approval
2. Risk Assessment and Surveillance Plan	Annual Review, Practice Change	Forward to BOD for Approval
Mammography Women's Center		
1. Diagnostic Mammography Policy	3 Year Review, Practice Change	Forward to BOD for Approval
Medical Staff		
1. Appropriate Use of Commercial Support and Exhibits Policy 8710 - 603	Practice Change	Forward to BOD for Approval
2. CME Speaker & Honoraria Reimbursement Policy 8710 - 604	Practice Change	Forward to BOD for Approval
3. Conflict of Interest Resolution Policy 8710 - 605	Practice Change	Forward to BOD for Approval
4. CPOE Power Plan Revisions-Additions Policy 8710-568	3 Year Review, Practice Change	Forward to BOD for Approval
5. Educational Planning; Needs Assessment; Objectives; and Evaluation of a Continuing Medical Education (CME) Activity Policy 8710 - 600	3 Year Review, Practice Change	Forward to BOD for Approval
6. Joint Providership Co-Providership Policy 8710 - 602	3 Year Review, Practice Change	Forward to BOD for Approval
7. Medical Staff Standards of Conduct Policy 8710-552	3 Year Review, Practice Change	Forward to BOD for Approval
8. Regularly Scheduled Series (RSS) Policy 8710 - 606	Practice Change	Forward to BOD for Approval
9. Surgical Assistance Policy 8710-545	Practice Change	Forward to BOD for Approval
Pharmacy		
1. Medication Management Program Policy	3 Year Review, Practice Change	Forward to BOD for Approval
Rehabilitation		
1. NICU Scope & Qualifications Policy 505	3 Year Review, Practice Change	Forward to BOD for Approval
Surgical Services		
1. Second Witness Procedure for High Risk Medication Administration and Documentation in PACU, SPRA and Pre-Op Hold Policy	DELETE	Forward to BOD for Approval
Women & Newborn Services		
1. Uterine Tamponade Devices Procedure	3 Year Review, Practice Change	Forward to BOD for Approval

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 07/09 **SUBJECT:** Code STEMI

REVISION DATE(S): 03/10, 08/11, 04/12, 09/13, 04/14 ~~**POLICY NUMBER: IV.UU**~~

~~Department~~ Patient Care Services Content Expert Approval:	~~03/17~~12/18
Clinical Policies & Procedures Committee Approval:	~~09/17~~01/19
Nursing Executive ~~Council~~ Committee Approval:	~~09/17~~01/19
Division of Cardiology Approval:	~~12/17~~01/19
Pharmacy ~~and~~ & Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~01/18~~02/19
Administration Approval:	03/19
Professional Affairs Committee Approval:	~~02/18~~ n/a
Board of Directors Approval:	02/18

A. **PURPOSE:**

1. To provide a systematic method for responding to ST Elevation Myocardial Infarction (STEMI) patients.
2. To assure compliance with Centers for Medicare and Medicaid (CMS) and San Diego STEMI Guidelines as outlined by the County of San Diego Emergency Medical Services (EMS) STEMI Receiving Centers (SRC) Standards.

B. **POLICY:**

1. The Emergency Department (ED) physician, cardiologist or Mobile Intensive Care Nurse (MICN) determines when a patient meets STEMI criteria by reviewing the 12 lead ECG obtained in the hospital or pre-hospital.
2. The Rapid Response Team (RRT) Registered Nurse (RN) determines when an inpatient meets STEMI criteria by reviewing the 12 lead ECG.
3. The decision for medical management by Coronary Angiography, Percutaneous Coronary Intervention (PCI) or the use of fibrinolytics will be in accordance with the decision of the treating physician.
4. ~~The decision to transfer patient to a SRC, when a PCI cannot be initiated in a timely manner, will be in accordance with the decision of the treating physician.~~
5. ~~4.~~ Hospital EKG's should be completed within a goal of 10 minutes of being ordered and delivered directly to a RRT RN or physician for interpretation.

C. **PROCESS FOR EMERGENCY DEPARTMENT PATIENTS:**

1. STEMI Team activation:
   - a. ED Secretary will activate the Code STEMI at the direction of the physician
     - i. Contacts Private Branch Exchange (PBX) at 66 and requests Code STEMI activation to the ED.
     - ii. Pages the on-call Cardiologist to the appropriate ED phone number to consult with ED physician.
       1) If no response within 5 minutes, contact PBX and requests STAT page for on-call Cardiologist to the appropriate ED phone number to consult with ED physician.
   - b. MICN nurse will activate the pre-hospital STEMI based on ***Acute MI***/***ACUTE MI SUSPECTED*** on the field 12 lead ECG, or verbal report from the transporting agency of STEMI.
     - i. Contacts PBX at 66 and requests Code STEMI activation to the ED.
2. STEMI Team Notification

a. PBX operator will notify STEMI team members by sending a bulk page indicating Code STEMI activation and indicate patient name and bed assignment in ED.
   i. Cardiac Cath Lab (CCL) team
   ii. EKG technician
   iii. Phlebotomist
   iv. Radiology technician

3. STEMI Team Response:
   a. Cardiologist will respond to page by calling ED and consulting with ED physician.
   b. Phlebotomist, EKG technician, and Radiology technician will report directly to patient bedside in ED within 10 minutes of receiving page.
   c. CCL team will respond to PBX confirming page was received and report to CCL and ED within 30 minutes of page.
4. STEMI Team Response Verification
   a. PBX will notify the Code STEMI originator of the STEMI team response.
   b. If no response from a CCL team member, PBX will notify the Cath Lab Supervisor on call.
5. STEMI **Diversion**~~Bypass~~ Plan:
   a. MICN will maintain current status with the San Diego County MICN Data Entry Network as to the ability to receive STEMI patients.
   b. Cardiologist will be responsible for determining the need for STEMI ~~Bypass~~**Diversion**.
   c. Criteria for Interfacility Transfer of patients, who are identified as STEMI patients, when PCI cannot be initiated, will be according to hospital policy.
   d. **Diversion is called only when the patient is currently in the Cath lab, at no time will a STEMI Diversion be called if a patient is not currently in the Cath lab.**
   ~~c.~~**e. In the event that Tri City is on STEMI diversion and the mobile intensive care nurse (MICN) receives a prehospital alert that a STEMI is in route, before diversion, the MICN will contact the CCL to discuss possible acceptance of the patient.**
   f. Indications for Diversion:
      i. CCL Room 1 and 2 are non-operational.
      ii. CCL Room 1 non-operational and room 2 occupied with an electrophysiology case.
      iii. CCL Room 1 non-operational and room 2 occupied with an STEMI case.
      iv. STEMI patient in room 1 and room 2 occupied with an electrophysiology case.
      v. Off hours and staff occupied with STEMI Case.
      vi. Off Hours acceptance of a STEMI transfer patient.
      vii. Hospital at BED Capacity.
      viii. Equipment not available.
   g. Notifications:
      i. Notify CCL Manager and CV Service line Administrator
      ii. Notify Emergency Department (ER) of STEMI diversion Start and Finish time
      ~~i.~~**iii. Notify Administrative Supervisor**
1. Cancellation of Code STEMI:
   a. The ED physician or cardiologist evaluating the patient may, at his/her clinical discretion, cancel a STEMI activation.

B. **PROCESS FOR IN-PATIENTS:**

1. Patient complains of new onset chest pain or any other symptoms suggestive of Acute Coronary Syndrome (ACS) on an Acute Care Unit, the primary Registered Nurse (RN) shall assess the patient and notify the Rapid Response Team (RRT) and the unit Assistant Nurse Manager (ANM) /Relief Charge RN.
2. Telemetry patients with new onset ST elevation, the primary RN shall:
   a. Initiate therapy as ordered and/or as outlined in the Patient Care Services (PCS)

Standardized Procedure: Code Blue and Emergency Care (Cardiopulmonary Arrest): Chest Pain/(Related to Coronary Artery Occlusion or Spasm) AND

b. Notify RRT and the unit ANM/Relief Charge RN

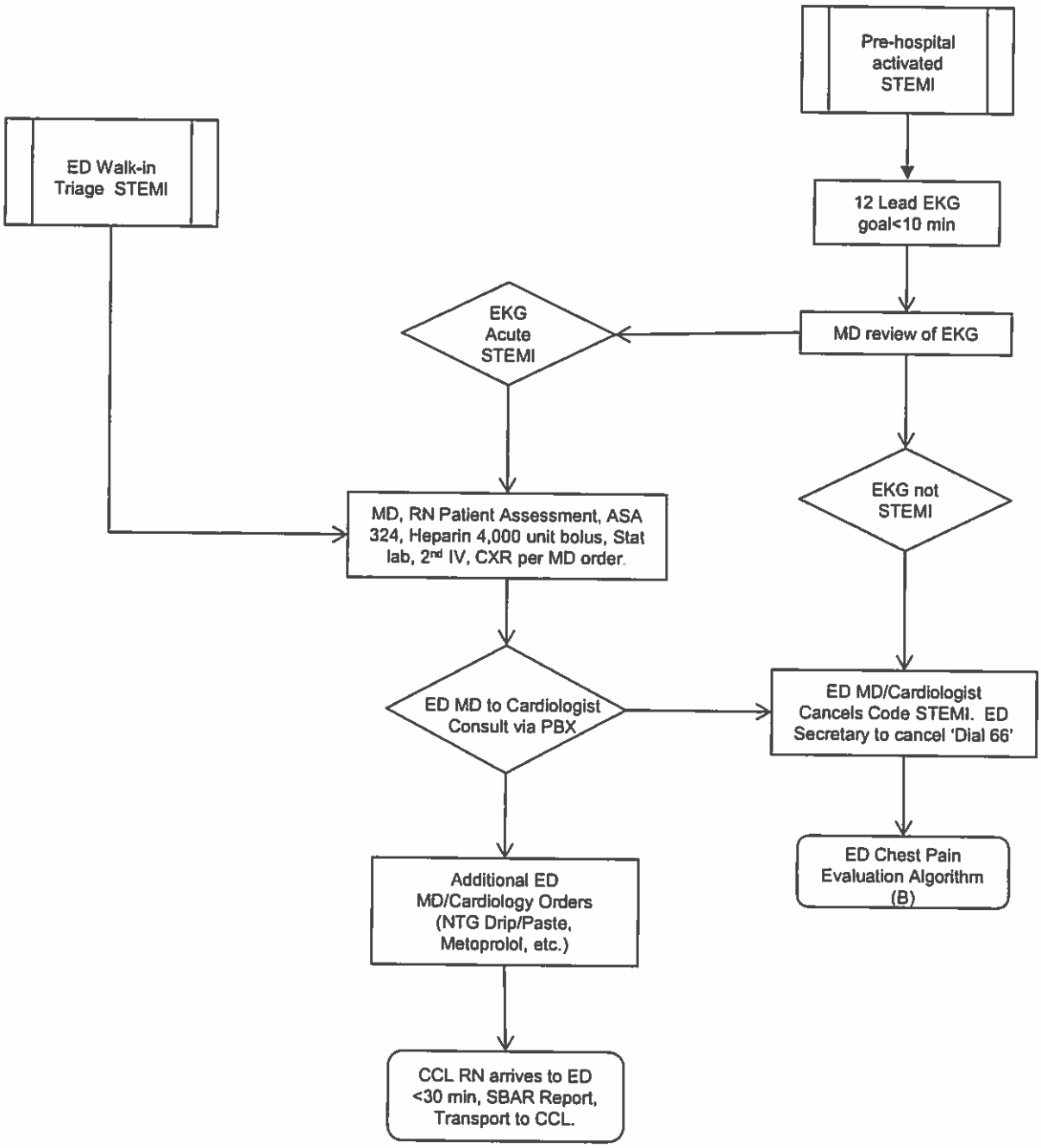
3. Rapid Response RN shall:
   a. Assess patient
   b. Order STAT ECG by dialing (760) 802-9484 or via PBX
   c. Treat patient per PCS Standardized Procedure: Rapid Response
   d. ECG technician performs ECG and hand-delivers ECG to RRT RN
   e. The RRT RN will review the ECG:
      i. If ECG is positive for ***Acute MI*** the RRT RN will:
         1) Dial 66 and request an IN-HOUSE CODE STEMI to room ___.
         2) Page attending physician to the patient's room to evaluate the patient.
         3) Call Pharmacy (x3012) to request delivery of STEMI Medication Kit
      ii. If ECG is negative for Acute MI, RRT treats patient according to standardized procedure. RRT or primary RN pages attending/physician for orders.
   f. PBX operator initiates IN-HOUSE CODE STEMI by announcing an overhead page "IN-HOUSE CODE STEMI room ___", and by sending a STEMI activation page to:
      i. Cardiac Cath lab (CCL) team
      ii. Phlebotomist
      iii. Radiology technician
      iv. Respiratory
   g. The attending physician will respond to the patient's room when an overhead IN-HOUSE CODE STEMI is paged. If no response by the attending physician within 5 minutes the RRT RN will call the hospitalist/on-call hospitalist. If no response from the hospitalist/on-call hospitalist in 5 minutes, the RRT RN will call ED charge nurse at 760-940-3509 for stat ER physician assistance to evaluate patient:
      i. Physician will verify the ECG
      ii. If positive for Acute MI, RRT RN will call PBX to page on call cardiologist to 760 802-3727
         1) If physician deems ECG to be negative for Acute MI, RRT will call PBX operator to cancel the IN-HOUSE CODE STEMI.
      iii. Attending physician, hospitalist/on-call hospitalist, ED physician communicates with the on-call Cardiologist.
   h. A pharmacist or pharmacy technician will deliver a STEMI Medication Kit upon request from the RRT RN. If not delivered within 5 minutes, the RRT RN will place a second call to the Pharmacy and/or contact a pharmacy technician
   i. Cath lab team reports to patient room to obtain report and transport patient to the CCL

C. **RELATED DOCUMENT(S):**
1. Code STEMI - ED STEMI Pathway
2. **Code STEMI** Pre-hospital STEMI Algorithm
3. ED Walk-In Triage Process – Chest Discomfort & Equivalent
4. In-House Code STEMI Flowchart – **Patient new onset ST elevation or chest pain**
5. STEMI Packet Instructions

D. **REFERENCE(S):**
1. Cardiac Cath Lab Policies and Procedures
2. Medical Staff Policy 520 "Emergency Room Call: Duties of the On-Call Physician"
3. Patient Care Service Policy VI.D "Transfer of Patients"
4. Emergency Department Policies and Procedures
5. **Emergency Department Bypass for ST-Segment–Elevation Myocardial Infarction Patients Identified With a Prehospital Electrocardiogram Akshay Bagai, James G. Jollis, Harold L. Dauerman, S. Andrew Peng, Ivan C. Rokos, Eric R. Bates, William J. French, Christopher B. Granger and Matthew T. Roe Circulation. 2013;128:352-359, originally published July 22, 2013 https://doi.org/10.1161/CIRCULATIONAHA.113.002339**

4.6. **California Code of Regulations Tittle 22. Social Security, Division 9. Prehospital Emergency Medical Services Chapter 7.1 ST Elevation Myocardial Infarction (STEMI) Critical Care System.**

Code STEMI – ED STEMI Pathway



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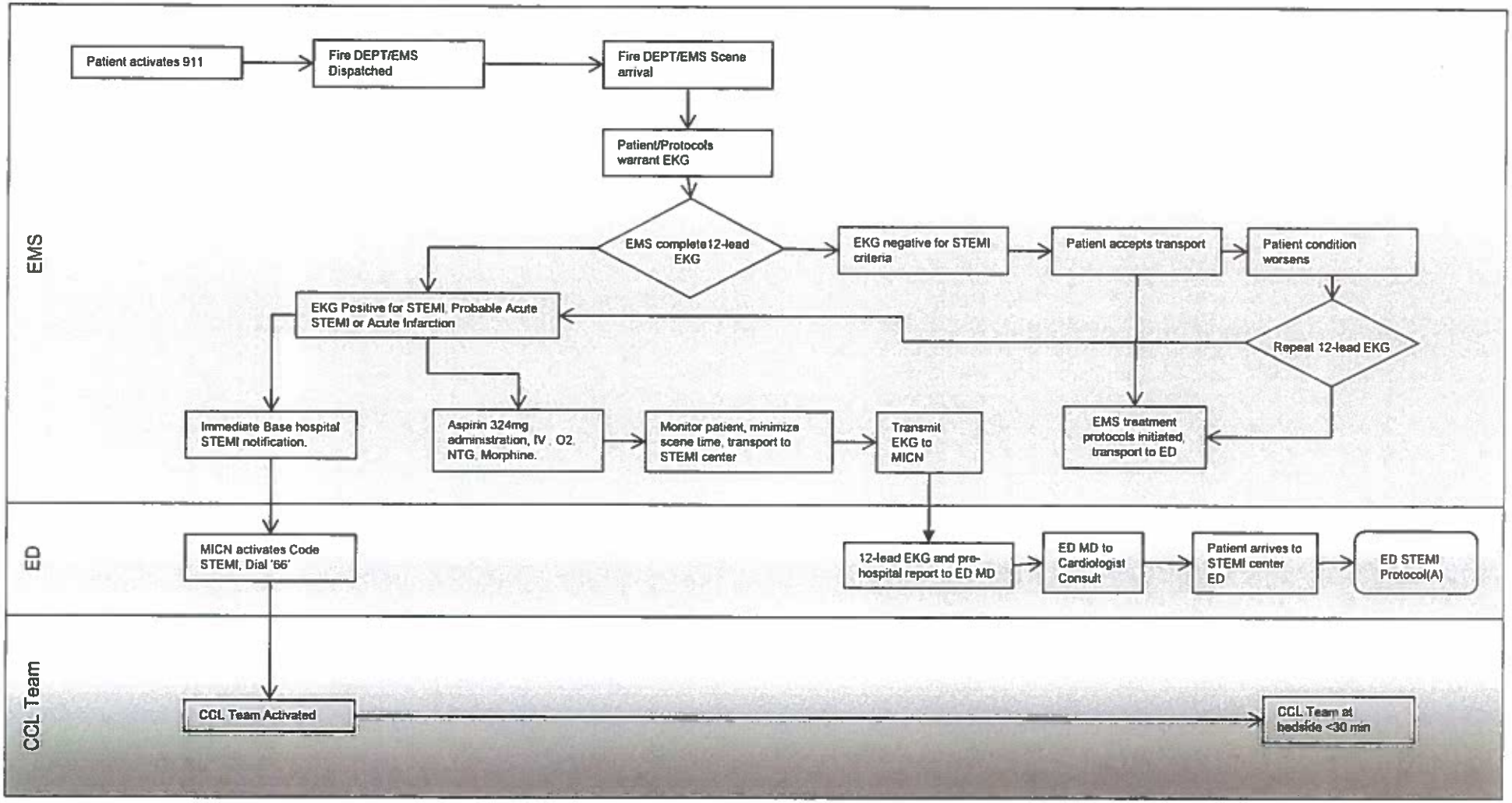
Tri-City Medical Center

Division of Cardiology	09/12, 11/12,, 12/17
Board of Directors	02/18

Code STEMI Pre-Hospital STEMI Algorithm

First Medical Contact to Device (FMC2D) Time Goal <90 minutes



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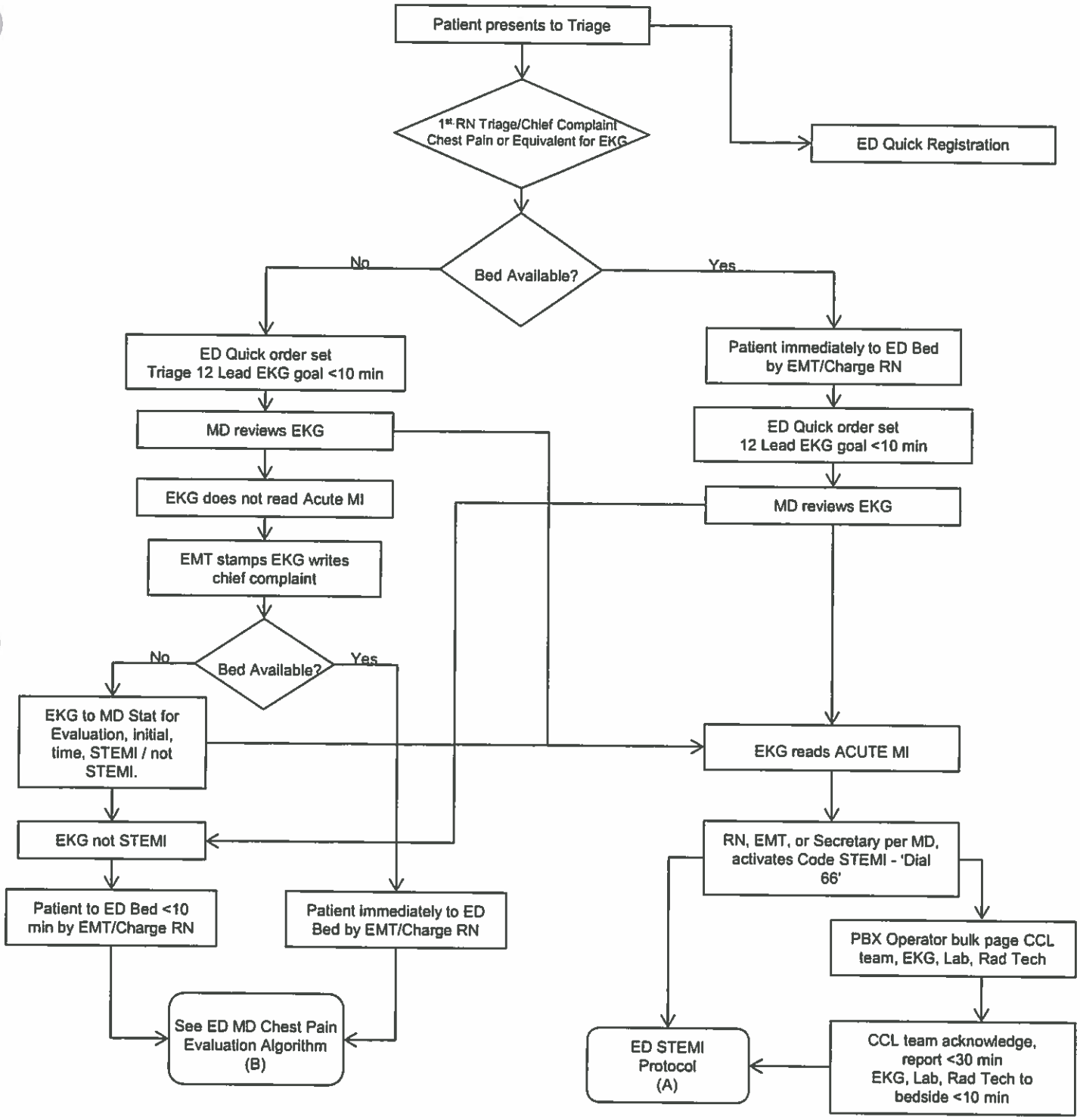
This Clinical Practice Guideline was developed to be of assistance to health care professionals by providing guidance and recommendations for particular areas of practice. The Guidelines should not be considered inclusive of all proper approaches or methods, or exclusive of others. The Guidelines cannot guarantee any specific outcome, nor do they establish a standard of care. The Guidelines are not intended to dictate the treatment of a particular patient. Treatment decisions must be made based on the independent judgment of health care providers and each patient's individual circumstances.

Division of Cardiology	07/13, 10/14, 12/17
Board of Directors	02/18

ED Walk-in Triage Process – Chest Discomfort & Equivalent



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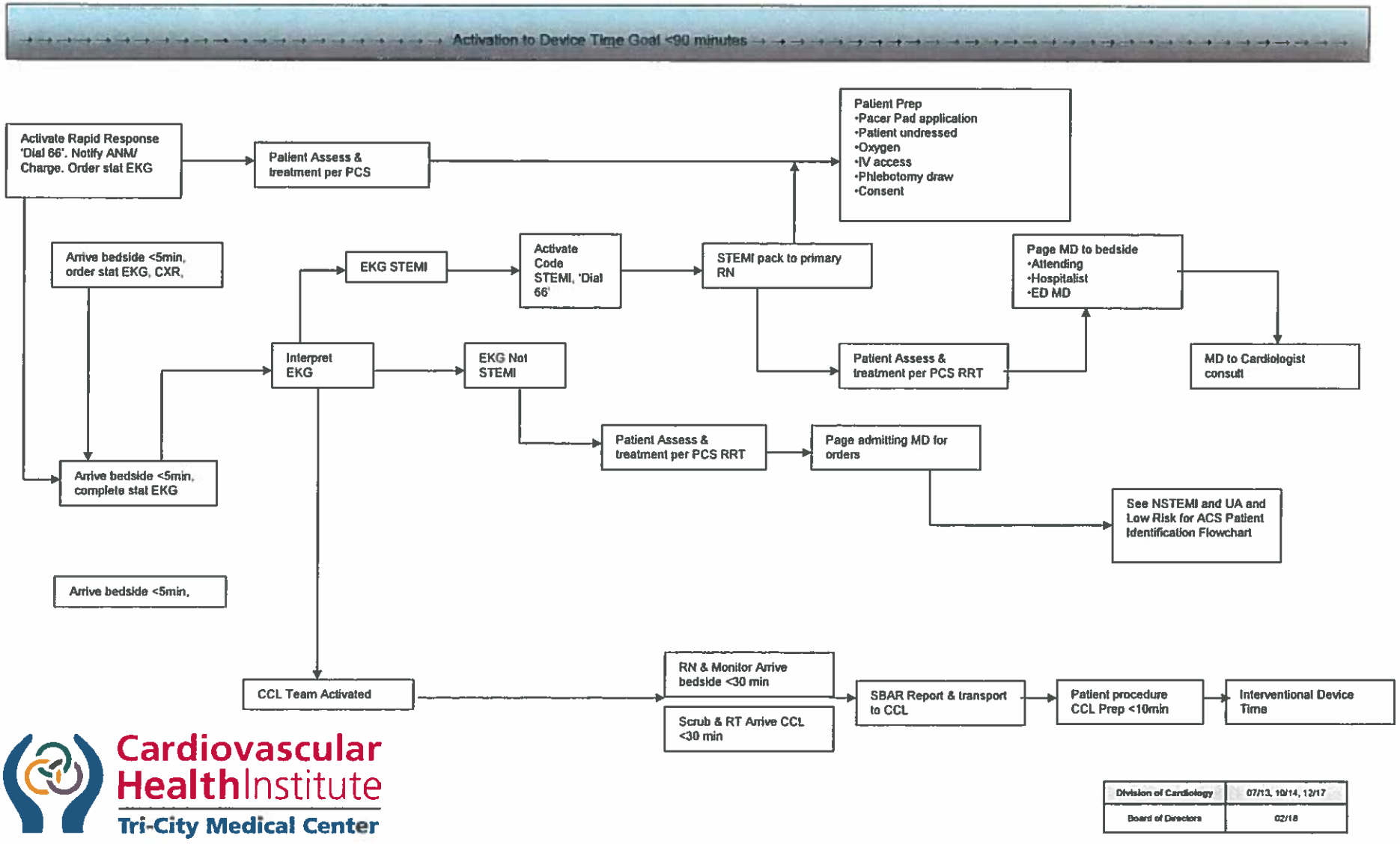
Division of Cardiology	09/12, 11/12, 12/17
Board of Directors	02/18

In-House Code STEMI Flowchart - Patient new onset ST elevation or chest pain



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Division of Cardiology	07/13, 10/14, 12/17
Board of Directors	02/18

STEMI PACKET INSTRUCTIONS

Goal – First Medical Contact to Intervention <90 minutes

Unit Departure to CCL <30 minutes

Code STEMI Activation

- ☐ Activate Red STEMI Packet, provide to the Unit Secretary or Primary RN.

Float RN / Tech

- ☐ Apply RADIOLUCENT pacer pads; anterior/posterior, cables pointing downward
- ☐ Undress patient completely, place clothing in belongings bag, encourage patient to void
- ☐ Obtain 1st vitals and bilateral BP's; BP q5 - 15 minutes thereafter
- ☐ Place patient on oxygen and insure oxygen tank on gurney is sufficiently full
- ☐ Make sure triple channel pump & portable defibrillator is available in room
- ☐ Complete patient belongings list and home medication list
- ☐ Shave patient's groin for procedure above knee to umbilicus both sides

Primary RN

- ☐ IV – 2 large bore (1 in left arm preferred), use extension tubing - Draw blood when starting IV (if possible)
  1) One red top, 2) One blue top, 3) One green top, 4) One small purple, 5) One large purple
- ☐ Medications: 1) Heparin bolus – NO drip (per physician order)
  2) Aspirin (ASA) (per physician order)
  3) Metoprolol (per physician order)
- ☐ Place preprinted consent on chart with patient sticker ready to be signed
  If no pre-printed consent is available, prepare as follows: "Cardiac catheterization with contrast and possible percutaneous transluminal coronary angioplasty with stent and possible sedation"
- ☐ Provide Red STEMI Packet to Cath Lab RN

Cath Lab

- ☐ Provide Red STEMI Packet to Cath Lab Tech for completion

Packet includes:
- STEMI Checklist
- Preprinted Consent

NOT A PART OF THE MEDICAL RECORD

Division of Cardiology	07/12, 12/17
Board of Directors	02/18

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**DILUTING IV MEDICATIONS FOR IV PUSH ADMINISTRATION**
~~Purpose:~~	~~To outline the RNs responsibility when prepa~~ ~~diluted before administration~~
~~Supportive Data:~~	~~Mosby's Nursing Skills, *Medication Administ*~~
~~Equipment:~~	~~1. Blunt tip access canula syringe (3 mL, 5~~ ~~2. 10 mL normal saline or sterile water vial~~ ~~3. Filter needle~~ ~~4. Alcohol swabs~~ ~~5. Needle or blunt tip needle~~

DELETE – procedure not needed, incorporate statement regarding dilution into Patient Care Services Policy: Medication Administration

~~A. **PROCEDURE:**~~

~~1. Verify the following against the electronic medication administration record (eMAR):~~
- ~~a. Patient name~~
- ~~b. Medication~~
- ~~c. Route~~
- ~~d. Dose~~
- ~~e. Administration time~~

~~2. Medication supplied by the manufacturer in a carpujet does not require dilution.~~

~~3. Verify compatibility of diluent with medication.~~

~~4. Check name of medication on vial/ampule label against MAR.~~

~~5. Check Expiration date printed on vial or ampule.~~

~~6. Perform hand hygiene.~~

~~7. Assemble medication and supplies at the admixture workstation.~~

~~8. Remove medication from glass ampule using a filtered needle or straw.~~
- ~~a. See Mosby's Nursing Skills, *Medication Administration: Intravenous Bolus.*~~

~~9. Change syringe access needle to a blunt tip access cannula syringe after withdrawing the medication using an ampule or vial preparation method.~~

~~10. Insert the blunt tip access cannula syringe into the 10 mL normal saline or sterile water~~ **vial** ~~(per the TCMC IV or medication manufacturer's guidelines) and withdraw the recommended amount of diluent. Never Use Pre-filled Normal Saline Syringes to Dilute or Mix Medications.~~

~~11. Discard the 10 mL normal saline or sterile water vial after desired amount of diluent has been removed.~~
- ~~a. 10 mL normal saline or sterile water vials may not to be used as multidose vials.~~

~~12. Remove cannula from vial, expel excess air bubbles from tip of syringe, and recap the blunt needle.~~

~~13.~~1. ~~Administer medication to the patient IV push per the physician orders and the Tri-City Medical Center IV Medication Guidelines or the medication manufacturer guidelines.~~

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
2/09; 9/15, **10/18**	06/11, 12/15, **11/18**	06/11, 01/16, **11/18**	n/a	03/16, **01/19**	07/11. 03/16, **02/19**	03/19	08/11, 04/16, n/a	08/11, 04/16

Tri-City Medical Center	Patient care services	DELETE: The product is no longer used at TCMC.

PROCEDURE:	D-STAT® RAD-BAND TOPICAL HEMOSTAT
Purpose:	To ensure continuity and patient safety using the D-Stat Rad-Band Topical Hemostat trans-radial (TR) band following radial artery catheterization by defining device application and removal, nursing assessment requirements, device complications and nursing interventions to resolve or minimize complications.
Supportive Data:	D-Stat® Rad-Band Topical Hemostat (Model 3501) Package Insert- Instructions for Use, Vascular Solutions, Inc. Vascular Solutions D-Stat Rad-Band Topical Hemostat Tips for Optimal Performance Vascular Solutions D-Stat Rad-Band Topical Hemostat Clinical Deployment Steps
Equipment:	D-Stat Rad-Band Pad Adjustable Retention Strap with foam comfort pads Pulse Oximeter with probe Small Tegaderm or Manufacturer's Adhesive Bandage 2x2 Gauze Dressing Wrist Positioning Splint

A. **DEFINITIONS:**

1. D-Stat Rad-Band Topical Hemostat: A radial artery compression device with a hemostat pad used to control surface bleeding from arterial access sites after radial artery catheter removal. For the purpose of this document, the D-Stat Rad-Band will be called a radial compression device.
2. D-Stat Pad: A pad containing thrombin and calcium chloride in a suspension that converts fibrinogen directly into fibrin.
3. Arterial Occlusion – A blockage of blood flow through an artery
4. Non-Occlusive Pressure Applied to an Artery – manual pressure or pressure applied with the use of a mechanical device that does not block (prevent) the flow of blood through an artery.
5. Occlusive Pressure Applied to an Artery – manual pressure or pressure applied with the use of a mechanical device that blocks the flow of blood through an artery

B. **POLICY**

1. The radial artery catheter may be removed by the procedural staff or a Registered Nurse (RN) on the receiving unit prior to applying the radial arterial compression device.
2. The RN on the receiving unit is responsible for monitoring, weaning, and removing the radial arterial compression device post procedure.
3. The D-Stat Rad-Band strap may not be used to apply occlusive pressure to the radial artery at any time.
4. The D-Stat Rad-Band pad may not be placed into a blood vessel and is contraindicated for patients with sensitivity to bovine-derived materials.

C. **PROCEDURE:**

1. Application of the Radial Arterial Compression Device

a. Remove the introducer radial artery catheter while applying non-occlusive manual compression by placing the D-Sat Rad-Band pad directly over the source of bleeding

b. Tighten the D-Stat Rad-Band by pulling on the retention strap until the device is secure on the patient's wrist and cessation of bleeding is observed, but the presence of pulses are still present

c. Do not apply occlusive pressure using the D-Stat Rad

d. Check pulses, both proximal and distal to the D-Stat Rad-Band, frequently to ensure arterial flow is present and loosen the retention strap as necessary

2.1. Post-Application of the D-Stat Rad-Band

Patient Care Services Content Expert	Clinical Policies and Procedures	Nurse Executive Committee	Medical Staff Department or Division	Pharmacy & Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
08/18	01/15, 09/18	02/15, 11/18	n/a	03/15, 01/19	2/15, 11/18	03/19	4/15, n/a	4/15

a. On arrival to nursing care area
   i. Mark retention strap at the current position. Marking the retention strap indicates the appropriate position to maintain hemostasis
   ii. Palpate radial pulse and assess perfusion of hand
   iii. Assess site for the presence of bleeding e.g., new or an increase presence of blood on the hemostat pad, blood oozing around pad and/or the presence of a hematoma
   iv. Assess site with each set of vital signs
b. Implement continuous pulse oximetry
   i. Place the probe on index finger or thumb of affected wrist distal to radial arterial compression device during compression and weaning of device.
   ii. Check pulse oximetry waveform:
      1) If pulse oximetry waveform is lost, decrease pressure slowly by loosening the retention strap until waveform returns.
      2) If pulse oximetry waveform is lost and bleeding is present see management of bleeding
c. Vital Signs
   i. Assess vital signs every 15 minutes times 6, then every 30 minutes times 4, then every two hours times two, then per Standards of Care.
   d. Neurovascular Assessments
   i. Perform a neurovascular assessment with vital signs and site assessments
   3. Management of Bleeding
   a. Ensure device is in the proper position
   b. Tighten retention strap to the position marked when patient arrived to unit or until hemostasis is achieved. Do not occlude the radial pulse.
   i. Notify the procedure Physician immediately if unable to regain hemostasis
   c. Palpate for the presence of a radial pulse. A palpable radial pulse must be present at all times.
   d. Do not tighten retention strap to occlude radial pulse
   e. Uncontrolled bleeding:
   i. Remove radial arterial compression device, elevate arm while applying manual pressure to stop the bleeding. Notify Physician immediately.
   4. Removal of Radial arterial Compression Device
   a. Maintain the radial arterial compression device in place for 30 minutes prior to weaning and may remain in place for a maximum of 1 hour with wrist positioning splint in place for 2 hours or as ordered by the Physician.
   b. Observe site for hemostasis (no bleeding noted or the formation of a new hematoma)
   c.i. Hold the band at a 45 degree angle close to the retainer to allow small, incremental adjustments to be made.
d. Loosen the retention strap one (1) click at a time every 15 minutes times four () by compressing the protruding tab on the clasp and slowly loosen the strap to the desired tension
   i. If hemostasis is achieved, decrease one (1) click every 5-10 minutes until the retention strap is loose
   ii. Assess for signs of bleeding i.e., oozing or hematoma with each click, if present reapply pressure by adjusting the retention band until bleeding stops ensuring a palpable pulse is present.
   iii. Reassess for achievement of hemostasis in 10 minutes, obtain vital signs
e. Assess for hemostasis, if achieved and tension on the retention strap is completely released:
   i. Secure the radial arterial compression device D-Stat pad by applying slight compression directly on the retainer while sliding the retention strap out of the side groove of the retainer

ii. Hold the tab of the D-Stat pad with one hand. With the other hand slowly pull the retainer back leaving the D-Stat pad in place, be careful not to disrupt the clot.
iii. Apply the D-Stat adhesive bandage or a tegaderm over the D-Stat pad
1) If the D-Stat pad is removed, apply a 2x2 gauze then apply a tegaderm
2) Do not stretch the adhesive dressing or tegaderm during application as tension can cause skin trauma
3) Do not leave the D-Stat pad in place for more than 24 hours; 24 hours or greater may result in skin irritation
iv. Immobilize affected arm using the wrist positioning splint for 2 hours post removal of the radial arterial compression device or as ordered

f. Removing the D-Stat Pad
i. Remove dressing within 24 hours or prior to discharge. Do not disrupt the clot
ii. Apply a small amount of saline to the D-stat pad to remove easily when stuck to the skin so as not to disrupt the clot.
iii. Apply a Ban-Aid to puncture site or leave open to air if ordered

5. Reportable Conditions
a. Notify the procedure Physician immediately if any of the following occur:
i. Unable to achieve hemostasis after repositioning device and tightening the retention strap
ii. New onset of distal pain, numbness, tingling, duskiness, bleeding, unable to palpate the radial pulse, or circulation to the hand appears compromised
iii. Patient complaint of chest pain or pressure not relieved with ordered treatment
iv. New onset arrhythmias

6. Documentation
a. Document the following in the Electronic Health Record (EHR):
i. All assessments
ii. Vital signs with pulse oximetry results
iii. Neurovascular assessments
iv. Dressing changes
v. Physician Notification
vi. Education provided – use Krames Custom Education leaflet Radial Artery Cardiac Catheterization /Angioplasty Discharge Instructions

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 12/01

SUBJECT: Emergency Cart (Crash Cart), Cardiopulmonary Arrest

REVISION DATE: 06/03, 10/04, 11/06, 10/07, 06/08, 08/09, 08/12

~~POLICY NUMBER: IV.O~~

Patient Care Services Content Expert Approval:	**~~03/16~~04/18**
Clinical Policies & Procedures Committee Approval:	**~~05/16~~08/~~18~~09/~~18~~01/19**
Nurse Executive Council Approval:	**~~05/16~~11/~~18~~01/19**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee:	**n/a**
Medical Executive Committee Approval:	**~~06/16~~11/~~18~~02/19**
Administration Approval:	**03/19**
Professional Affairs Committee Approval:	**~~07/16~~ n/a**
Board of Directors Approval:	**07/16**

A. **POLICY:**

1. Emergency Carts (crash carts) shall be checked at least daily for integrity and expiring products by a licensed healthcare provider or designee on the unit. This is documented by date, shift, and signatures in a logbook kept on top of the cart.
   - **a. The licensed healthcare provider or designee** checking cart will ensure missing items are replaced immediately. If items cannot be replaced in a timely manner, the cart should be replaced by the Sterile Processing Department (SPD).
   - **~~a.~~b.** A crash cart may be left on a unit that is closed if properly secured.
     - i. **The crash cart does not require checking until the unit is re-opened.**
       - 1) **The licensed healthcare provider or designee will write "Unit Closed" in the logbook for the dates when the unit was closed.**
2. Crash carts shall be stored in a visible or secure location.
3. SPD shall immediately replace any cart used during a Code Blue, Code Caleb or Code Pink **with an Emergency Cart that has been checked for integrity and expiring products.**
   - **a. The replacement cart shall be deemed ready for use upon arrival to the unit.**
   - **~~a.~~b.** After a code, one (1) lock is used to lock the cart before it is returned to SPD for cleaning.
   - **~~b.~~c.** The used crash cart shall remain locked and monitored until it is returned to ~~the~~ SPD.
4. The Code Blue Committee shall make recommendations for content changes based on code evaluations and recommendations from the American Heart Association.

B. **PROCEDURE FOR CHECKING CODE BLUE, CODE PINK AND CODE CALEB CRASH CARTS:**

1. All documentation of cart checks is completed on the department specific Emergency Equipment/Supplies Checklist. All fields must be completed and the document signed.
   - a. Check the integrity of all locks/tags. If any lock/tag is broken, call SPD to replace the cart.
     - i. Adult cart document:
       - 1) Lock number on the locking bar on the crash cart.
     - ii. Pediatric cart document:
       - 1) Medication drawer expiration date and lock number
       - 2) IV drawer expiration date and lock number
       - 3) Red Airway Bag expiration date and lock number

iii. Neonatal cart document:
1) Medication drawer expiration date and lock number
2) IV drawer expiration date and lock number

b. Check the medication sticker and document medication expiration date. **Ensure the sticker number matches the lock number. Notify Pharmacy of any lock number discrepancies.**
i. Notify Pharmacy of expired medications.

c. **Check non-medication supply sticker(s) and document the** expiration dates.

~~e.~~**d.** Check IV solution sticker and document expiration date.
i. Notify SPD if any supplies are expired.

e. **Presence and function of suction equipment** (except for neonatal cart).
i. **Suction unit shall be checked unplugged for adequate function.**
~~d.~~**ii.** Battery level of suction unit will be checked while unit is unplugged to ensure adequate charge.

~~e.~~**f.** Presence of Resuscitation Code Record and Evaluation/Debriefing form on clipboard appropriate to type of cart (adult, pediatric, neonatal).

~~f.~~**g.** Resuscitation algorithms appropriate for type of cart (adult, pediatric, neonatal).

~~g.~~**h.** The inventory lists attached to side of cart.
i. The list is maintained and updated by SPD.

~~h.~~**i.** One pack of ECG electrodes ~~(three pack)~~.

~~i. Defibrillator or AED pads appropriate for type of cart (except for neonatal cart), Ensure pads are not expired.~~

j. Presence of resuscitation bag (Ambu) and supplies appropriate for type of cart (adult, pediatric, neonatal).
i. Check the mask to ensure the seal is sufficiently inflated.

k. Presence of oxygen tank (except for neonatal cart).
i. Replace tank if gauge reads 1000 p.s.i. or less.

l. Presence of extension cord/multi-outlet cord.

m. Presence of backboard (except for neonatal cart).

n. For Pediatric/Broselow Cart only:
i. Scissors
ii. Two (2) Alaris Pumps

2. For units with Automatic External Defibrillators (AED):
a. Check unit for flashing hourglass
i. If hourglass is not visible or not flashing, notify Clinical Engineering immediately.
b. Ensure two (2) packs of AED pads appropriate for type of cart (except for neonatal cart), Ensure pads are not expired.
c. **Note:** HouseWide AED's are checked daily by Security Staff.

3. For units with defibrillators, check defibrillator for proper functioning **per Patient Care Services ~~Policy~~Procedure: Defibrillator Checks**.
a. **Ensure ~~D~~d**efibrillator pads appropriate for type of cart (except for neonatal cart), Ensure pads are not expired.

~~**Twenty-four (24) hour units will check defibrillator every shift while unit is open.**~~
~~**Episodic unit (i.e., procedural areas) shall check defibrillators once a day when unit is open.**~~

~~4. Process for checking defibrillator~~
~~i. Check unit cleanliness and inspect cables and connectors for integrity.~~
~~1) ECG electrodes should not be pre-attached to the leads.~~
~~ii. Ensure that there is you have a charged battery in the unit – testing will be performed with the unit unplugged from the power supply.~~
~~iii. Verify adult paddles are installed and are pushed all the away into their holders on the side of the M series unit.~~
~~iv. Ensure the Multi-Function Cable is plugged into the unit.~~
~~1) The Multi-Function Cable should not be plugged into the test connector.~~

~~v. Switch to monitor, listen for four beep tone. The message MONITOR should display.~~
~~1) If staff you need to adjust the time or date on the unit, depress the softkey on the far right prior to switching to MONITOR and adjust as needed (this should be performed every two weeks).~~
~~vi. Switch to PACER and set to a rate of 150 per minute.~~
~~vii. Press recorder button.~~
~~viii. Pacer pulses occur every two large divisions.~~
~~ix. Press 4:1 button, pulses occur every 8 large divisions.~~
~~x. Stop recorder~~
~~1) Note that signing, dating and retaining the recorder output is not a requirement.~~
~~xi. Set PACER OUTPUT to 0 mA and ensure that there is no CHECK PADS message.~~
~~xii. Disconnect Multi-Function Cable from the unit. Set PACER OUTPUT to 16 mA and ensure that there is a CHECK PADS message and alarm.~~
~~xiii. Connect multifunction cable to test connector,~~
~~xiv. Press Clear Pace Alarm softkey; CHECK PADS message will disappear and pace alarm stops.~~
~~xv. Disconnect multifunction cable from test connector,~~
~~xvi. Switch unit to DEFIB and set energy to 30 joules~~
~~1) The messages CHECK PADS and POOR PAD CONTACTS will alternately display.~~
~~xvii. Plug the Multi Function Cable into its test connector.~~
~~1) The message DEFIB PAD SHORT will display.~~
~~xviii. Press the CHARGE button on the front panel or on the apex paddle handle.~~
~~xix. Wait for the charge read tone to sound and verify that the energy ready value displayed on the monitor registers 30 joules.~~
~~1) The message will read DEFIB 30J READY~~
~~2) The strip chart recorder will print a short strip indicating TEST OK energy delivered if the unit delivered energy within specifications. . Note that signing, dating and retaining the recorder output is not a requirement.~~
~~3) During the Energy Delivery Test, unit will only discharge when energy level is set to 30 joules.~~
~~4) If TEST FAILED appears, contact Clinical Engineering (Biomed) or ZOLL Technical Service Department immediately.~~
~~Plug device back into the electrical socket after testing is complete.~~
~~xx. Ensure Multi Function Cable is plugged into the unit after testing is complete.~~

C. **FORM(S):**
1. Tri-City Medical center Crash Cart Checklists – Age Specific

D. **RELATED DOCUMENT(S):**
1. Patient Care Services (PCS) Policy: Rapid Response Team
2. PCS Procedure: Defibrillator Checks
~~2.~~**3.** PCS Procedure: Malignant Hyperthermia Management
~~3. Tri-City Medical Center Crash Cart Checklist Sample~~
4. Women & Newborn **Services** Procedure: Obstetrical (OB) Hemorrhage

TRI-CITY MEDICAL CENTER CRASH CART CHECKLIST - SAMPLE

GENERAL	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
LOCK # (check mark if unchanged from previous day)											DELETE																				
MEDICATION DRAWER EXPIRATION DATE																															
CART EXPIRATION DATE																															
SUCTION UNIT TESTED																															
CARDIOPULMONARY ARREST RECORDS & EVALS																															
RESUSCITATION ALGORITHMS																															
CART INVENTORY LISTS																															
ECG Electrodes (3 Pack)																															
AMBUBAGS/SUPPLIES																															
O_2 TANKS (psi > 1000)																															
EXTENSION/OUTLET CORD																															
BACKBOARD																															
2 WEST																															
DEFIB TESTED PLUGGED UNPLUGGED (DC 304)																															
DEFIB BATTERY CHECKED																															
MULTIFUNCTION PADS x3 (Check exp date)																															
PACEMAKER (on top of cart) Check Battery																															
Suction Supplies (tubing and Yankauer with suction unit)																															
SUPPLEMENTAL INTUBATION TRAY																															
SIGNATURE OF PERSON CHECKING CART Legend: ✓ = Present																															

UNIT:_____ TRI-CITY MEDICAL CENTER ADULT CRASH CART CHECKLIST MONTH/YEAR:_____

Legend: ✓ = Present/Checked R = Replaced	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
YELLOW LOCK # (check mark if unchanged from previous day)																															
YELLOW LOCK # MATCHES ORANGE STICKER #																															
MEDICATION DRAWER EXP DATE																															
CART (STERILE SUPPLIES) EXP. DATE																															
IV SOLUTION DRAWER EXP DATE																															
SUCTION UNIT TESTED(test unplugged, ensure battery is charged)																															
CARDIOPULMONARY ARREST RECORDS & EVALS																															
RESUSCITATION ALGORITHMS																															
CART INVENTORY LISTS																															
AMBU BAG																															
O_2 TANKS (PSI >1000)																															
EXTENSION/OUTLET CORD																															
BACKBOARD																															
REMOVE EXTRANEOUS SUPPLIES FROM TOP OF CART																															
AED		Yes				No																									
AED FLASHING BLACK HOURGLASS																															
AED PADS x2 (CHECK EXP. DATE)																															
DEFIBRILLATOR		Yes				No																									
DEFIB TESTED/BATTERY CHECKED																															
ECG ELECTRODES (Check exp. date)																															
GEL DEFIB PADS (Check exp. date)																															
MULTIFUNCTION PADS x2 (Check exp. date)																															
TIME UPDATED TWICE MONTHLY																															
SIGNATURE OF PERSON CHECKING CART, AED AND/OR DEFIBRILLATOR																															
DEFIB TESTED/BATTERY CHECKED (2nd CHECK)																															
SIGNATURE OF PERSON COMPLETING SECOND DEFIBRILLATOR CHECK (IF APPLICABLE) NOTE: Episodic unit (i.e. procedural areas) shall check defibrillators once a day when unit is open																															

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**GOWNING & GLOVING**
Purpose:	To outline the **process of** ~~nursing responsibilities in~~ gowning and gloving **for surgery and other invasive procedures.** ~~the surgical team:~~ **Surgical gowns and gloves are worn to protect patients and surgical team members from transmission of pathogens by establishing a barrier to minimize the passage of microorganisms, body fluids, and particulate matter between sterile and unsterile areas.** ~~A. Gowning~~ ~~B. Gloving, closed~~ ~~C. Gloving, open~~ ~~D. Changing a contaminated gown before donning sterile gloves~~ ~~E. Gowning and gloving team members~~
Equipment:	Sterile gown and gloves

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

1. **Surgical gowns and gloves shall be selected for use based on procedure-related requirements, end user requirements and preferences, and patient-related requirements.**
2. **Surgical gowns and gloves must provide a barrier and should be resistant to tears and punctures.**
3. **Barrier materials used for surgical gowns should be as lint-free as possible.**
4. **Scrubbed team members should perform surgical hand antisepsis before donning sterile gowns and gloves.**
5. **Scrubbed team members should don sterile gowns and gloves in a sterile area away from the main instrument table.**
6. **Scrubbed team member's hands and arms should be completely dry before donning a sterile gown.**
7. **Scrubbed personnel should select gowns of appropriate size and sleeve length.**
   a. **Gowns shall be of adequate size to cover completely in the back and sleeves of adequate length to prevent cuff exposure outside the glove.**
   b. **Gowns with excessive size or sleeve length increase risk of contamination.**

~~1.~~8. The front of a sterile gown is considered sterile from the chest to the level of the sterile field. Gown sleeves are considered sterile from two inches above the elbow to the cuff, circumferentially.

   a. The neckline, shoulders, ~~underarms, sleeve cuffs and gown back~~**and axillary areas of the surgical gown** are areas of friction and are not considered an effective microbial barrier, **therefore are considered contaminated**~~and are not sterile~~.
   b. **Sleeve cuffs are considered unsterile when scrubbed personnel's hands pass through and beyond the cuff.**
   c. **The back of the surgical gown cannot be constantly monitored and is considered unsterile.**

9. **Scrubbed personnel should inspect gloves for integrity after donning, before contact with the sterile field, and throughout use.**
10. **The closed assisted gloving method should be used to glove team members during initial gowning and gloving.**
11. **Scrubbed team members should wear two pairs of surgical gloves, one over the other, during surgical and other invasive procedures with potential for exposure to blood, body fluids, or other potentially infectious materials.**
    a. **When double gloves are worn, a perforation indicator system should be used (i.e., a colored pair of surgical gloves worn beneath a standard pair of surgical gloves).**

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Committee	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
04/94, 01/13 04/18	09/09, 01/13, 05/18	11/09, 01/13, 05/18	01/19	n/a	01/10, 05/13, 02/19	03/19	02/10, 6/13 n/a	02/10, 06/13

~~2.~~12. **Contaminated gloves should be changed as soon as possible. The preferred method of changing contaminated gloves is assisted gloving, where one member of the sterile team assists another. If this method is not feasible, open gloving must be used to change contaminated gloves. If it is not possible to change gloves at the moment the break in technique occurs, a new glove may be placed over the contaminated/damage glove until it can be changed.**

~~3. Gowns shall be of adequate size to cover completely in the back and sleeves of adequate length to prevent cuff exposure outside the glove.~~

~~4. Sleeve cuffs are considered unsterile when scrubbed personnel's hands pass beyond the cuff.~~

B. **PROCEDURE:**

1. **Gowning:**

~~5.~~a. Scrubbed ~~Nurse~~ personnel:

~~a.~~i. Open sterile gown and gloves on surface away from the main instrument table.

~~b.~~ii. Perform surgical ~~scrub~~**hand antisepsis**

~~c.~~iii. If a wet scrub was performed, dry hands and arms with a sterile towel. Be careful not to contaminate the sterile field or towel **by dripping water onto the sterile field or touching the towel to scrub attire or unsterile surroundings**.

~~d.~~iv. Grasp the ~~inner neckline of the~~**sterile** gown, **touching only the inside surface of the gown, step back away from sterile field** and allow the gown to unfold completely.

~~e.~~v. Insert arms into respective armholes ~~in~~**of** the gown, **keeping**~~leaving~~ hands inside **the sleeves**~~gown~~, above the cuffs **and keeping arms at shoulder height**.

~~6.~~b. Circulating ~~N~~nurse/designee:

~~a.~~i. Pull gown over **the** shoulders of scrubbed personnel, touching only the inside of the gown.

~~i.~~ Secure **Velcro tabs and ties** at the neckline and waist.

~~B.~~2. ~~GLOVING, CLOSED~~**Closed Gloving**:

~~1.~~a. Scrubbed personnel

~~a. Inspect gloves for integrity before donning them.~~

~~b. Contaminated gloves should be changed as soon as possible. The preferred method of changing contaminated gloves is assisted gloving, where one member of the sterile team assists another. If this method is not feasible, open gloving must be used to change contaminated gloves. If it is not possible to change gloves at the moment the break in technique occurs, a new glove may be placed over the contaminated/damage glove until it can be changed.~~

~~c. Closed gloving technique:~~

i. Grasp the folded cuff of the glove, keeping hands inside the cuff of the gown.

ii. Place the glove upside down on enclosed hand with the fingers pointing toward the body, and keeping thumb lined up with the thumb of the glove.

iii. Grasp inside the glove cuff with the enclosed thumb.

iv. With opposing enclosed hand, stretch the glove up and over the ~~stockinette~~ **sleeve** cuff.

v. Advance the hand through the cuff of the sleeve, keeping the ~~stockinette~~ **sleeve** cuff completely covered by the glove.

vi. Repeat for other hand.

vii. Pass gown tab with attached tie to another member of the team.

~~d.~~b. Circulating nurse/designee:

i. Hold card attached to sterile tie while scrub ~~nurse~~**person** pivots. Do not touch the sterile tie.

ii. Hold card securely while scrub **person** pulls sterile tie away.

~~iii.~~ Scrubbed personnel will tie **gown** at **the** waist.

~~C.~~3. ~~GLOVING, OPEN~~**Open Gloving**:

a. **Scrubbed personnel wearing a sterile gown shall:**

~~1.~~i. Extend hands through cuff of the sterile gown.
~~2.~~ii. Grasp the inner side of the glove cuff with the opposite hand. Do not touch the outside of the glove.
~~3.~~iii. Insert hand into glove and pull glove up over the entire cuff of the gown.
~~i.~~ Place gloved hand under the cuff of the opposite glove, lift and insert ungloved hand into glove, pull the glove over the hand completing covering the gown cuff.

~~D.~~4. Changing a contaminated gown: ~~(AND BEFORE DONNING STERILE GLOVES):~~
~~1.~~a. Circulating ~~N~~nurse **shall** unties~~-~~ scrub's gown and removes~~.~~ Do not touch bare arms.
~~a.~~ Scrubbed personnel repeat entire gowning and closed gloving procedure.

~~E.~~5. Gowning & gloving other team members:
~~1.~~a. Scrubbed personnel
~~a.~~i. Pass **a sterile** towel to newly scrubbed team member, if wet scrub performed. Do not contaminate self by touching bare hands or arms of scrubbed team member.
~~b.~~ii. Open gown, cuff hands under the neckline of the sterile gown, allow to completely unfold,and place over outstretched arms of team member.
~~c.~~iii. Release **the** gown, allowing **the** circulating nurse to pull **the** gown over **the** shoulders of **the scrubbed** team member and secure at neckline and waist.
~~d.~~iv. Grasp sterile glove, palm facing **the** ungloved team member, thumb to thumb.
~~e.~~v. Stretch cuff open and grasp firmly while team member advances hand into the glove.
~~f.~~vi. Repeat with other glove, then turn gown of team member, if a wrap around gown.
~~g. If powdered gloves are used, remove glove powder with damp towel.~~

~~F.~~C. REFERENCE(S):

1. **Rothrock, J. (2015).** Alexander's Care of the Patient in Surgery, ~~12th~~**15th** -Edition. **St. Louis, MO: Elsevier.**
~~1.~~2. **Conner, R. (2017). Guidelines for Perioperative Practice, 2017 Edition. Denver, CO: Association of PeriOperative Registered Nurses.**
~~2. AORN Perioperative Standards and Recommended Practices, 2012 Edition.~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**08/01**	**SUBJECT:**	**Medication Administration**
REVISION DATE(S):	**06/02, 01/03, 06/03, 12/03, 02/04, 03/05, 03/06, 04/07, 03/08, 09/08, 04/09, 03/10, 01/11, 07/11, 04/12, 02/14, 12/15**	**~~POLICY NUMBER: IV.I~~**	

Patient Care Services Content Expert Approval:	**~~03/17~~07/18**
Clinical Policies & Procedures Committee Approval:	**~~03/17~~09/18~~11~~/18**
Nurse Executive Committee Approval:	**~~03/17~~11/18**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**~~05/17~~01/19**
Medical Executive Committee Approval:	**~~06/17~~02/19**
Administration Approval:	**03/19**
Professional Affairs Committee Approval:	**~~07/17~~, n/a**
Board of Directors Approval:	**07/17**

A. **DEFINITION(S):**

1. Titrating Orders – orders in which the dose is either increased or decreased in response to the patient's clinical status. See Patient Care Services (PCS) Titrating Medications Policy.
2. Taper Orders – orders in which the dose is decreased by a specified amount with each dosing interval.
3. Indefinite Hold Medication Order – order for discontinuation of the medication (refer to PCS Automatic Stop Orders Policy).
4. Barcode medication administrator (BCMA) device [point of care (POC)] Solution designed to support positive patient identification using bar code technology. It is based on Cerner Millennium® Mobile technology and is deployed using hand-held devices with integrated bar code scanners.
5. Scheduled medications include all maintenance doses administered according to Tri-City Medical Center (TCMC) medication administration timeframes (e.g., QID, TID, BID, daily, weekly, monthly, and annually). Scheduled medications do not include:
   a. STAT AND Now doses
   b. First doses and loading doses
   c. One-time doses
   d. Specifically timed doses (e.g., antibiotic for surgical patient to be given a specified amount of time before incision, drug desensitization protocols)
   e. On-call doses (e.g., pre-procedure sedation)
   f. Time-sequenced or concomitant medications (e.g., chemotherapy and rescue agents, n-acetylcysteine and iodinated contract media)
   g. Drugs administered at specific times to ensure accurate peak/trough/serum drug levels.
   h. Investigation drugs in clinical trials
   i. PRN medications
6. STAT-medications to be given as soon as possible and within 30 minutes of availability of the medications.
7. Time-critical scheduled medications are those where early or delayed administration of maintenance doses of greater than 30 minutes before or after the scheduled dose may cause harm or result in substantial sub-optimal therapy of pharmacological effect. Examples of time-critical medications/medication types may include, but are not limited to:
   a. Antibiotics
   b. Anticoagulants

c. Insulin
d. Anticonvulsants
e. Immunosuppressive agents
f. Pain medication
g. Medications prescribed for administration within a specified period of time of the medication order
h. Medications that must be administered apart from other medications for optimal therapeutic effect (i.e. ciprofloxacin and multivitamin)
i. Medications prescribed more frequently than every 4 hours

8. Non-time-critical scheduled medications are those where early or delayed administration within a specified range of 1 hour should not cause harm or result in substantial sub-optimal therapy or pharmacological effect.
9. Controlled Substance: is a drug, compound, mixture, preparation or substance included in Schedule II, III, IV, or V.

B. **POLICY:**

1. Medication Order Process
   a. Medications shall be administered only upon the order of medical staff members or allied health professionals who have been granted clinical privileges to write such orders under the guidelines of their respective scopes of practice.
      i. Medications shall be administered according to the guidelines set forth in Administering Medication per Scope of Practice.
      ii. See PCS Physician/Provider Orders Policy for information on ordering medication including telephone/verbal orders and PRN medications.
   b. Medication orders shall be reviewed by pharmacists before administration by a licensed healthcare provider, unless a physician is overseeing administration of the medication, i.e. "Non-Profile" Pyxis areas.
      i. See Pharmacy Unlabeled Uses of FDA Approved Medications Policy for information on additional information on unlabeled use of medications
   c. Registered Nurses (RN) shall verify all new medication orders for accuracy using Nurse Review each time an order is added to the Electronic Medication Administration Record (eMAR) by the pharmacist per PCS Physician/Provider Orders Policy. The paper MAR is to be used ONLY if the eMAR is unavailable to staff.
      i. Respiratory Care Practitioners may conduct medication review for all nebulized and inhaled medications if the RN has not completed Nurse Review and one of the above medications is due for administration.
      ii. Under the supervision of a physician, physician assistant, or other appropriate licensed person, medical assistants in an outpatient setting may administer medications, except controlled substances, in several ways to a patient, including simple injections, ingestion or pre-measured medications.
      iii. Medical assistants who receive the appropriate training are allowed to administer injections of scheduled drugs only if the dosage is verified and the injection is intramuscular, intradermal or subcutaneous. The supervising physician or physician assistant must be on the premises as required in section 2069 of the Business and Professions Code, except as provided in subdivision (a) of that section. However, this does not include the administration of any anesthetic agent.
   d. A nurse may obtain medications not yet reviewed by a Pharmacist through the Pyxis override function only if need is deemed urgent or emergent.
      i. Urgent indications include those in which significant patient harm could result from a delay secondary to a pharmacist's review of the order.
      ii. Emergent indications include situations in which life, limb, or eyesight is threatened.
      iii. In each individual case, the need for the override must outweigh the risk of omitting the pharmacist's review of the order.

e. If orders are received with more than one set of ranges (dose and frequency), then the healthcare professional must clarify the order with the physician.
   i. If clarification is not obtained before the dose is needed, the RN shall implement range orders at the smallest ordered dose and the longest time interval between doses, if repeated dosing would be required. However, if the patient assessment indicates a clinical need for more aggressive intervention, then the individual implementing the range-dosed medication may initiate treatment at a higher dosage or administer the medication at the more frequent time interval within the parameters of the order.
   ii. Adjustments within the dose range are based on:
      1) Patient assessment
      2) Prior dose administered
      3) Time interval between doses
      4) Effectiveness of prior doses

f. The RN shall assess the patient and if therapy is not meeting clinical needs or desired response, the physician shall be contacted for dosage and/or frequency adjustment.

g. All continuous infusions of controlled substances shall have the medication in a secured device (for example lock box or locked infusion pump).

2. Medication Administration Process

a. The Electronic Medication Administration Record (eMAR) or paper MAR shall be evaluated at the beginning of each shift and PRN to:
   i. Verify medications to be administered during the shift.
   ii. Review and document review of allergies in the medical record.
   iii. Conduct Nurse Review (RN Sign-off) on any medications that have not yet been reviewed (identified with the icon of Eyeglasses) per PCS Physician/Provider Orders Policy.

b. Once BCMA application on hand-held devices is implemented, the departments shall use BCMA for medication administration.

c. Medications brought from home may be administered only on the order of a physician per PCS Medication Brought in by Patient Policy.
   i. A pharmacist shall positively identify the medication, print and initial a patient-specific medication label, and affix it to the medication container.

d. Prior to administration of heparin, the amount ordered and prepared shall be verified by a 2nd RN or licensed practitioner per PCS Medication High Risk/High Alert Policy.
   i. Identification of the patient shall take place in the patient's room
   ii. Behavioral Health Unit will not be required to validate in patient's room due to safety issues
   iii. Document first and last name and title of second practitioner who verified the medication via BCMA device or electronic medical record.

e. Prior to administration of intravenous insulin, heparin, 10% magnesium sulfate, tissue plasminogen activator (tPA) and patient controlled analgesia (PCA), or any medication given through an epidural, the amount ordered, amount prepared, initial infusion rate, and any changes in infusion rate shall be verified by a second RN or licensed practitioner per PCS Medication High Risk/High Alert Policy.
   i. Validation process shall take place in the patient's room.
   ii. Document initiation and dose changes on eMAR/paper MAR. Document first and last name and title of second practitioner who verified under the comments section.
      1) Document epidural/PCA assessment in IView.

f. For maximum amounts of solution to be administered intramuscularly in one site see Intramuscular Administration Amount per Site.

g. Medication shall be administered immediately by the licensed healthcare provider withdrawing the medication from an ampule or vial. If not administered immediately by the licensed staff, syringe must be labeled appropriately.

i. Non-controlled - medications shall be withdrawn from a single dose vial at bedside.
ii. Controlled Medication – requiring waste upon removal shall be performed according to PCS Controlled Substance (Narcotics) Management Policy and PCS Wasting Narcotics via Pyxis Machine Procedure.

h. Medication from ampules shall be prepared and labeled appropriately prior to entering patient room.

i. Medication from multi-dose vials shall be prepared and labeled appropriately prior to entering patient room or operating room.
i. Only vials clearly labeled by the manufacturer for multiple dose use can be used more than once.
ii. Limit use of a multi-dose vials to a single patient whenever possible.
iii. Multi-dose medications used for more than one patient are stored and accessed away from the immediate areas where direct patient contact occurs.
iv. If a multi-dose vial is taken into a patient room/operating room, it can only be used for that patient and must be discarded after use.
v. When multiple dose vials are used more than once, use a new needle and new syringe for each entry.
vi. Disinfect the vial's rubber septum before piercing by wiping (using friction) with an approved antiseptic swab. Allow the septum to dry before inserting a needle or other device into the vial.
vii. All multi-dose vials once opened or punctured, shall be labeled with an expiration date of 28 days or the manufacturer's date or package insert recommendations, whichever is shorter.

j. Label all medications, medication containers (i.e., syringes, medicine cups, basins), or other solutions on and off the sterile field in perioperative and other procedural settings. Refer to PCS Labeling Medication On and Off the Sterile Field Procedure.

k. Never administer medications from the same syringe to more than one patient, even if the needle is changed or you are injecting through an intervening length of IV tubing.

l. Do not enter a medication vial, bag, or bottle with a used syringe or needle.

~~**Medication supplied by the manufacturer in a carpujet does not require dilution.**~~

m. A medication may only be diluted in the neonatal and pediatric population unless specified by the manufacturer ~~**if needed for sufficient volume to administer over appropriate timeframe.**~~

~~m.~~**n.** Never use medications packaged as single-dose or single-use for more than one patient. This includes ampules, insulin pens, bags, and bottles of intravenous solutions, and sterile water bottles.
i. Use a single-dose/single-use vial for a single patient during the course of a single procedure
ii. Discard the vial after this single use, used vials should never be returned to stock on clinical units, drug carts, anesthesia carts etc.
iii. If a single dose/single use vial must be entered more than once during a single procedure for a single patient to achieve safe and accurate titration of dosage, use a new needle and new syringe for each entry
iv. Select the smallest vial necessary when making treatment decisions to reduce waste

~~n.~~**o.** Always use aseptic technique when preparing and administering injections.

~~o.~~**p.** For patients age 13 years and younger, the maximum IV solution volume for administration is 500 mL.

~~p.~~**q.** Educate the patient/family/significant other according to comprehension level. Education should include:
i. Drug name
ii. Dose
iii. Purpose

iv. Ask if they have any questions/concerns about taking the medication especially new or first time medications.
v. Side effects of medications.
1) Adverse drug reactions or side effects may occur with the first dose or any subsequent dose.
vi. Licensed healthcare providers shall provide teaching materials (drug leaflets, handbooks, videos, lectures, demonstration, and equipment) to all patients (parents, significant others) to prepare them for successful self-medication.
vii. Document all teaching on the Education – All Topics Form.

~~q.~~**r.** Discuss any unresolved, significant patient/family concerns about the medication with the patient's physician, prescriber (if different from the physician), and/or relevant staff involved with the patient's care, treatment, and services. Document in the medical record.

~~r.~~**s.** The licensed healthcare provider shall accurately document medication at the time of administration.

~~s.~~**t.** Scheduled medications shall be administered within 1 hour prior to the order time and 1 hour after the order time.

~~t.~~**u.** If a medication cannot be given at the time ordered, the appropriate reason shall be documented on the eMAR/paper MAR.

~~u.~~**v.** When administering medications from a standardized procedure, the health care provider shall enter the order electronically
i. Exception: Orders generated by screening in Cerner

~~v.~~**w.** If a medication is not administered or used, it shall be returned, wasted within 1 hour or at the end of procedure per Patient Care Services Controlled Substance (Narcotics) Management Policy.

3. Self Administration/Non-Staff
a. Persons who administer medications, but are not staff members (including the patient if self-administering), must demonstrate ability to safely administer medication before being allowed to self-administer medications. This includes understanding medication name, type, reason for use, how to administer medication (including process, time, frequency route and dose) and anticipated action/side effects of medication administered
i. If they cannot demonstrate the ability to safely administer medications:
1) They will not be able to self-administer until the ability is demonstrated.
2) Licensed healthcare providers will provide teaching using Tri-City Medical Center approved drug leaflets, handbooks, videos, lectures, demonstration, and equipment to all patients (parents, significant others) to prepare them for successful self-medication.
3) Discharge planning shall include a follow-up plan as needed.

4. Monitoring Effects of Medications on Patients
a. Effects of medications on patients are monitored to assess the effectiveness of medication therapy and to minimize the occurrence of adverse events.
i. Each patient's response to medication administered is monitored according to his or her clinical needs.
ii. Ongoing patient medication monitoring will use a collaborative approach between patient care providers, physician, pharmacists and the patient, family or caregiver.
b. Monitoring will address the patient's response to the prescribed medication and actual or potential medication-related problems.
c. The results of patient medication monitoring will be used to improve the patient's medication regimen and/or other clinical care and treatment processes.
i. The physician/Allied Health Professional will be notified if the medication therapy is not achieving the desired effect.

5. Medication Handling, Storage, and Disposal
a. All medications received from the pharmacy shall be placed in approved storage areas as soon as possible, not to exceed 30 minutes from the time of receipt.

b. Any medication removed from the medication storage area:
   i. Shall remain with the individual at all times and shall not be left unattended including flushes and vials.
   ii. Shall not be left on or in any area exceeding 80°F. This includes the pockets of the healthcare provider.
   iii. No medications~~, including flushes and vials,~~ shall be left at the bedside.
      1) Exception: Appropriately labeled topical ointments, creams, or pads as approved by the Pharmacy and Therapeutics Committee and ordered for bedside storage by the physician/Allied Health Professional
      ~~1)~~**2) Exception: In areas with designated storage area ~~the Post Anesthesia Care Unit (PACU)~~, medications shall be kept secured~~in wall-mounted lock boxes within each individual patient bay. Medications will be properly labeled and discarded/wasted before the patient is transferred/discharged from PACU. Medications shall never be left unattended outside a lock box~~.**

c. Access to medications and syringes are limited to appropriate staff via locked or computerized controlled access.

d. In all inpatient areas, insulin pens, creams, inhalers, eye drops and other medications that are not stored in the Pyxis medication station must be kept in patient-specific bins in a locked cabinet in the medication area.
   i. The primary nurse will be responsible for transferring these medications when a patient is transferred to another unit or room.
   ii. The primary nurse will be responsible for returning un-used medications or disposing of opened medications when a patient is discharged from the hospital.
   iii. The primary nurse must clean the medication bin with a sani-wipe after patient transferred or discharged.

e. A device holder will be used when administering a medication from a pre-filled syringe.

f. Any intravenous solutions spiked outside of a laminar flow hood must be initiated/administration started within 1 hour of being spiked.

g. Nursing personnel shall only compound or admix when not feasible for pharmacy to do so (i.e. emergency or product stability is short). Refer to Patient Care Services procedure Admixture, Intravenous). Medication preparation is performed by using aseptic technique as appropriate in a clean, uncluttered, functionally separate area, to minimize the possibility of contamination.

h. Unused/Intact Medication removed from the Medication Pyxis and not administered shall be returned to the Pyxis "Return Bin" with the exception of refrigerated and some designated controlled substance medication.
   i. For non-controlled medications that are too large, place into the red external "Return to Pharmacy" bin.
   ii. For controlled substances that are too large to be returned to the Medication Pyxis, contact pharmacy for assistance.

i. At discharge, unused intact medications shall be returned to the pharmacy.

j. For proper disposal of pharmaceutical waste,
   i. See Administrative Policy #276 Handling of Pharmaceutical Waste, Expired Medications, and Expired IV Solutions.
   ii. See the Patient Care Services procedure Hazardous Drugs for hazardous drug disposal and waste.

k. Patient specific medications maybe delivered by TCMC personnel as designated per Pharmacy.

6. Medication Error/Near Miss Reporting – see Administrative Policy Incident Report - Quality Review Report (QRR) RL Solutions Policy Number 8610-396

C. **PROCEDURE:**

1. For Departments Using BCMA:
   a. Prior to administering a medication, the licensed healthcare provider shall:

i. Verify correct patient
   1) Use two patient identifiers (see PCS Identification, Patient Policy)
ii. Verify medications due per eMAR
   1) Verify RN review completed, no eyeglasses icon, in all areas (except ED)
   2) Review allergies to make sure all information is current and correct before administration of any medications
   3) Review for any contraindication(s) for administering medication

a. Prepare medications for one patient at a time with the patient's current, updated eMAR for accuracy.
   i. Verify correct dose, route and time
   ii. Verify expiration date on medication package
   iii. Visually inspect medication integrity (i.e., discoloration, particulates, turbidity when a medication should be clear) or torn packaging may be signs of medication deterioration
   iv. Take all medication in their original packages into patient room to be scanned. When any medication is removed from package for mixing, crushing, or splitting, the package must be taken into patient room.
      1) Medications shall be crushed and administered separately.
      2) Crusher shall be cleaned after each crush if medication cups are not used inside of crusher.
      3) Pill splitter shall be cleaned after each use
b. Retrieve hand-held device from the unit specific secure hand-held device storage area.
c. Scan the "Aztec" barcode on the patient ID band to ensure the right patient record is opened on the BCMA application.
d. If a patient ID band does not scan, the licensed healthcare provider may replace the patient ID band, or manually search for the patient on the hand-held device using the patient identifiers on the patient ID band. Scan each medication with the hand-held device to ensure additional medication "rights" for mistake free medication are identified.
   i. Verify correct:
      1) Patient
      2) Dose
      3) Time
      4) Medication
      5) Route/ Rate (if applicable)
      6) Documentation
      7) Reason
e. Assess and resolve any warning message(s).

2. Educate the patient/family/significant other and address any unresolved concerns about the medication.
   a. Name of the drug, the dose, and the purpose according to the patient's ability to comprehend.
   b. Side effects of medications.
      i. Adverse drug reactions or side effects may occur with the first dose or any subsequent dose.
   c. Licensed healthcare providers shall provide teaching materials (drug leaflets, handbooks, videos, lectures, demonstration, and equipment) to all patients (parents, significant others) to prepare them for successful self-medication.
   d. Document all teaching on the Education – All Topics Form.
3. Administer medications after the medications are scanned and all "rights" are assured to be accurate.
   a. STAT or one-time medications shall be given as soon as they are available and the exact time given shall be documented.
   b. The licensed health care provider administering oral medication shall remain with the patient until the medication is successfully administered.

4. Sign the medications on the hand-held device after the medication is given and/or successfully administered. Comments may be added as required.
   a. The BCMA application will automatically update the Cerner system (eMAR) with the data entered.

D. **FOR DEPARTMENTS NOT USING BCMA:**
1. Prior to administering a medication, the licensed healthcare provider shall:
   a. Verify correct patient
      i. Use two patient identifiers (see PCS Identification, Patient Policy)
   b. Verify medications due per eMAR
      i. Verify RN review completed, no eyeglasses icon, in all areas (except ED)
      ii. Review allergies and/or contraindication(s) for administering medication
2. Prepare medications for one patient at a time with the patient's current, updated eMAR for accuracy.
   a. Verify correct dose, route and time
   b. Verify expiration date on medication package
   c. Visually inspect medication integrity (i.e., discoloration, particulates, and turbidity when a medication should be clear) or torn packaging may be a sign the medication deterioration
   d. Medication may be withdrawn from vial at bedside and shall be administered immediately. If medicine is prepared in the Medication room – the syringe must be labeled appropriately.
   e. The medication "rights" are identified before the medication is administered. Verify the following are correct:
      i. Patient
      ii. Dose
      iii. Time
      iv. Medication
      v. Route/ Rate (if applicable)
      vi. Documentation
      vii. Reason
   f. Medications shall be crushed and administered separately. Crusher shall be cleaned after each crush if medication cups are not used inside the device.
3. Educate the patient/family/significant other and address any unresolved concerns about the medication.
   a. Name of the drug, the dose, and the purpose according to the patient's ability to comprehend.
   b. Side effects of medications.
      i. Adverse drug reactions or side effects may occur with the first dose or any subsequent dose.
   c. Licensed healthcare providers shall provide teaching materials (drug leaflets, handbooks, videos, lectures, demonstration, and equipment) to all patients (parents, significant others) to prepare them for successful self-medication.
   d. Document all teaching on the Education – All Topics Form.
4. Administer medications after all "rights" are assured
5. The licensed health care provider administering oral medication must remain with the patient until the medication is successfully administered.
6. The licensed healthcare provider shall then accurately document medication administration in the eMAR or paper MAR as soon as possible after the dose is given.

E. **OUTPATIENTS:**
1. Any medication brought to the hospital by a patient who is to receive outpatient testing is the sole responsibility of the patient.
2. The hospital shall not administer nor handle any medications brought into the facility by patients for outpatient testing.

F. **CHEMOTHERAPY ADMINISTRATION:**

1. Chemotherapeutic agents shall be administered by TCMC chemotherapy credentialed RNs per the Oncology Chemotherapy Administration.
2. Notify pharmacy and oncology unit if chemotherapeutic agents are to be administered in areas other than dedicated chemotherapy area.

G. **HAZARDOUS DRUGS, HANDLING OF:**

1. See PCS Hazardous Drugs Procedure

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

1. Administrative Policy: Incident Report - Quality Review Report (QRR) RL Solutions – 8610-396
~~1.~~2. ~~Medication:~~ Administering Medication per Scope of Practice
~~2.~~3. **How Fast Can I Give That? IV Push Rate**
4. ~~Medication:~~ Intramuscular Administration Amount per Site
~~3.~~5. **Intravenous (IV) Medication Administration by Location**
~~4.~~6. ~~Medication~~**Medication** Administration Time Frames
~~5.~~7. PCS Procedure: Chemotherapy Administration
~~6.~~8. PCS Procedure: Admixture, Intravenous
~~7.~~9. PCS Policy: Automatic Stop Orders
~~8.~~10. PCS Policy: Controlled Substance (Narcotics) Management
~~9.~~11. PCS Procedure: Hazardous Drugs
~~10.~~12. PCS Policy: Identification, Patient
~~11.~~13. PCS Procedure: Labeling Medication On and Off the Sterile Field
~~12.~~14. PCS Policy: Medication Brought in by Patient
~~13.~~15. PCS Policy: Medication, High Risk/High Alert
~~14.~~16. PCS Policy: Physician/Provider Orders
~~15.~~17. PCS Policy: Titrating Medications
~~16.~~18. PCS Procedure: Wasting Narcotics via Pyxis Machine
19. Pharmacy Policy: Unlabeled Uses of FDA-Approved Medications

I. **EXTERNAL LINK(S):**

~~17.~~1. **Elsevier Medication Administration: Intravenous Bolus**

Administering Medication per Scope of Practice

X indicates who may administer	IV	IV PUSH	IVPB	PO	SQ	IM	SL	Intra-dermal	Topical	Inhalant Aerosol
RN	X	X	X	X	X	X	X	X	X	X
LVN I/Licensed Psychiatric Technician				X	X	X	X	X	X	X
LVN II (IV-certified) May only administer electrolytes, vitamins, nutrients, blood, and blood products	X			X	X	X	X	X	X	X
Respiratory Care Practitioners								X		X
Physical Therapist									X	
Licensed Physical Therapy Assistant									X	
Radiologic Technologists under physician guidance*	X			X						
Nuclear Med Technician*	X									
EKG/Echo Tech under direct supervision of physician as part of EKG/Echo procedure							X			
Medical Technicians								X		
Student RCP under supervision										X
Medical Assistants				X	X	X	X	X	X	

*Only RN's may administer IV mediations via PICC and central lines.

How Fast Can I Give That?
IV Push Rate

Medication	Rate of Admin
acetaZOLAMIDE	3 minutes
adenosine*	1 to 2 seconds
alteplase	**Stroke** 1 minute
aminophylline*	30-60 seconds
amiodarone	**Pulseless VT or VF:** Rapid IV push
atropine*	Rapid IV push
aztreonam	3-5 minutes
benztropine	1 minute
bumetanide	Rapid IV push
calcitriol	Rapid IV push
calcium chloride*	2-5 minutes or 100mg/min
calcium gluconate*	2-5 minutes or 200mg/min
ceFAZolin*	3-5 minutes
cefoTEtan	3-5 minutes
cefTAZidime*	3-5 minutes
cefTRIAXone*	2-4 minutes
cisatracurium*	5-10 seconds
cosyntropin	2 minutes
desmopressin	1 minute
dexamethasone*	1-4 minutes
dextrose 50%	200mg/kg/min
digoxine immune fab (Digifab)	IV bolus if cardiac arrest imminent
diltiazem	2 minutes
diphenhydrAMINE	25mg/minute
enalaprilat	5 minutes
EPINEPHrine*	Rapid IV push

Medication	Rate of Admin
esmolol	30-60 seconds
etomidate	30-60 seconds
famotidine*	2 minutes
fentaNYL*	1-2 minutes
flumazenil	30 seconds
fosphenytoin	150mg PE/minute
furosemide*	40mg/minute
glucagon	1 minute
glycopyrrolate	2 minutes
haloperidol	5mg/minute
heparin	5000 units/minute
hydrALAZINE	5mg/minute
hydrocortisone *	**For Doses<500mg:** 30 seconds
HYDROmorphone	2-5 minutes
insulin regular/ lispro	50 units/minute
ketamine	1 minute
ketorolac	15 seconds
labetalol	10mg/minute
levothyroxine*	1 minute
lidocaine*	**Stable VT:** 25-50mg/minute **VF or Pulseless VT:** Rapid IV bolus
lorazepam*	2mg/minute
magnesium sulfate	**Eclampsia/seizure:** 3-4 minutes **Cardiac Emergency:** Rapid IV push
meperidine	2-5 minutes
methocarbamol	3mL/minute
methohexital	1mL/5 seconds
methylergonovine	1 minute

Medication	Rate of Admin
methylPREDNISolone	**≤ 125mg:** 3-15 minutes **250mg:** 15-30 minutes **>500mg:** 30-60 minutes
metoclopramide*	**≤ 10mg:** 1-2 minutes
metoprolol	2-5mg/minute
midazolam*	**RSI:** 30 seconds **Other:** 2-5 minutes
morphine*	2-5 minutes
nalbuphine	2-3 minutes
naloxone*	30 seconds
octreotide	3 minutes
ondansetron	2-5 minutes
pantoprazole	2 minutes
phenobarbital*	50mg/minute
phenytoin	50mg/minute
prochlorperazine	5mg/minute
rocuronium	Rapid IV injection
sodium bicarbonate*	**Cardiac arrest:** Rapid IV push **Other:** 3-5 minutes
succinylcholine	10-30 seconds
vecuronium	Rapid IV push
verapamil	2.5mg/minute

~~Refer to P&P: Diluting IV Medications for IV Push Administration & Intravenous (IV) Medication Administration by Location for more information~~

**Last Updated August 30, 2018

*For NICU administration refer to Neofax guidelines

Intramuscular Administration Amount per Site

Age group (years)	Needle Length-max	Needle gauge	Volume-Max	Site(s)
Infant (0-1.5)	5/8 inch	25-27	0.5-1 mL: infant less than 1500 gm, maximum 0.5 mL	• Vastus lateralis • Rectus femoris
Toddler/ Preschool (1.5-3)	1 inch	22-23	1 mL	• Vastus lateralis • Rectus femoris • Dorsogluteal (for children who has been walking for at least one year)
Preschool (3-6)	1 inch	22-23	Deltoid: 0.5 mL All other sites: 1.5 mL	• Vastus lateralis • Rectus femoris • Dorsogluteal • Ventrogluteal (for children who have been walking for several years) • Deltoid (for children over 4 – 5 years of age due to small muscle mass)
School Age (6-15)	1-1 ½ inch	22-23	Deltoid: 0.5 mL All other sites: 1.5-2.0 mL	• Vastus lateralis • Rectus femoris • Dorsogluteal • Ventrogluteal • Deltoid
Adolescent (up to 21)	1-1 ½ inch	22-23	Deltoid: 1 mL All other sites: 2-2.5 mL	• Vastus lateralis • Rectus femoris • Dorsogluteal • Ventrogluteal • Deltoid
Adults	1-1 ½ inch	22-27(for aqueous solutions) 18-25 (for viscous or oil-based medications)	3 mL	

INTRAVENOUS (IV) MEDICATION ADMINISTRATION BY LOCATION					
		X = Approved for Level of Care Indicated			
Drug Name	Drug Class	ZONE 1 (OR, ICU, CCL, IR, ED, PACU)	ZONE 2 (2E/2W, 3P, 4E/4W, PCU)	ZONE 3 (1N, 2P, 4P, 1S-Rehab, L&D, Post-Partum)	Comments
Abciximab (ReoPro)	Antiplatelet	X	X		May be used post cath for limited duration in Zone 2 areas. Must use 0.22 micron filter.
Acetaminophen (Ofirmev)	Analgesic	X	X	X	
AcetaZOLAMIDE(Diamox)	Diuretic	X	X	X	
Adenosine (Adenocard)	Antiarrhythmic agent, diagnostic agent	X	X		IV PUSH ONLY. Infusion not recommended. If given centrally, reduce dose by 50%; otherwise use peripheral site as proximal to trunk as possible (not lower arm, hand, lower leg, or foot). Continuous ECG monitoring required. May be given as IV push in any unit pursuant to Rapid Response and Code Blue Standardized Procedures. Transfer to Critical Care Area as soon as possible
Albumin	Blood Product Derivative	X	X	X	
Allopurinol (Aloprim, Zyloprim)	Xanthine Oxidase Inhibitor	X	X	X	
Alteplase Tissue Plasminogen Activator (t-PA, Activase)	Thrombolytic	X	X	X	Infusion in Zone 1 only. CathFlo (2mL syringe) may be used to declot ports in any area. May be given IV push in any unit during Code Blue situations per MD order.
Aminocaproic acid (Amicar)	Hemostatic Agent	X			Do not administer as an IV push
Amiodarone (Cordarone)	Antiarrhythmic agent	X	X (Fixed Rate, no titration by Nurse)		** Central line preferred, must use 0.22 micron filter. IV Push during cardiac arrest only per ACLS. May be administered in any unit pursuant to Rapid Response and Code Blue Standardized Procedures. Transfer to Critical Care Area as soon as possible.

ZONE 1 = OR, ICU, CCL, IR, ED, PACU
ZONE 2 = 2E/2W, 3P, 4E/4W, PCU
ZONE 3 = 1N, 2P, 4P 1S – Rehab, L&D, Post-Partum

INTRAVENOUS (IV) MEDICATION ADMINISTRATION BY LOCATION					
		X = Approved for Level of Care Indicated			
Drug Name	Drug Class	ZONE 1 (OR, ICU, CCL, IR, ED, PACU)	ZONE 2 (2E/2W, 3P, 4E/4W, PCU)	ZONE 3 (1N, 2P, 4P, 1S-Rehab, L&D, Post-Partum)	Comments
Antibiotics (i.e. penicillin G, ampicillin/sulbactam, piperacillin/tazobactam, ceftriaxone, ceftazidime, levofloxacin, trimethoprim/sulfamethoxazole, clindamycin, aztreaonam, amikacin)		X	X	X	Administration of some antibiotics may be preferred via central line. Contact pharmacy for more information.
Antifungals (i.e. amphotericin, fluconazole, voriconazole, micafungin)		X	X	X	
Antivirals (i.e. acyclovir, ganciclovir, Foscarnet)		X	X	X	**Central line preferred
Argatroban	Anticoagulant, Direct Thrombin inhibitor	X	X	X	
Atropine	Anticholinergic	X	X		May be used by GI lab RN's for salivation reduction and anti-spasmodic effect of the esophagus, stomach, and pylorus. May be given in any unit pursuant to Rapid Response and Code Blue Standardized Procedures.
Azathioprine (Imuran)	Immunosuppressant	X	X	X	Use Hazardous Medications handling precautions
Bivalirudin (Angiomax)	Anticoagulant, Direct Thrombin inhibitor	X	X		PCI and Cardiac Surgery only; not for inpatient use. May be used post cath for limited duration in ZONES 1 and 2.
Blood Factors (i.e. Factor VIII (Alphanate), Recombinant Factor VIII (Benefix), Recombinant VIIa (NovoSeven), Factor XI (Alphanine), Prothrombin Complex Concentrate (PCC, Profilnine SD)		X	X	X	Alphanine (Factor IX) and Prothrombin Complex Concentrate (PCC or Profilnine SD) are NOT interchangeable. Prothrombin Complex Concentrate contains Factors II, IX, and X).
Bumetanide (Bumex)	Loop Diuretic	X	X (Fixed Rate only, no titration by nurse)	X (IV Push Only)	
Buprenorphine (Buprenex)	Opioid	X	X	X	
Butorphenol (Stadol)	Opioid	X	X	X	
Caffeine sodium benzoate	Central Nervous System Stimulant	X	X	X	
Calcitriol (Rocaltrol)	Vitamin D Analog	X	X	X	May be administered as a bolus into the venous line at the end of dialysis by dialysis nurses

ZONE 1 = OR, ICU, CCL, IR, ED, PACU
ZONE 2 = 2E/2W, 3P, 4E/4W, PCU
ZONE 3 = 1N, 2P, 4P 1S – Rehab, L&D, Post-Partum

INTRAVENOUS (IV) MEDICATION ADMINISTRATION BY LOCATION					
		X = Approved for Level of Care Indicated			
Drug Name	Drug Class	ZONE 1 (OR, ICU, CCL, IR, ED, PACU)	ZONE 2 (2E/2W, 3P, 4E/4W, PCU)	ZONE 3 (1N, 2P, 4P, 1S-Rehab, L&D, Post-Partum)	Comments
Calcium Chloride	Electrolyte	X	X	X	Central line preferred. Infusion preferred. May be given IV push over 5-10 minutes during emergencies and/or Code Blue Only.
Calcium Gluconate	Electrolyte	X	X	X	If used to treat magnesium toxicity in L&D/Postpartum, patient must be on a cardiac monitor.
Chemotherapeutic agents (i.e. bleomycin, CARBOplatin (Paraplatin), CISplatin (Platinol), Cytarabine, conventionalcyclophosphamide (Cytoxan), dacarbazine, DOCEtaxel (Taxotere), Doxorubicin (Adriamycin), DOXOrubicin liposomal (Doxil), epirubicin, etoposide (Toposar), Fluorouracil (Adrucil), gemcitabine (Gemzar), idarubicin, ifosfamide (Ifex), Irinotecan (Camptosar), methotrexate, Oxaliplatin (Eloxatin), PACLitaxel (Taxol), vinBLAStine, vincristine (Oncovin)		X	X	X	Chemotherapy for all floors to be delivered to 2P, EXCEPT chemo for Progressive Care Unit patients, IR and OR patients. Chemo will be delivered directly to those areas. See Chemotherapy Administration P&P. Handling precautions- dispose of as hazardous chemical waste.
ChlorproMAZINE (Thorazine)	Antipsychotic	X	X	X	Slow IV infusion (Max rate 1 mg/minute) for hiccups only. IM injection is preferred for all other indications. Do not administer an IV push
Clevidipine (Cleviprex)	Antihypertensive agent, Calcium Channel Blocker	X			Use within 12 hours of puncturing vial
Conivaptan (Vaprisol)	Vasopressin antagonist	X	X		**Central line preferred. Monitor serum sodium at least every 8 hours. Change infusion site every 24 hours if peripheral line used
Conjugated Estrogens (Premarin IV)	Estrogen Derivative	X	X	X	Use Hazardous Medications handling precautions
Cosyntropin	Corticosteroid, Diagnostic agent	X	X	X	
CycloSPORINE (sandIMMUNE)	Immunosuppressant	X	X		Requires close observation for at least during the first 30 minutes of infusion and monitored frequently thereafter. Anaphylaxis has been reported with IV use, reserve for patients who cannot take oral form. Use Hazardous Medications handling precautions

ZONE 1 = OR, ICU, CCL, IR, ED, PACU
ZONE 2 = 2E/2W, 3P, 4E/4W, PCU
ZONE 3 = 1N, 2P, 4P 1S – Rehab, L&D, Post-Partum

INTRAVENOUS (IV) MEDICATION ADMINISTRATION BY LOCATION					
		X = Approved for Level of Care Indicated			
Drug Name	Drug Class	ZONE 1 (OR, ICU, CCL, IR, ED, PACU)	ZONE 2 (2E/2W, 3P, 4E/4W, PCU)	ZONE 3 (1N, 2P, 4P, 1S-Rehab, L&D, Post-Partum)	Comments
Dantrolene (Dantrium, Revonto, Ryanodex)	Skeletal Muscle Relaxant	X		X (L&D Only)	
Deferoxamine (Desferal)	Antidote	X			
Desmopressin (DDAVP)	Vasopressin analog	X	X	X	
Dexamethasone (Decadron)	Corticosteroid	X	X	X	
Dexmedetomidine (Precedex)	Sedative	X			
Diazepam (Valium)	Benzodiazepine	X	X	X	IV Push Only. Continuous infusion is not recommended. GI lab RN may give IV push under direct supervision of a physician
Digoxin (Lanoxin)	Cardiac glycoside	X	X	X	
Digoxib immune fab (DigiFab)	Antidote	X	X		Slow IV infusion over 30 minutes. If cardiac arrest imminent, may give via IV push. Stopping the infusion and restarting at a slower rate may help if an infusion-related reaction occurs.
Dihydroergotamine (DHE 45)	Antimigraine	X	X	X	
Diltiazem (Cardizem)	Calcium Channel Blocker	X	X (Fixed Rate only, no titration by Nurse)		May be given in any unit pursuant to Rapid Response and Code Blue Standardized Procedures. Transfer to Critical Care Area as soon as possible
DiphenhydrAMINE (Benadryl)	Antihistamine	X	X	X	
DOBUTamine (Dobutrex)	Adrenergic agonist	X	X (Fixed Rate only, no titration by Nurse)		** Central line preferred

INTRAVENOUS (IV) MEDICATION ADMINISTRATION BY LOCATION					
		X = Approved for Level of Care Indicated			
Drug Name	**Drug Class**	**ZONE 1 (OR, ICU, CCL, IR, ED, PACU)**	**ZONE 2 (2E/2W, 3P, 4E/4W, PCU)**	**ZONE 3 (1N, 2P, 4P, 1S-Rehab, L&D, Post-Partum)**	**Comments**
DOPamine (Intropin)	Adrenergic agonist	X	X (Fixed Rate only, no titration by Nurse)		**Central Line Preferred – may initiate using peripheral vein during emergent situations until central access is obtained May be administered in any unit pursuant to Rapid Response and Code Blue Standardized Procedures. Transfer to Critical Care Area as soon as possible
Enalaprilat (Vasotec)	ACE inhibitor	X	X	X (IVPB only)	
ePHEdrine	Adrenergic agonist	X		L&D only	
Epidural infusions (i.e. bupivicaine +/- opioid)		X	X	X	
EPINEPHrine (Adrenalin)	Adrenergic agonist	X			** Central Line Preferred – may initiate using peripheral vein during emergent situations until central access is obtained May be administered in any unit pursuant to Rapid Response and Code Blue Standardized Procedures. Transfer to Critical Care Area as soon as possible
Eptifibatide (Integrillin)	Antiplatelet	X	X		May be used post cath for limited duration
Erythromycin	Antibiotic	X	X	X	** Central line preferred
Erythropoietin (Epogen, Procrit, EPO)	Erythropoetin Stimulating agent	X	X	X	IV push for dialysis patients only
Esmolol (Brevibloc)	Beta-blocker	X	X (Fixed Rate only, no titration by Nurse)		** Central line preferred
Ethacrynic acid (Edecrin)	Diuretic	X	X	X	IV Push only. Administer each 10mg over 1 minute not to exceed 100mg per dose.
Etomidate (Amidate)	Sedative/hypnotic	X			May be given on any patient care unit for emergency intubation purposes only. Must be administered by MD.
Famotidine (Pepcid)	Histamine blocker	X	X	X	
Fenoldopam (Corlopam)	Antihypertensive	X			

ZONE 1 = OR, ICU, CCL, IR, ED, PACU
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ZONE 3 = 1N, 2P, 4P 1S – Rehab, L&D, Post-Partum

INTRAVENOUS (IV) MEDICATION ADMINISTRATION BY LOCATION					
		X = Approved for Level of Care Indicated			
Drug Name	Drug Class	ZONE 1 (OR, ICU, CCL, IR, ED, PACU)	ZONE 2 (2E/2W, 3P, 4E/4W, PCU)	ZONE 3 (1N, 2P, 4P, 1S-Rehab, L&D, Post-Partum)	Comments
Fentanyl (Sublimaze)	Opioid analgesic	X	X (IV push only)	X (L&D Only as IV Push)	IV PUSH doses for pain: Permitted in ZONE 1, ZONE 2, and in L&D only. IV PUSH doses for procedural sedation: Permitted in ZONE 1, ZONE 2, and L&D. Nurse must meet requirements of the PCS Procedure "Sedation/Analgesia Used During Therapeutic or Diagnostic Procedures" to administer. If DEEP sedation is required ,fentanyl must be administered by a physician Fentanyl continuous infusion restricted to ZONE 1 *(Exception: Comfort Care patients may receive titrated infusion in all units)*
Flumazenil (Romazicon)	Antidote	X	X	X	
Folic acid	Nutritional supplement	X	X	X	
Fosphenytoin (Cerebyx)	Anticonvulsant	X	X	X	Use hazardous medication precautions
Furosemide (Lasix)	Diuretic	X	X (IV Push or as Fixed Rate Infusion. No titration by Nurse.	X (IV Push Only)	.
Glucagon	Antidote	X	X (IM/IV Only)	X (IM/IV Only)	Continuous infusion in ZONE 1 only.
Glycopyrrolate (Robinul)	Anticholinergic	X	X	X (Comfort Care Only)	
Granisetron	Antiemetic	X	X	X	
Haloperidol (Haldol)	Antipsychotic	X	X		Max single IV dose is 5mg. Refer to Haloperidol IV Administration Standardized Procedure
Heparin	Anticoagulant	X	X	X	HIGH ALERT MEDICATION. 2nd RN to verify dose and pump settings at initiation of therapy and dose changes

ZONE 1 = OR, ICU, CCL, IR, ED, PACU
ZONE 2 = 2E/2W, 3P, 4E/4W, PCU
ZONE 3 = 1N, 2P, 4P 1S – Rehab, L&D, Post-Partum

INTRAVENOUS (IV) MEDICATION ADMINISTRATION BY LOCATION					
		X = Approved for Level of Care Indicated			
Drug Name	Drug Class	ZONE 1 (OR, ICU, CCL, IR, ED, PACU)	ZONE 2 (2E/2W, 3P, 4E/4W, PCU)	ZONE 3 (1N, 2P, 4P, 1S-Rehab, L&D, Post-Partum)	Comments
Hetastarch (Hespan)	Volume Expander	X	X	X	Crystalloids (NS or LR) preferred in critically ill patients
HydraLAZINE (Apresoline)	Vasodilator	X	X	X	
Hydrocortisone (SoluCORTEF)	Corticosteroids	X	X	X	
HYDROmorphone (Dilaudid)	Opioid analgesic	X	X (IV Push. Fixed Rate infusion permitted. No titration by nurse.)	X (IV push and PCA only)	PCA and IV push allowed in all patient care areas. Hydromorphone continuous infusion in ZONE 2 requires patient to be on End Tidal CO2 monitor and continuous pulse oximetry) *(Exception: Comfort care patients may receive titrated infusion in all units).*
Ibutilide (Corvert)	Antiarrhythmic	X			Patient must be monitored with continuous ECG for a minimum of 4 hours after dose received
Immune Globulin (IVIG, i.e. Gammagard, Gamunex)		X	X	X	
Regular Insulin (Humulin R)	Insulin	X	X (No continuous infusion)	X No continuous infusion(Exception : L&D)	High Alert Medication. IV push permitted for hyperkalemia only on all units – must be followed by dextrose 50% Continuous infusion permitted only for ZONE 1 and L&D
Iron Products (Iron Dextran, Ferrlecit, Venofer)		X	X	X	
Isoproterenol (Isuprel)	Adrenergic agonist	X			May be administered in any patient care area during Code situations. Transfer to Critical Care Area as soon as possible
Ketamine (Ketalar)	Sedative/hypnotic	X			Can only be administered by MD **for procedural sedation.** **Can be administered by RN for pain.**~~.~~ ~~**Continuous infusions not permitted**~~
Ketorolac (Toradol)	NSAID	X	X	X	
Labetalol (Trandate)	Beta Blocker	X	X (IV Push Only)	X (IV Push Only)	Continuous infusions are restricted to ZONE 1 (Max cumulative dose on infusion is 300 mg/24 hours. Consider alternate BP lowering agent if not at goal)
LevETIRAcetam (Keppra)	Anticonvulsant	X	X	X	

ZONE 1 = OR, ICU, CCL, IR, ED, PACU
ZONE 2 = 2E/2W, 3P, 4E/4W, PCU
ZONE 3 = 1N, 2P, 4P 1S – Rehab, L&D, Post-Partum

INTRAVENOUS (IV) MEDICATION ADMINISTRATION BY LOCATION					
		X = Approved for Level of Care Indicated			
Drug Name	**Drug Class**	**ZONE 1 (OR, ICU, CCL, IR, ED, PACU)**	**ZONE 2 (2E/2W, 3P, 4E/4W, PCU)**	**ZONE 3 (1N, 2P, 4P, 1S-Rehab, L&D, Post-Partum)**	**Comments**
Levothyroxine (Synthroid)	Thyroid hormone	X	X	X	
Lidocaine (Xylocaine)	Antiarrhythmic	X	X (Fixed Rate only, no titration by Nurse)		May be administered in all units pursuant to Rapid Response and Code Blue Standardized Procedures. *For information regarding use in potassium IVPB see General and Concentrated Electrolytes Policy*
LORazepam (Ativan)	Benzodiazepine	X	X (IV push. Fixed rate infusion permitted on 2E/2W if patient mechanically ventilated)	X (IV push only)	Continuous infusion on Critical Care Areas only. (Exception: Patients on 2E/2W that are mechanically ventilated may receive lorazepam at a fixed rate. Comfort care patients may receive titrated infusion in all units).
Magnesium sulfate	Electrolyte	X	X	X	
Mannitol (Osmitrol)	Osmotic agent	X	X	X	Must use 0.22 micron filter.
Meperidine (Demerol)	Opioid analgesic	X	X	X	PCA and Continuous infusion not recommended
Methyldopa (Aldomet)	Antihypertensive agent	X	X	X	
Methylprednisolone (soluMEDROL)	Corticosteroid	X	X	X	
Metoclopramide (Reglan)	Antiemetic	X	X	X	
Metoprolol (Lopressor)	Beta Blocker	X	X		May be administered by a Rapid Response Nurse on any unit pursuant to MD order
Midazolam (Versed)	Benzodiazepine	X	X (IV push only unless on Comfort Care)	X (IV push for procedures only by an RN qualified to give moderate sedation)	Continuous infusion in ZONE 1 only. *(EXCEPTION: Continuous titrated infusion permitted on Telemetry units for Comfort Care patients.)* IV PUSH doses for procedural sedation: Permitted in all units. Nurse must meet requirements of the PCS Procedure "Sedation/Analgesia Used During Therapeutic or Diagnostic Procedures" to administer. If DEEP sedation is required ,midazolam must be administered by a physician

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Drug Name	**Drug Class**	**ZONE 1 (OR, ICU, CCL, IR, ED, PACU)**	**ZONE 2 (2E/2W, 3P, 4E/4W, PCU)**	**ZONE 3 (1N, 2P, 4P, 1S-Rehab, L&D, Post-Partum)**	**Comments**
Milrinone (Primacor)	Inotropic agent	X	X (Fixed Rate only, no titration by Nurse)		No titration of infusion on Tele (Fixed rate only)
Morphine	Opioid analgesic	X	X (IV Push. Fixed Rate infusion permitted. No titration by nurse.)	X (IV push and PCA only)	PCA and IV push allowed in all patient care areas. Morphine continuous infusion in ZONE 2 requires patient to be on End Tidal CO2 monitor and continuous pulse oximetry) *(Exception: Comfort care patients may receive titrated infusion in all units)*
Non-hazardous monoclonal antibodies (i.e. bevacizumab (Avastin), Cetuximab (Erbitux) Trastuzumab (Herceptin), RITUXimab (Rituxan))		X	X	X	
Nalbuphine (Nubain)	Opioid analgesic	X	X	X	
Naloxone (Narcan)	Antidote	X	X	X	
Neostigmine (Prostigmine)	Antidote	X			
Neuromuscular Blocker Agents i.e. cisatracurium (Nimbex), rocuronium (Zemuron), vecuronium, succinylcholine		X			HIGH ALERT MEDICATION. Mechanically ventilated patients in ZONE 1 areas ONLY. Allowed on any patient care area for intubation purposes only. Continuous infusions require concomitant continuous sedation.. Succinylcholine IV push not for continuous infusion.
NiCARdipine (Cardene)	Calcium Channel Blocker	X	X (Fixed Rate only, no titration by Nurse)		**Central line preferred. May be administered in any unit pursuant to Rapid Response Standardized Procedures.
Nitroglycerin	Vasodilator	X	X (Fixed Rate only, no titration by Nurse)		May be administered in any unit pursuant to Rapid Response and Code Blue Standardized Procedures. Transfer to Critical Care Area as soon as possible
Nitroprusside (Nipride)	Vasodilator	X			

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Norepinephrine (Levophed)	Adrenergic agonist	X			**Central Line Preferred – may initiate using peripheral vein during emergent situations until central access is obtained May be administered in any unit pursuant to Rapid Response and Code Blue Standardized Procedures. Transfer to Critical Care Area as soon as possible
Octreotide (sandoSTATIN)	Somatostatin analog	X	X	X	
Ondansetron (Zofran)	Antiemetic	X	X	X	
Oxytocin (Pitocin)	Oxytocic agent	X	X	X	Use Hazardous Medications handling precautions
Pamidronate	Bisphosphonate	X	X	X	** Central line preferred
Papaverine	Vasodilator	X			MD must be present at bedside. IV push only
Paracalcitol (Zemplar)	Vitamin D analog	X	X	X	
Pantoprazole (Protonix)	Proton pump inhibitor	X	X	X	
PentaMIDINE (Pentam)	Antibiotic	X	X	X	
PENTObarbital (Nembutal)	Barbiturate	X			If given IM, no more than 5 mL (250 mg) should be injected at any one site IV Push – do not administer faster than 50 mg/min
PHENObarbital (Luminal)	Barbiturate	X	X	X	Not for continuous infusion If given IM, no more than 5 mL (250 mg) should be injected at any one site
Phentolamine (Regitine)	Antidote	X	X	X	
Phenylephrine (Neosynephrine)	Adrenergic agonist	X		X (L&D only)	**Central Line Preferred – may initiate using peripheral vein during emergent situations until central access is obtained
Phenytoin sodium (Dilantin)	Anticonvulsant	X	X	X	** Central line preferred. Must use 0.22 micron filter.
Phytonadione (Vitamin K)	Antidote	X	X	X	Do not administer as IV push

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		X = Approved for Level of Care Indicated			
Drug Name	Drug Class	ZONE 1 (OR, ICU, CCL, IR, ED, PACU)	ZONE 2 (2E/2W, 3P, 4E/4W, PCU)	ZONE 3 (1N, 2P, 4P, 1S-Rehab, L&D, Post-Partum)	Comments
Potassium Chloride	Electrolyte	X	X	X	Do not administer as IV push Maximum infusion rate of 10 mEq/hour *(Exceptions: Patients in ZONE 1 and ZONE 2 on continuous ECG monitoring and with a central line may receive at a rate of 20 mEq/hour. See General and Concentrated Electrolytes Policy)* Maximum IV fluid concentration = 40 mEq/Liter of solution with a infusion rate of 10 mEq/hour (May infuse at a rate of 20 mEq/hour in ZONE 1 and ZONE 2 if on continuous ECG monitoring)
Potassium Phosphate	Electrolyte	X	X	X	Do not administer as IV push Maximum infusion rate of phosphate 7 mmol/hr (10 mEq/hr potassium via peripheral line or central line without cardiac monitoring. Maximum infusion rate of phosphate up to 14 mmol/hr (20 mEq/hr potassium via central line with cardiac monitoring in ZONE 1 or ZONE 2. *See Pharmacy Policy General and Concentrated Electrolytes)*
Pralidoxime (Protopam)	Antidote	X			
ProCHLORperazine (Compazine)	Antiemetic	X	X	X	When given as IV push do not exceed rate of 5 mg/min
ProMETHAZINE (Phenergan)	Antiemetic	X	X	X	Do not administer as IV push. Must dilute in at least 25 mL NS or call pharmacy.
Propofol (Diprivan)	Sedative	X			Mechanical ventilation required for patients receiving a continuous infusion of propofol. IV push/bolus doses must be administered by a physician. In emergency situations this may be performed on any unit.
Propranolol (Inderal)	Beta Blocker	X	X		Continuous infusions are not recommended.
Protamine Sulfate	Antidote	X	X	X	IV push in ZONE 1 only
PyridOSTIGMINE bromide (Mestinon)	Antidote	X			Do not administer as an IV push
PyridOXINE (Vitamin B6)	Antidote	X	X	X	

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Remifentanyl (Ultiva)	Opioid analgesic	OR only			
Quinidine gluconate	Antiarrhythmic	X			
Sodium Bicarbonate	Electrolyte	X	X	X	** Central line preferred. If running continuously it is preferred that the line remain dedicated for sodium bicarbonate only. Refer to Pharmacy Policy General and Concentrated Electrolytes for additional information
Sodium Chloride 3% (Hypertonic saline)	Electrolyte	X	X		HIGH ALERT MEDICATION, DOUBLE CHECK Do not administer IV Push. **Central Line Preferred – may initiate using peripheral vein during emergent situations until central access is obtained. May be infused in any patient care area for emergent situations pending transfer to ZONE 1 or ZONE 2 Refer to Pharmacy Policy General and Concentrated Electrolytes for additional information
Sodium Phosphate	Electrolyte	X	X	X	Do not administer as an IV Push. Refer to Pharmacy Policy General and Concentrated Electrolytes
Tacrolimus	Immunosuppressant	X	X		Do not administer as an IV push. Requires close observation for at least during the first 30 minutes of infusion and monitored frequently thereafter. Anaphylaxis has been reported with IV use, reserve for patients who cannot take oral form. Use hazardous medication handling precautions
Thiamine	Nutritional supplement	X	X	X	
Tranexamic Acid	Hemostatic Agent	X	X	X	
Valproate (Depacon)	Anticonvulsant	X	X	X	

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Vasopressin (Pitressin)	Vasoconstrictor	X			** Central line preferred. May be administered via IV push in any patient care area during emergency situations pursuant to a physician order. Transfer to Critical Care Area as soon as possible. Continuous infusions allowed in ZONE 1 only. IM or SQ administration for Diabetes Insipidius is permitted in all units.
Verapamil (Calan, Isoptin)	Calcium Channel Blocker	X			May be administered via IV push in any patient care area during Code situations pursuant to a physician order.
Zoledronic acid (Reclast, Zometa)	Bisphosphonate	X	X	X	

Refer to references such as Elsevier Online Skills for additional information on administration and monitoring. Alternate infusion rates may be permitted at provider discretion. List is not inclusive, if medication not on list- please contact pharmacy for more information.

**Central Line Preferred indicates that the medication is associated with venous irritation. Certain situations may require that the medication be administered peripherally (i.e. emergency situations, waiting on central line placement, or very short duration of infusion planned). Infusion of these medications/solutions through a peripheral vein may lead to loss of vascular access or damage to the vein and/or surrounding tissue, resulting in chemical phlebitis and thrombus formation. Other factors including vein size, infusion rate, catheter dwell time, catheter size, and location also influence the risk of phlebitis. Monitor closely for signs and symptoms of infiltration and/or phlebitis if given peripherally.

Approval Process:	Dates
Department Review:	12/17
Clinical Policies and Procedures:	01/18
Nurse Executive Committee:	01/18
Pharmacy & Therapeutics Committee:	03/18
Medical Executive Committee:	03/18

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Medication Administration Time Frames

Daily	-	0900
qam	-	0900
qhs	-	2100
bid	-	0900 - 2100
tid	-	0900 - 1500 - 2100
qid	-	0900 - 1300 - 1700 - 2100
q4h	-	0100 - 0500 - 0900 - 1300 - 1700 - 2100
q6h	-	0600 - 1200 - 1800 - 2400
q8h	-	0500 - 1300 - 2100
q12h	-	0900 - 2100

Specific Medications:
Warfarin - 1700
Standard capillary blood glucose checks AC and HS - 0800, 1130, 1730, and 2100
Standard capillary blood glucose checks every 6 hours - 0600, 1200, 1800, and 2400
Lithium - 2000
Digoxin - 1200
Diuretics - 0900 - 1700 (ordered BID)
Medications ordered with meals shall be given according to tray delivery times.
Respiratory medications shall be given per unit specific policy.
Bupropion, Venlafaxine, Modafinil, Methylphenidate: if ordered BID 09:00 and 14:00

In addition to the above standard administration times, the pharmacist shall designate the appropriate administration time for certain medications to optimize drug therapy. Some examples are as follows:
Proton Pump Inhibitors – BID 0600 – 2100
Statins – Daily 2100
Carafates – Q6 2400 – 0600 – 1100 – 1600

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 12/17

SUBJECT: Monitor Technicians (MTs): Communication Process

REVISION DATE(S):

Patient Care Services Content Expert Approval:	~~01/17~~08/18
Clinical Policies & Procedures Committee Approval:	~~02/17~~09/18
Nurse Executive Committee Approval:	~~02/17~~11/18
Division of Cardiology Approval:	~~04/17~~12/18
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~06/17~~02/19
Administration Approval:	03/19
Professional Affairs Committee Approval:	~~11/17~~ n/a
Board of Directors Approval:	12/17

A. **PURPOSE:**

1. To identify the process
   a. Registered Nurses (RN) and nursing support staff will use to communicate with the Monitor Technicians (MT) at the central monitoring (CM) station.
   b. MTs will use to communicate with RNs and nursing support staff.
   c. For ensuring visible electrocardiogram (ECG) tracings are displayed on centralized and decentralized monitoring stations.

B. **DEFINITION(S):**

1. Cardiac Monitored Units – Telemetry ~~South Tower (2 East, 2 West, 4 East, 4 West) Telemetry 3 Pavilion (3P)~~ and the Progressive Care Unit (PCU).
2. Central Monitoring (CM) station – A centralized location for monitoring the following patient information: ECG tracings, vital signs (VS~~S~~) such as respiratory rate, blood pressure, oxygen saturation, invasive line numerical values
3. Delay in Communication – Failure of MTs to notify a licensed RN immediately for interruptions in the display of a cardiac rhythm at the CM station. Failure of RNs and nursing support staff to communicate interruptions in monitoring to a MT at the CM station.
~~4. Emergency Department (ED) Cardiac Monitoring Stations – Stations A, B, C, and D~~
~~5.~~4. Interruptions in Monitoring – An event resulting in patient information not being displayed or not identifiable on centralized and decentralized monitors.
~~6.~~5. Medical Monitored Units – 4 Pavilion (4P) and PCU- may have patients requiring medical monitoring
   a. Medical Monitored is synonymous to heart rate monitoring
~~7.~~6. Decentralized Monitors – Monitor screens located on or near nurses' station ~~in the~~on Telemetry ~~units~~, PCU, and 4P used to display duplicate patient information from the CM station. ~~Decentralized monitors are also located in the ED.~~
~~8.~~7. Nursing Support Staff - Unlicensed staff e.g., Advanced Care Technicians (ACTs), Lift Team Technicians (LTT), Unit Secretaries (US)~~/Coordinators~~, ~~Emergency Medical Technicians (EMT)~~ and Transporters
~~9.~~8. Transmitter/transceiver (TTX) Devices – Automatic communication devices that allow bidirectional transmission of patient information from decentralized monitoring devices to the CM station
   a. The TTX devices used on Telemetry ~~units~~, PCU and 4P are identified as one of the following: (The TTX devices will be identified in this policy as a tele box)~~:~~

i. Tele box
ii. Telemetry box
iii. Monitor

~~c. TTX devices are called monitors in the ED~~

~~10.~~9. Transmitter/transceiver (TTX) Number – A number assigned to each tele box. This number will be clearly displayed on each tele box at all times.

a. Telemetry ~~South Tower and 3P~~ tele boxes are **will also be labeled with a room number and** ~~also labeled~~ using labeling tape colors as follows:

i. Blue = Private Rooms
ii. Yellow = Semi-private A bed
iii. Red = Semi-private B bed

C. **POLICY:**

1. ECG Alarm Default Parameters
   a. Alarm default parameters are identified by the Clinical Alarm Committee.
   b. The RN assigned to the patient will provide the MT instructions for modifying default alarm parameters based on patient assessment, history, medications, and treatments when necessary
   c. ~~ED,~~ Telemetry~~,~~ and PCU RNs are responsible for:
      i. Validating alarm parameters per hospital policy
      ii. Modifying alarm default parameters from decentralized locations
      iii. Providing specific instructions to MTs to modify alarm default parameters from the CM station
   d. MTs will not modify alarm default parameters independently. MTs may modify alarm default parameters when directed by a RN.
   e. MTs will contact the Telemetry ANM for instructions for modifying alarm default parameters for 4P patients. After making the alarm default parameter modifications as directed by the Telemetry ANM/Relief Charge RN, the MT will contact the 4P RN assigned to the patient.
   f. US~~/Unit Coordinators~~ ACTs, LTTs, and other nursing support staff will not adjust alarm default parameters or make modifications to the decentralized monitors.
2. Alarm Notification Parameters
   a. MTs will notify the primary RN or designee when any of the following are displayed on the CM: The following list is not inclusive.
      i. Changes in patient's baseline cardiac rhythm or rate
      ii. Heart rate less than 50 or greater than 130 beats per minute (beats per minute (bpm)
      iii. Systolic blood pressure less than 90 millimeters of mercy (mmHG) or greater than 180 mmHG
      iv. Respiratory rate less than 10 breaths per minute or greater than 28 breaths per minute
      v. Oxygen saturation less than 92%
      vi. Interruptions in the following established values (previous viewable) if applicable:
         1) Oxygen saturation
         2) Respiratory rate
      vii. Changes in baseline cardiac rhythm or rate
         1) This includes changes in the R-to-R interval that are 2 seconds or longer, when the average heart rate is equal to or greater than 50
      viii. Ectopic findings as follows: (this is not an inclusive list)
         1) Ventricular Tachycardia – 3 or more Premature Ventricular Contractions (PVC) and/or new onset PVCs
         2) Ventricular Fibrillation (VF)
      ix. Asystole
      x. New ectopic beats, new events, or increase in frequency of the following:

1) Premature Atrial Contractions (PAC)
2) PVCs
3) Changes in the PR interval prolonged greater than 0.21 seconds or less than or equal to 0.10 seconds
4) New junctional and idioventricular
5) New heart blocks
6) Widen QRS (new onset delayed conduction displayed as a QRS greater than 0.11 as directed by a RN)
7) Presence of cardiac device implemented beats e.g., pacemaker or implanted cardioverter defibrillator (ICD) not previously discussed by RN
8) Pacemaker failure to sense or failure to capture
9) Fusion beats (new onset or an increase in occurrences)

~~3. Emergency Department~~
~~a. RN Responsibilities – ED RNs may delegate the following task to an Emergency Medical Technician (EMT)~~
~~i. Admissions~~
~~1) Admit patient to the monitor per department practices~~
~~2) Enter patient's medical record number (MRN) in the MRN and Patient Name field~~
~~3) Select the monitoring options required for the patient e.g., cardiac rhythm, blood pressure, oxygen saturation, respiration, etcetera as instructed by the RN~~
~~4) Turn off monitoring options that are not required to decrease false alarms at the CM station~~
~~5) EMTs may modify default alarm parameters as directed by an RN~~
~~ii. Discharges~~
~~1) Discharge patients according to department practices. This task may be delegated to an EMT~~
~~2) Communicate discharges to the MT at the CM station by implementing the following:~~
~~a) Select the *DISCHARGE* function~~
~~b) Ensures all alarms are suspended by selecting the *SUSPEND MONITORING* function~~
~~iii. Interruptions in Monitoring~~
~~1) The RN or designee shall communicate interruptions in monitoring for procedures or tests outside of the ED to the CM station by selecting the *MENU SLEEP* function~~
~~b. MT Responsibilities for Monitoring ED Patients:~~
~~i. Verify patient's MRN is displayed on the monitoring screen~~
~~1) If the MRN is not displayed contact the primary RN or designee~~
~~a) When unable to contact the primary RN, contact the ED charge RN~~
~~ii. Notify ED personnel as follows for:~~
~~1) Alarm notifications as outlined in this policy~~
~~2) Patient information not displaying at the CM~~
~~3) Interruptions in monitoring~~

~~4.~~3. 4P and PCU: Nursing Staff Responsibilities
a. Verifying a cardiac rhythm is present at the CM station
i. 4P RNs, ACTs, US, and PCU ACTs will contact MTs by using the TCMC patient telephone located in the patient rooms or by using a telephone at the nurses' station
ii. PCU RNs may contact MTs by using unit cellular telephones or ensure a cardiac rhythm is present by viewing the patient's rhythm on the decentralized monitor
b. Admissions and Transfers (RN and ACT)

i. Select a tele box
1) Call the MT and provide the following:
a) Patient's first and last name (no initials)
i) Initials may be used for PCU patients
b) Medical Record Number (MRN)
c) Room assignment
d) Tele box number
i) When the tele box is placed in the room by another staff, verify the tele box number

ii. Verify the patient's first, ~~and~~ last name and MRN ~~is~~ are displayed on the decentralized monitoring screen

iii. Once the patient arrives to the nursing unit and is attached to the tele box, verify a visible cardiac rhythm is displayed at the CM station as outlined in this policy.

c. Interruptions in Monitoring (RNs, ACTs, and LTT)

i. Interruptions in monitoring related to patient care or a patient leaving the unit for test or procedures shall be communicated to the MT as follows:
1) 4P RNs, ACTs, and LTTs call the MT from the patient's room or use a telephone located on the nursing unit prior to or after removing the tele box. Provide the rationale for interrupting monitoring.
2) PCU
a) RNs may suspend the alarms by selecting the *Off Unit* function and the appropriate test or procedure label within the monitoring system to communicate the interruption in monitoring to the CM station.
b) ACTs call the MT from the nurses' station

ii. Resuming Interruptions in Monitoring
1) Interruptions in monitoring shall be resumed immediately by RNs and ACTs after receiving notification
a) RNs and ACTs shall resume monitoring as follows:
i) Ensure the tele box is attached to the electrodes placed on the patient's chest
ii) Verify a cardiac rhythm is visible at CM station as outlined in this policy

d. Discharges, Transfers Off Unit or Discontinuing Medical or Telemetry Monitoring

i. 4P RNs or designee will notify the MT at the CM station and request the MT discharge the patient from the CM

ii. PCU RNs may discharge patients as outlined ~~for~~ the Telemetry ~~units~~

~~5.4.~~ Telemetry ~~South Tower and 3P~~: Nursing Staff Responsibilities

a. Verifying a cardiac rhythm is present at the CM station

i. RNs and ACTs will contact MTs by using the TCMC patient telephone located in the patient rooms or by using a telephone at the nurses' station

ii. RNs may ensure a cardiac rhythm is visible by viewing the patient's rhythm on the decentralized monitor

b. Admissions and Transfers – Assistant Nurse Manager (ANM)/Relief Charge/Designee

i. Prior to a patient's arrival to a Telemetry unit:
1) Notify the receiving unit nursing staff and provide the following information
a) Patient's first and last name
b) Room assignment
c) Admitting or transfer diagnosis
d) Admitting or transferring physician
e) Name of transferring or admitting location
2) Notify the MT and provide the following information, prior to the patient's arrival to the nursing unit:
a) Patient's name

b) Room assignment
c) Admitting or transferring location

c. RN Responsibilities
i. Admission and Transfers
1) Verify the patient's first and last name, MRN~~,~~ and room number ~~is~~ are displayed on the decentralized monitor. See the Management of Telemetry Patients policy for additional information
2) The following task may be delegated to an ACT
a) Select the tele box for the patient room number and bed number assigned to the patient's room number and bed number if applicable
i) When the tele box is placed in the room by another staff, verify the room number located on the tele box prior to applying to the patient
b) Verify a visible cardiac rhythm is displayed at the CM station as outlined in this policy
ii. Interruptions in Monitoring
1) ACTs and LTTs
a) Call the MT from the patient's room or use a telephone located on the nursing unit prior to or after removing the tele box. Provide the rationale for interrupting monitoring
b) RNs may suspend the alarms by selecting the Off Unit function and the appropriate test or procedure label using the decentralized monitor to communicate the interruption in monitoring to the CM station.
iii. Resuming Interruptions in Monitoring
1) Interruptions in monitoring shall be resumed as outlined in the Management of Telemetry Patients policy.
2) Verify a cardiac rhythm is visible as outlined in this policy
iv. Discharges
1) RNs may communicate discharges to the CM station by implementing one of the following:
a) Discharge the patient using the decentralized monitor
b) Notify the MT to discharge the patient from the CM station
i) This task may be delegated to an ACT, LTT, or US

~~6.~~**5.** MT Responsibilities: Telemetry ~~Units~~, PCU, and 4P
a. Admissions and Transfers
i. Enter patient information in the CM
1) Use the bed board system to verify the spelling of the patient's name and the MRN
ii. Enter the following information:
1) Patient's name (first and last) no initials
a) Exceptions: patient's initials may be used for PCU patients
2) ~~Medical record number~~**MRN**
3) Room Number
iii. Review alarm default parameters per hospital policy~~.~~
1) If alarm default parameters have been modified, contact the primary RN for instructions to adjust the parameters to default settings or to continue current default parameters
iv. Implement the MT Shift Task Process outlined in the Management of Telemetry Patient policy
v. Monitor the patient's admission and transfer status using the bed board system
1) Contact the nursing units to verify patient's arrival 30 minutes after a bed is placed in the *Ready* status, if a cardiac rhythm is not displayed at the

CM station

a) Call the nursing units every 30 minutes until a cardiac rhythm is displayed or until notification has been obtained from nursing staff indicating one of the following:
   i) Patient has not arrived to the unit
   ii) Change in bed or unit assignment
   iii) Cancelation of the admission or transfer
   iv) RN or ACT providing direct care that delays applying the tele box

b. Discharges
   i. Discharge the patient from the CM as directed by the primary RN
   ii. Update the Shift Hand-off Worksheet as outlined in the Management of Telemetry Patients policy

c. Interruptions in Monitoring
   i. When notified by nursing staff or transporters a patient is leaving a unit for a test or procedure or for notification of patient care
      1) Suspend the alarms, select the appropriate label if informed of the location of the test or procedure
   ii. Interruptions without notifications from nursing staff
      1) Notify a RN or ACT immediately when a patient's cardiac rhythm is not visible
      2) Call the Telemetry AMN/Relief Charge if one or both of the following occur:
         a) Unable to contact nursing staff
         b) Monitoring is not resumed after notifying nursing staff and the nursing staff did not inform the MT of the rationale for the delay in monitoring or acknowledge they are aware of the interruption
   iii. Delay in resuming monitoring after receiving notification from a Transporter
      1) When a Transporter is unable to reapply a tele box or after reapplying a tele box a cardiac rhythm is not displayed on the CM, MTs will:
         a) Call the nurses' station and inform a RN or ACT
         b) If monitoring is not resumed after informing a RN or ACT implement the process outlined in Alarm Notification: Nursing Staff

d. Alarm Notification: Nursing Staff
   i. 4P and PCU
      1) Contact the primary/relief RN assigned to the patient to communicate the alarm notification.
      2) Document the primary/relief RN's name and time on the MT's Shift Hand-off tool.
      3) When the primary/relief RN is not available:
         a) Communicate the alarm notification to the staff answering the telephone
         b) Document the staff's name and time on the MT's Shift Hand-off tool
         c) Inform the staff to tell the primary or relief RN contact the MT immediately to discuss the alarm notification
      4) When the primary/ relief RN does not contact the MT to discuss the alarm notification, the MT will call the unit a 2nd time and request to speak with the primary RN.
      5) When the primary RN remains unavailable, the MT will:
         a) Contact the Telemetry ANM/Relief Charge to obtain further monitoring instructions
         b) The Telemetry ANM/Relief Charge will contact the 4P or PCU ANM/Relief Charge to communicate the alarm notification

c) The 4P or PCU ANM/ Relief Charge will contact the primary/relief RN to ensure appropriate assessment and monitoring plans are discussed and implemented.

6) When the Telemetry ANM/Relief Charge is not available, the MT will contact the Rapid Response RN by telephone for further monitoring instructions

ii. Telemetry ~~Units~~
1) Notify the nursing staff
2) When unable to contact the primary/relief RN, the MT will contact:
a) Any RN or ACT on the patients assigned unit
b) When unable to contact any RN or ACT, notify the PRN RN
c) When unable to contact the PRN RN, notify the ANM/relief charge
i) When unable to contact the ANM/relief charge notify the Rapid Response RN by telephone

~~7.~~6. LTT and US Responsibilities
a. Communicate messages from RNs and ACTs to the MT at the CM station
b. Communicate messages from the MTs to the RNs and ACTs

~~8.~~7. Transporting Staff Responsibilities
a. Prior to transporting a patient from a nursing unit:
i. Notify the primary/ relief RN
ii. Notify the MT at the CM station and provide the following:
1) Patient's name
2) Room Number
3) Department name of test or procedure
iii. Remove tele box and leadwires from the electrodes
1) Prior to removing the tele box and leadwires, inform the patient and receive their verbal consent
a) When a patient refuses to have the tele box and leadwires removed ask a RN or ACT to remove the tele box and leadwires
b) Remove the electrodes per the test or procedure department's policy
iv. Place the tele box and leadwires on the patient's bedside table
v. Do not place the tele box and leadwires on the bed, chair, or meal tray
vi. Transport the patient off the unit per department process
b. Returning Patients to a Nursing Unit
i. Notify the primary/relief RN or ACT
ii. If the electrodes are attached to the patient's chest, reapply the leadwires and tele box. If the leadwires have been removed, inform the MT and ask an ACT or RN to reapply the leadwires
iii. Call the MT from the patient's room provide the following information
1) Patient's Name
2) Room Number
3) Ask the MT if a rhythm is displayed at the CM station if the answer is:
a) Yes, a cardiac rhythm is visible at CM station
i) Place the upper side rails in the up position, place the bed in the low position and lock the wheels
ii) Place the call button and TV remote within the patient's reach
iii) Ensure the bedside table is within the patient's reach
b) No, a cardiac rhythm is not visible CM station
i) Place the upper side rails in the up position, place the bed in the low position and lock the wheels
ii) Place the call button and TV remote within the patient's reach and ensure the bedside table is within the patient's

reach

iii) Leave the patient's room and inform any RN or ACT, the patient's cardiac rhythm is not displayed for the MT

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

1. **Management of Electrocardiogram Alarms Nursing Interventions for PCU and 4 Pavilion Registered Nurses**
2. Patient Care Services Policy: Clinical Alarm Management
3. ~~1.~~ **Patient Care Services Policy: Identification, Patient**
4. Patient Care Services Policy: Management of ECG Strips
5. ~~2.~~ **Patient Care Services Policy: Off Unit Transfer Process**
6. ~~3.~~ Patient Care Services Policy: Rapid Response Team and Condition Help (H)
7. ~~4.~~ Telemetry Policy: Management of Telemetry Patients

E. **REFERENCE(S):**

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2. Nihon Kohden. (2015). Clinical reference guide: CNS-6201 2nd generation central monitor bedside monitoring and telemetry applications. Version 02-53
3. Northwestern Memorial Hospital. (2008). Telemetry: Care of the patient on centralized telemetry monitoring. Patient Care Service Policy. Retrieved from http://ww2.nmh.org/oweb/MagnetDoc/02_tl_transformational_leadership/tl5-e__-_telemetry_down_time_procedure_policy___5.11.pdf
4. Tri-City Medical Center. (2015). Clinical alarm management
5. Tri-City Medical Center. (2016). Management of telemetry patients
6. Welch Allyn. (2014). Telemetry monitoring medical/surgical floor. Retrieved from www.welchallyn.com
7. Lazzara, P.B., Santos, A.R., & Walker, R. (2010, November). The evolution of a centralized telemetry program. *Nursing Management*. DOI-10.1097/01.NUMA.0000388670.02663.b6
8. Whelan, L. and Stanton, M.P. (2013, March). Risk management updating telemetry practices to improve the culture of safety. *Nursing Management.* DOI-10.1097/01.NUMA.0000427192.74586.45
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Management of Electrocardiogram Alarms Nursing Interventions for PCU and 4 Pavilion Registered Nurses

PRIORITY	ALARM	ALERT DEFINITION	MONITOR TECHNICIAN ACTIONS	PCU AND 4P RN INTERVENTIONS
Life Threatening	ASYSTOLE (PAUSE)	Asystole greater than 3 seconds *Default setting is greater than 2 seconds	**Immediate** Contact nursing unit with name of rhythm using a. Emergency phone b. Land line • Confirm asystole in 2 leads c. Document name of rhythm on worksheet	a. Answer phone (task may be delegated) b. Assess patient (LOC, carotid pulse) • Pulse present = call RRT, obtain vital signs (VSS) (BP, HR, RR, SPO2, Temp) c. No pulse, get crash cart, start CPR d. Call Code Blue (delegate task)
	VF	Ventricular Fibrillation		
	VT	New greater than 6 beats, Sustained VT (30 beats or greater)		
	LOW HEART RATE (HR)	Sustained HR less than or equal to 40 or less		
Potential Life Threatening	ASYSTOLE (PAUSE)	Less than 3 seconds, confirm in all leads. *Default setting is greater than 2 seconds	**Immediate** a. Contact nursing unit b. Ask to speak with RN assigned to patient or inform any RN assigned to the unit c. Provide alert information to RN d. Provide name of rhythm e. Document rhythm and rate on worksheet f. Document RN's name on worksheet	a. Assess patient LOC, skin temp, obtain VSS (BP, HR, RR, SPO2) b. Inform ANM/relief charge, Call RRT, if required. If stable notify physician c. 4P transfer patient to Telemetry or ICU if ordered for arrhythmia ~~treatment~~ **management** d. PCU treat as ordered
	VT	Non-sustained, new onset,		
	LOW HR	10 beats or more below patient's baseline This includes junctional		
	HEART BLOCK (HB)	All types new onset (HB), conversion from baseline rhythm to a HB		
Critical Warning	VT PVC (one, couplet, triplet, bigeminal, trigeminal)	Less than 10 beats and HR less than 150 Less than 8 beats and HR less than 120 Run of VT (4-10 beats regardless of HR) New onset PVC or an increase in the number of PVC or frequency		a. Assess patient LOC, skin temperature, obtain ~~vital signs~~VS b. Inform ANM/relief charge c. Call RRT, if required • Provide RRT history, recent labs, intake and output, etc. d. If stable notify physician
	ST & High HR	New onset, HR 101 to 149, sustained (may be Afib, Aflutter, PAT, etc.)		
	SVT	New onset, sustained HR 150 or greater (may be Afib, Aflutter, MAT, AT, PSVT, PAT, etc)		
	Low HR	New onset, sustained 59 or less		Assess LOC, VSS, call RRT, if required/consult
	Pacemaker or ICD	Inappropriate firing or failure to fire		Assess LOC, VSS, call RRT, if required/consult
	ST Elevation	New onset		Assess LOC, VSS, call RRT, if required/consult
Non-Critical Requires Response	Low battery No signal, No Tele, No Comm	Patient not monitored, no rhythm present	**Immediate** Call nursing unit	Change battery, put leads on patient & call MT from pt's room to ensure rhythm is present. PCU call from nurses' station or cell
	Artifact	Artifact present	Call nursing unit	Check lead wire attachment to electrodes, change electrodes, move equipment away from tele (box) transmitter

May 11, 2018 PFR

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: PRE-OPERATIVE MEDICATION INSTRUCTIONS TO SURGICAL PATIENTS

I. **POLICY:**

A. Patients are to be provided instructions during the Pre-Operative Education appointment regarding their prescription medication management, as applicable, before surgery.

1. This education may occur through an appointment in-person or via telephone.

II. **PROCEDURE:**

A. The Registered Nurse (RN) in the Pre-Operative Education Department shall **instruct patients** ~~tosupply the following prescription medication instructions to each patient during their appointment~~:

~~A.~~**1. Stop angiotensin converting enzyme (ACE) inhibitors and angiotensin II receptor blocker (ARB) agents twenty four (24) hours prior to surgery.**

~~1.~~**2. Consult with their surgeon, primary care physician and/or cardiologist for medications that can affect bleeding (e.g., anticoagulants, platelet inhibitors, herbal medications) for discontinuation guidelines.**

~~B.~~**3. Take all of their morning medications prior to surgery, except the following:**

a. Insulin

~~a.~~**b. Oral hypoglycemic agents**

~~2. Beta-Blocker: Take your usual prescribed dose the morning of surgery with a sip of water.~~

~~3. Anti-hypertensive medications: Take your usual prescribed dose the morning of surgery with a sip of water.~~

~~4. Ace Inhibitors: Take your usual prescribed dose the morning of surgery with a sip of water.~~

~~5. Diuretics: Take your usual prescribed dose the morning of surgery with a sip of water.~~

~~6. Oral diabetic medications: Do not take the morning of surgery~~

~~7. Insulin: If the patient is on an insulin regime, they must contact their primary care physician for instructions.~~

~~8. Pain Medications: Patient is to contact the surgeon's office for instructions~~

~~Any other prescription medications: Patient is to contact the surgeon's office for instructions~~

III. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**

A. Initial training: Orientation

B. Ongoing: Annually ~~validation~~ through Skills **Validation**~~Lab~~ **process.**

IV. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

A. This procedure has been developed by ~~the Clinical Manager of~~ Surgical Services ~~and Pre-Operative Education~~, with approval from ~~the Senior Director of~~ Nursing **Leadership**~~, the Department of Anesthesia,~~ and the **Operating Room** (OR) Committee.

~~Department Review~~ Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Executive Council	Pharmacy & Therapeutics Committee	~~Department of Surgery~~ Operating Room Committee	Inter-disciplinary Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
10/12, 07/13, 09/17; 03/18	10/12, 07/13, 09/15, 0308/18	10/12, 07/13, 09/15, 09/18	11/12, 07/13, 09/15	12/15, 07/18	01/13, 02/14, 01/16, 01/19	02/13, 02/14, 01/16, 02/19	03/19	02/16, n/a	02/13, 02/14, 02/16

V. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**

A. RN's in the Pre-Operative Education Department.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**PRE-OPERATIVE PATIENT PREPARATION**
Purpose:	To outline the nursing care and management of patients prior to surgery.
Supportive Data:	The primary reason for pre-operative nursing care is to prepare a patient physically, psychologically, and cognitively for any impending surgery or invasive procedure. Pre-operative ~~C~~care is provided by the nurse at the time of the Pre-Operative ~~Teaching~~**Education** appointment, patient's admission to the hospital and just prior to the patient's transfer to the ~~Procedure/Operating area~~**Operating Room (OR)/Procedural Room.** ~~Surgeries are either planned~~**elective** ~~or emergent.~~ This procedure is ~~developed~~**intended** to address the ~~aspects of~~ care for ~~planned~~ **elective** surgical patients. This procedure does not preclude the expeditious delivery of care to the patient in an emergency situation.

A. **POLICY:**

1. ~~There must be a written order or direct telephone order for the surgical procedure written on the consent. The surgical procedure shall not be copied from the surgical schedule~~**A physician/Allied Health Professional (AHP) order is required for all surgeries/procedures. The surgery/procedure on the consent form is transcribed from the physician/AHP order. Refer to Patient Care Services (PCS) Policy: Consent for Operative or Other Procedures for complete information regarding surgical/procedural consents.**
2. ~~Informed~~ Consents **forms are required to be completed** ~~shall be obtained~~ for:
   a. ~~Procedure or s~~**S**urgery/**procedure**
   b. Blood transfusion or refusal~~.~~
   c. Anesthesia ~~(in the pre-op holding area after Anesthesiologist has spoken with the patient)~~
   d. Photography
   e. Hysterectomy (when applicable)
   f. Sterilization permit (when applicable)
   ~~f.~~**g. Required documents/consents for participation in studies/trials (i.e. Intra Operative Radiation Therapy ([IORT]))**
3. The admitting Registered Nurse (RN)~~, who may delegate components of data collection to the Licensed Vocational Nurse (LVN), shall complete the Admission Assessment, Admission Patient History and Medication Patient History Form on all surgical patients~~ **shall physically assess the patient and obtain/verify the patient's past medical history and medication history**.
4. Physician/**AHP** orders are required for pre-operative ~~tests,~~ labs, x-ray, ECG, and diet/NPO**, as applicable.** Notify **the** physician/**AHP** as appropriate for significant findings, unusual patient circumstances, and signs of possible infection~~s~~.
5. The patient and/or ~~their significant other~~ **designee** shall be provided with appropriate pre-operative ~~teaching handouts and information~~ **instructions and education.**
6. A completed Pre-Operative Checklist ~~and Procedural Verification Checklist~~ shall be completed prior to **transfer** ~~the patient going~~ to ~~surgery or~~**the Operating Room/**-procedure room.
7. For pregnant patients, refer to ~~Patient Care Services~~ **PCS** Policy: Pre-, Intra- and Post-Operative Assessment of Fetal Heart Rate (FHR) and Uterine Activity for Non-Obstetric Procedure/Surgery.

B. **PRE-OPERATIVE EDUCATION**

1. Pre-operative **education**~~instruction~~ is provided to the patient at their ~~p~~Pre-~~o~~Operative **Education**~~teaching~~ appointment (outpatients) or on the nursing unit (inpatients).

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Committee	Operating Room Committee	Pharmacy &Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
4/93, 10/09, 6/10, 03/18	08/11, 03/18, 08/18, 12/18	08/11, 09/18, 12/18	01/19	n/a	02/19	03/19	09/11, n/a	09/11

2. ~~Patients and their family members (when applicable)are provided with appropriate teaching handouts and t~~The following information ~~is reviewed~~**shall be included in pre-operative patient education**:
   a. Surgery/**procedure** to be performed~~ and anticipated anesthesia~~
   b. Instructions regarding **existing** implanted medical devices (when applicable)
   c. Anticipated pre-surgical ~~hospital~~ routine:
      i. ~~Validation~~ **Signing/verification** of consent~~s~~ **forms**
      ii. ~~Validation~~ **Completion/review** of **significant diagnostic tests, such as** lab work, x-rays, **and** ECG
      iii. ~~GI preparation (d~~**Diet/NPO orders and diet** progression~~, NPO)~~
      iv. ~~GU preparation (v~~**V**oiding, catheterization~~)~~
      v. **Intravenous** (IV) initiation and purpose
      vi. Marking of surgical site by surgeon
      vii. Pre-op**erative** medications
      viii. Preparation for surgery~~,~~ **in** ~~p~~**P**re-~~o~~**O**perative holding area (**explaining** need for early arrival time)
      ix. Family waiting areas~~, patient representatives~~ **and communication with family/support persons during the perioperative period**
   d. Anticipated post-surgical ~~hospital~~ routine:
      i. ~~Pain management, nausea medications~~**Management of pain and nausea**
      ii. Vital signs
      iii. IV
      iv. Dressings, drains, tubes
      v. Activity progression **(turning, splinting)**
      vi. Respiratory interventions, oxygen use **(coughing, deep breathing)**
      vii. Communication mechanisms
      viii. Diet progression
   e. Patient rights and responsibilities in:
      i. Pain management: Instruct patient regarding the various methods of **pain control,** analgesic administration and how to evaluate their level of pain and comfort.
      ii. Communicating symptoms, relief
      iii. Required activities (turn, cough and deep breathe, ambulation, leg exercises)
      iv. Limitations (Foley, IV, safety, bed rest)
      v. Participation in self care (eating, toileting, hygiene)
      vi. Designated responsible adult **and transportation** for outpatients **(refer to PCS Policy: Outpatient Post-Anesthesia/Procedure Discharge/Transportation Guidelines).**

   ~~Teach and observe, as needed, satisfactory return demonstrations by the patient of the following self care activities:~~
   ~~Cough, deep breathing~~
   ~~Use of incentive spirometer~~
   ~~Turning, splinting~~

3. **Review documentation for completeness** ~~the following documentation~~ **including but not limited to:**
   a. **Surgical Patient History form (for outpatients and AM Admits), or Admission Assessment/Patient History form (for inpatients)**
   b. **Education All-Topics form**
   c. **Privacy Code information has been obtained and documented per PCS Policy: Privacy Code**~~form and Power Plan~~
   d. **Medication History**
   e. **Preferred Pharmacy**

C. **PRE-OPERATIVE PATIENT CARE**

1. **Ensure completion of** ~~Carry out~~ physician/**AHP**'s orders for required pre-operative tests (i.e., labs, x-ray and ECG).
~~1.~~2. Obtain test results and notify physician(s) of ~~any~~ abnormal~~ities~~ **results**.
3. Implement **gastrointestinal (GI) preparation and** dietary changes as ordered (i.e., bowel prep or NPO).
~~2.~~4. **Chlorhexidine Gluconate (CHG) Instructions**
   ~~1.~~a. **Inpatients:** Implement the pre-operative shower/bath regimen and skin preparation using Chlorhexidine Gluconate (CHG) wipes, unless otherwise ordered by physician:

~~Outpatients are instructed on the pre-operative skin preparation process during their pre-operative education appointment. These patients perform the first skin prep at home the night before surgery.~~
~~Inpatients shall receive the first pre-operative skin preparation on their respective units the night prior to surgery.~~
~~Instructions for pre-operative skin preparation:~~

i. The night prior to surgery, have the patient shower (or assist with bed- bath) using warm~~,~~ (not hot) water and regular soap and shampoo, at least one hour before using the CHG wipes. Thoroughly wash ~~and clean at and around~~ the proposed incision site **and surrounding area.** ~~and d~~**D**ry with a clean towel.
ii. Do not shave the area of the proposed surgical incision for at least two days before surgery, unless ordered by the physician (if hair removal is ordered, use surgical clippers). Do not shave anywhere on the body from the neck down before ~~prepping~~**using CHG, as** ~~(~~this may ~~cause burning of the skin)~~ **increase risk of sensitivity to CHG**.
iii. **Skin preparation with CHG wipes shall be repeated the morning of surgery (or within four hours prior to surgery for scheduled afternoon/evening cases or add-on procedures).**
   ~~i.~~1) **For inpatients and admissions from the Emergency Department, the CHG skin preparation shall be performed in the patient's respective unit prior to being transported to surgery.**
~~ii.~~iv. Allow skin to dry and cool completely before applying CHG wipes.
~~iii.~~v. Perform pre-operative skin preparation with CHG wipes.
   1) Open all three packages of wipes and transfer the contents onto a clean prep table. Each package contains two wipes. Discard the blue foam pad from each package.
   2) Use one cloth to prep each of the following areas of the body (a total of six cloths will be used for the skin preparation):
      a) ~~Neck and chest area~~**Left arm**
      b) ~~Both arms and hands~~**Right arm**
      ~~Abdomen, groins and hips~~
      c) Left leg and foot (front and back)
      d) Right leg and foot (front and back)
      e) ~~Back, from base of neck to buttocks~~**Chest and abdomen**
      ~~e)~~**f) Back, from base of neck to buttocks**
   3) Discard each cloth after ~~a~~-single use **and~~.~~ discard any unused cloths after the package has been opened.**
      a) Do not flush wipes down the toilet.
   4) **Supply patient with a clean gown and clean bed linens after the CHG skin preparation has been completed.**
   ~~3)~~**5) If on a monitored unit, do not place electrodes on or near the surgical site.**

~~1) Discard any unused cloths after package has been opened.~~
~~ii. Skin preparation with CHG wipes is to~~**shall** ~~be repeated the morning of surgery (or within four hours prior to surgery for scheduled afternoon/evening cases or add-on procedures).~~

~~1) For outpatients and AM Admits, the CHG skin preparation will be repeated in Pre-Operative Hold area prior to surgery.~~

~~2)~~6) ~~For inpatients and admissions from the Emergency Department, the CHG skin preparation shall be performed on~~in the patient's ~~their respective unit prior to being transported to surgery.~~

~~3) Apply clean gown to patient after the CHG skin preparation has been completed.~~

~~iii. If on a monitored unit, do not place electrodes on or near the surgical site.~~

b. Outpatients are instructed on the pre-operative skin preparation process during their Pre-Operative Education appointment. Outpatients are to take a shower with CHG solution at home the night before and the morning of surgery.

i. Patients undergoing head or neck surgery should be instructed to shampoo their hair prior to surgery.

ii. For outpatients and AM Admits, skin preparation with CHG wipes will be performed in Pre-Operative Hold area prior to surgery.

~~b.~~**c. Do not** use ~~chg~~**CHG** wipes on:

i. ~~Pregnant p~~**P**atients ~~(~~scheduled for cesarean delivery~~)~~ or ~~patients scheduled for~~ post-partum tubal ligation

ii. Breast feeding women undergoing non-obstetrical procedure**(s)**

iii. Premature or low birth weight infants

iv. Infants receiving phototherapy

v. Children less than two months old

vi. Patients with known allergies to CHG

vii. Lumbar punctures or in contact with the meninges

viii. Open skin wounds

ix. Eyes, ears, mouth, face, hair or genital area

x. When applied to sensitive skin, CHG may cause skin irritation such as temporary itching sensation and/or redness. If irritation persists or rash or hives occur, rinse affected areas and discontinue use.

~~c.~~**d. Do not** shower, bathe, or apply any lotions, powders**, cosmetics**, or creams on the patient's skin after using the CHG wipes.

e. Once the patient is prepped with the CHG wipes, ensure the product has dried before placing them under a warm blanket or forced air warming device. Heat will open the pores allowing the solution to penetrate the skin deeper than necessary, which can increase risk of skin irritation.

~~3.~~**5.** For all elective surgeries, ~~no general anesthesia, regional anesthesia, monitored care anesthesia, or conscious sedation will be administered except under the following conditions~~**the following guidelines are recommended**:

a. Patients ~~must~~**should** be NPO prior to surgery ~~time~~ for:

i. **Two (2)**~~Six (6)~~ hours after clear liquids

ii. Eight (8) hours after solids

b. Oral medications may be taken with small amounts of clear liquids **(Outpatients, refer to PCS Standardized Procedure: Pre-Operative Medication Instructions to Surgical Patients)**.

~~Patients under 10 years of age must be NPO for a period of time as indicated below:~~

~~Infants 0 – 1 year of age:~~

~~No solids the day of procedure~~
~~Formula or breast milk until four (4) hours before procedure~~
~~Clear liquids until 2 hours prior to procedure~~
~~NPO thereafter until the procedure.~~

~~Ages 1 to 2 years:~~

~~No solids the day of procedure~~
~~Full liquids until six (6) hours prior to procedure~~
~~Clear liquids until three (3) hours prior to procedure~~
~~NPO thereafter until the procedure~~

~~Ages 3 to 10 years:~~
~~No solids the day of procedure~~
~~Clear liquids until four (4) hours prior to procedure~~
~~NPO thereafter until the procedure~~

c. Placement of a naso-gastric tube does not affect the above criteria.
d. For all emergency operations in which the above criteria ~~is~~**are** not satisfied, the surgeon must document in the patient's chart that the case is an emergency~~,~~ prior to the administration of anesthesia.

D. **DAY OF SURGERY/PRIOR TO TRANSFER**

1. Pre-**operative** and surgical/**procedural** RNs review the chart for completeness, including:
   - **a. Pre-operative orders**
   - ~~a.~~**b.** Pre-**operative** test results
   - ~~b.~~**c.** ~~Consent for Surgery and Other Operative Procedures and Anesthesia Pre-Op Questionnaire~~**Necessary consent forms**
   - **d.** History and Physical (H&P)
   - **e. Physician Pre-Procedure Documentation form**
   - **f. Request for Services form (for Justice Involved Individuals)**
   - ~~c.~~**g. Privacy Code information has been obtained and documented**~~form and Power Plan~~ **per PCS Policy: Privacy Code**

   ~~Completed pre-procedural portion of the Procedural Site Verification Checklist~~
   - ~~d.~~**h.** Completed ~~patient~~ Admission Assessment/Patient History **form (inpatients) or Surgical Patient History form (outpatients and AM Admits)**~~and Admission Assessment Powerform~~
   - ~~e.~~**i.** ~~Medication Reconciliation form~~**Medication History**
   - ~~f.~~**j.** ~~Patient's pre-procedural / operative~~ Pain Target Level has been determined and recorded in the Pain Assessment
   - ~~g.~~**k.** Pre-**Operative**/Pre-Procedure checklist (including disposition of patient belongings)
2. Assess patient's physical, psychological, and cognitive readiness for surgery:
   - a. Perform baseline physical assessment and vital signs as appropriate
   - b. Review aspects of pre-op ~~teaching~~ **education** as needed~~ for patient's knowledge base~~
3. **On the day of surgery, a pre-operative urine HCG is required for all women~~ under~~ age 55 and under~~ years old~~, except patients with documented hysterectomy, bilateral tubal ligation, bilateral tubal occlusion, or bilateral oophorectomy.**
   - **a. Contact physician/AHP for urine HCG order if not already ordered.**
   - **b. HCG results for inpatients are accepted up to one day prior to surgery. If urine HCG result was obtained greater than one day prior to surgery, a new test is required.**

~~3.~~**4.** Reportable Conditions
   - a. Report to the physician/**AHP:** ~~(surgeon) and Operating Room (OR) Assistant Nurse Manager~~:
     - i. Incomplete physician/**AHP's** pre-operative orders
     - ii. Abnormal test/lab results not noted to have been reported to primary surgeon
     - iii. Evidence of significant findings in review of systems ~~(i.e. cardiopulmonary instability, infectious state, major disabilities/deformities, urinary pain / burning, coughing, shortness of breath, edema, cyanosis and / or coolness of extremities, or confusion)~~
     - iv. Unusual patient circumstances, **such as** excessive anxiety or fear, **voicing abuse, etc.** ~~of the patient~~
     - v. ~~Missing History and Physical (H&P) or Interval Note~~**Incomplete physician/AHP documentation**
     - vi. Incorrect/unsigned consent forms
5. Initiate IV therapy ~~as ordered~~ and give pre-**operative** medications ~~(except antibiotics)~~ as ordered.

a. Assure **on-call** antibiotics ~~are attached to the chart~~**accompany the patient** for administration in the OR**, unless antibiotic to be initiated in Pre-Op Hold.**~~perating Room.~~

b. Do not initiate **on-call** pre-operative antibiotic infusion on patient care floor/unit (must be started within 60 minutes prior to incision time). **Continue existing scheduled antibiotic regimen if dose is due pre-operatively. If scheduled dose will be due during patient's time in OR, send the antibiotic for administration peri-operatively.**~~.~~

~~b.~~**6.** Remove all personal items (i.e. prosthetics, jewelry, **piercings,** eyeglass, hearing aids and dentures).

~~c.~~**7.** If the patient has valuables, refer~~ence~~ **to PCS Policy** ~~Administrative Policy # 317~~**: Patient Valuables Liability and Control**

~~d.~~**8.** Prior to leaving the pre-**operative/pre-**procedure area, verify that the ~~Licensed Independent Practitioner (LIP)~~ **physician/AHP** has marked the correct surgical site when ~~laterality is involved~~**applicable.**~~:~~ **Refer to PCS Procedure: Universal Protocol for complete procedural verification and site marking information.**

~~i. The site is marked by the licensed independent practitioner performing the procedure by writing their initials with a skin marker~~

~~ii. Refer to the PCS Universal Protocol procedure for complete details on site marking~~

~~iii. Pre-Op Hold/Primary Nurse and surgical nurse verify the correct surgical site is marked against the:~~

~~1) H&P or Emergency Department Record~~

~~2) Consent~~

~~e.~~**9.** Have patient void on call to the OR, if appropriate.

~~f.~~**10.** Complete preparation of patient according to physician's orders and to Pre-Operative/Pre-Procedure checklist ~~Powerform~~ prior to scheduled surgery time.

~~g.~~**11.** Inform family/**designee**~~significant other~~ of patient going to the OR and ~~orient~~ **guide** him/her to waiting area on the first floor~~ and Patient Representative's services~~.

a. Verify and document in the Pre-Operative/Pre-Procedure checklist the contact information (name, relationship, phone number and location during surgery) of the responsible **person**~~adult for ambulatory patients~~.

12. Review documentation for ~~C~~completeness ~~the following documentation~~ including but not limited to:

a. Pre-Operative/Pre-Procedure Checklist
b. Vital signs
c. Pre-Operative Systems Assessment (for outpatients and AM Admits)
d. Medications administered
~~i.~~e. Complete Medication History (including last dose of medications)
f. Disposition of patient belongings
g. Patient education
~~ii.~~h. Privacy Code information has been obtained and documented per PCS Policy: Privacy Code ~~form~~ (if not already completed)

~~Record the following data in Powerchart:~~

~~Pre-Operative/Pre-Procedure Checklist~~

~~Pre-Procedure Verification~~

~~Complete a system shift assessment~~

~~Document nursing actions/interventions related to reportable conditions and time/method of transfer to holding/operating area in clinical note section of Powerchart.~~

~~Record medications administered on the Medication Administration Record (MAR).~~

~~Document disposition of patient belongings if patient is ambulatory with discharge planned for after surgery.~~

~~Document and complete Anesthesia Consent after informed consent given by anesthesiologist in Pre-Operative Hold Area.~~

~~Send Transfer Medication Reconciliation Form.~~

~~2. Document on Off-Unit/Transfer Assessment Powerform.~~

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

1. **PCS Policy: Consent for Operative or Other Procedures**
2. **PCS Policy: Outpatient Post-Anesthesia/Procedure Discharge/Transportation Guidelines**
3. **PCS Policy: Patient Valuables Liability and Control**
4. **PCS Policy: Pre, Intra and Post-Operative Assessment of Fetal Heart Rate (FHR) and Uterine Activity for Non-Obstetric Procedure/Surgery**
5. **PCS Policy: Privacy Code**
6. **PCS Procedure: Universal Protocol**
7. **PCS Standardized Procedure: Pre-Operative Medication Instructions to Surgical Patients**

F. **REFERENCE(S):**

1. **Conner, R. (2017). Guidelines for Perioperative Practice, 2017 Edition. Denver, CO: Association of PeriOperative Registered Nurses.**
2. Manufacturer's Instructions; 2% Chlorhexidine Gluconate Cloth Patient Pre-Operative Skin Preparation. SAGE Products, Inc. Retrieved from www.sageproducts.com **March 5, 2018.**
3. **Schick, L & Windle, P. E. (2016). *PeriAnesthesia Nursing Core Curriculum*. (3rd ed.). St Louis, MO: American Society of PeriAnesthesia Nurses.**

~~3. (Attachment 1)~~

PROCEDURAL VERIFICATION CHECKLIST

Pre-procedure Phase To be initiated on Floor / Unit	Staff Initials	Comments
1. Verify that the patient's informed consent describes the procedure, site and side, as appropriate. Procedure:_____		
2. Verbally confirm the procedure, site and side, with the patient or Health Advocate.		
3. Review the medical record and history and physical for consistency in identifying the correct procedure, site and side.		
4. Site marked by LIP armband applied per procedure		
5. Results of diagn ogic tests available, matc		
6. Confirm availabi equipment, devic		
		Date / Time
7. Review the me the correct procedure, site and side.		
8. Confirm patien side; Site mark		
9. Confirm accura		
10. Confirm correct		
11. Confirm availab implants		
12. Confirm Blood/Blood Products available as ordered		
13. Confirm availability of special fluids/antibiotics for irrigation		
14. Relevant images and results properly labeled and displayed		
15. Safety Precautions based on patient history or medication use		
16. Pre-operative/pre procedural antibiotics given as ordered		
17. Require procedural team to take a *"TIME OUT"* immediately before the incision or start of the procedure for final confirmation of the correct patient, correct procedure, and correct site/side.	Time:	
Signature	Intra-Op RN / Health Care Provider	Date / Time

Affix Patient Label

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

7420-1011
(Rev. 12/08)

PROCEDURAL VERIFICATION CHECKLIST

PRE-OP INSTRUCTIONS

PLEASE READ AND FOLLOW THE INSTRUCTIONS LISTED

OTHER INSTRUCTIONS:

Please arrive at the hospital on: _____

DATE **TIME**

DO NOT

1. **DO NOT** eat any solid food after _____
2. Other diet _____
3. **DO NOT** drink any liquids including water, after _____.
4. Limit alcohol intake the night before surgery.
5. **DO NOT** smoke or use tobacco products the day of surgery.
6. **DO NOT** chew gum, eat candy or lozenges on the AM of your surgery.
7. **DO NOT** wear makeup, lotion or powder.
8. **DO NOT** bring any valuables including jewelry, money, credit cards, checkbooks, etc.
9. **DO NOT** bring children or pets with you to the hospital the day-of-surgery, unless pet is a "Service Animal". Arrangements **MUST** be made for someone to care for the Service Animal during your su
10. **DO NOT** shave opera prior to surgery.

DELETE

BE SURE TO

- ❑ Wear loose comfortable clothing that is easy to get into and out of.
- ❑ Wear a pair of socks to keep your feet warm and comfortable shoes that are easy to put on and have a non-slip sole for safety.
- ❑ You must remove any body piercing jewelry before coming to the hospital.
- ❑ Be prepared to remove contact lenses. Bring solutions and case.
- ❑ Bring pacemaker / AICD card.

Contact your doctor immediately if you notice any change in your physical condition, such as a cold, upset stomach, fever, chest pain.

You may take medications as instructed by your surgeon with a sip of water in the morning of surgery at home _____

_____

_____

- ❑ Shower or bathe the morning of surgery.
- ❑ Shower using surgical soap - Follow instructions
- ❑ Shower and follow RN instructions sheet for using chlorhexidine pre surgical wipes.
- ❑ Bring breathing apparatus (Incentive Spirometer, inhalers or CPAP - Continuous Positive Airway pressure machine) to the hospital on the day-of-surgery.
- ❑ **Prep:** _____

_____

FOR OUT-PATIENT SURGERY ONLY

1. [illegible] adult **MUST** you home.
2. eceive post-op
3. t be able to remain with you a minimum of four hours after discharge.
4. The Outpatient Surgery nurse will call you 24 to 48 hours after your discharge to answer questions and check on your recovery.
5. In case of an unforeseen event, you may be admitted as an inpatient after your surgery.

OTHER INSTRUCTIONS:

_____

_____

_____

_____

_____

I have read, understood, and will follow the above "Pre-op" instructions:

PATIENT'S SIGNATURE	DATE/TIME	NURSE'S SIGNATURE	DATE/TIME

Affix Patient Label

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8580-1001

(Rev. 01/10)

PRE-OP INSTRUCTION SHEET

White - Chart Canary - Patient

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 04/05	**SUBJECT:** Titrating Medications, Adult Patients
REVISION DATE(S): 08/07; 02/09; 12/11, 05/12	~~**POLICY NUMBER: IV.GG**~~
Patient Care Services Content Expert Approval:	03/18
Clinical Policies & Procedures Committee Approval:	04/18
Nurse Executive Committee Approval:	04/18
Pharmacy & Therapeutics Committee Approval:	05/18
Critical Care Committee Approval:	~~03/17~~10/1802/19
Medical Executive Committee Approval:	04/17
Administration Approval:	03/19
Professional Affairs Committee Approval:	~~06/17~~ n/a
Board of Directors Approval:	06/17

A. **PURPOSE:**

1. To define the manner in which medications requiring titration to patient effect are utilized.

B. **POLICY:**

1. It is the policy of Tri City Healthcare District to allow orders for medication titration, which is the progressive increase or decrease of the medication dose in response to the patient's clinical status.
   a. This policy pertains to the areas where titration occurs (Intensive Care Unit, Emergency Department, Post-Anesthesia Care Unit, Pain Clinic, Endoscopy, Interventional Radiology, Labor and Delivery).
2. All orders for medications that require titration must include the following:
   a. Medication name
   b. Medication route
   c. Initial or starting rate of the infusion
   d. Defined maximum rate of infusion
   e. Defined incremental units for which the infusion rate may be increased or decreased
   f. Defined frequency for how often the infusion rate may be adjusted
   g. Objective clinical endpoint (RASS score, Pain score, heart rate, systolic blood pressure, etc)
3. Medications ordered for titration must be approved by the Pharmacy and Therapeutics Committee. Safe dose ranges for medications that are to be titrated must be reviewed and approved by that committee.
   a. A dose limit (maximum and minimum limits) at which the licensed independent practitioner must be called for each titrated medication must be set. These dose limits will correspond to the maximum and minimum dose ranges defined in the Alaris Medication Safety System Infusion pumps.
   b. If a titrated medication continues at or above the dose limit, the Registered Nurse (RN) shall contact the licensed independent practitioner ordering the titrated medication to approve the current dose at least every 24 hours by writing specific orders with a new dose limit at which he/she should be contacted.
   c. Clinical staff must assess the patient frequently when titrating mediations to detect potential problems as early as possible.
4. The attached table defines the medications currently approved for titration.

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

1. Patient Care Services Policy: Medication Administration
2. Titratable Drips Reference

Titratable Drips Reference

DRUG	STANDARD CONCENTRATION	YIELDS	CHART IN	USUAL DOSE RANGE	Titration Parameter
Argatroban	250 mg / 250 mL NS	1 mg/mL	mcg/kg/min	0.25 – 10 mcg/kg/min	Titrate per Protocol
*Cisatracurium	100 mg/100 mL NS	1 mg/mL	mcg/kg/min	1-10 mcg/kg/min;Start 3mcg/kg/min;titrate by 0.3mcg/kg/hr every 10 min	Goal train-of-four 2:4 or Bedside Shivering Assessment Scale Score of 0
Clevidipine (Cleviprex)	**25mg/50mL**	**0.5mg/mL**	**mg/hr**	**1-21mg/hr; Start 1mg/hr; dose may be doubled every 90 seconds until blood pressure goal reached. As blood pressure approaches goal, increase dose less than double every 10 min**	**Keep Systolic blood pressure LESS than 165mmHg**
Dexmedetomidine (Precedex)	400 mcg / 100 mL NS	4 mcg/mL	mcg/kg/hr	0.2 – ~~1.4~~ ~~1.7~~ **1.5** mcg/kg/hr; Start 0.4 mcg/kg/hr; titrate by 0.1 mcg/kg/hr every ~~30~~ ~~5~~ **20** minutes	To maintain RASS of 0 to -2
Diltiazem (Cardizem)	125 mg / 100 mL NS (Total volume =125 mL)	1 mg/mL	mg/hr	5 – 15 mg/hr Start 5mg/hr; titrate by 2.5 mg/hr every 15 min	Keep Systolic blood pressure LESS than 165 mmHg and/or keep heart rate less than 120 BPM
*Dobutamine (Dobutrex) (Premix)	500 mg / 250 mL D5W	2 mg/mL	mcg/kg/min	2 – 20 mcg/kg/min; Start 2.5 mcg/kg/min; titrate by 0.5 mcg/kg/min every 15 min	Keep Cardiac Index GREATER than 2.2 L/min per square meter
*Dopamine (Premix)	400 mg / 250 mL D5W	1.6 mg/mL	mcg/kg/min	2 – 20 mcg/kg/min; Start 5 mcg/kg/min; titrate by 2 mcg/kg/min every 5 min	Keep Heart Rate GREATER than 60 BPM and/or keep Mean Arterial Pressure GREATER than 65 mmHg and/or Systolic Blood Pressure GREATER than 90 mmHg
*Epical (Adrenalin/calcium)	2 mg Epinephrine, 1Gm CaCl/250 mL D5W	8 mcg/mL	mcg/min	Based on Epi (as below)	Keep Heart Rate GREATER than 60 BPM and/or Systolic Blood Pressure GREATER than 90 mmHg

DRUG	STANDARD CONCENTRATION	YIELDS	CHART IN	USUAL DOSE RANGE	Titration Parameter
*Epinephrine (Adrenalin)	4 mg / 250 mL NS	16 mcg/mL	mcg/min	1 – 10 mcg/min; Start 2 mcg/min; titrate by 2 mcg/min every 5 min *Weight based for CV Surgery Patients* 0.01 – 0.5 mcg/kg/min; Start at 0.02 mcg/kg/min and titrate by 0.02 mcg/kg/min every 5 min	Keep Heart Rate GREATER than 60 BPM and/or Systolic Blood Pressure GREATER than 90 mmHg
Esmolol (Brevibloc) (Premix)	2500 mg / 250 mL D5W	10 mg/mL	mcg/kg/min	50 – 200 mcg/kg/min; Start 50 mcg/min; titrate by 50 mcg/kg/min every 5 min	Keep Heart rate LOWER than 120bpm and/or systolic blood pressure LOWER than 165mmHg
Fentanyl	1500 mcg / 150 ml NS	10 mcg/mL	Mcg/hr	50-300 mcg/hr, Start 50 mcg/hr, titrate by 50 mcg every 15 minutes	Keep Goal pain scale at less than or equal to 2 or at or lower than patient reported acceptable pain level.
Furosemide (Lasix)	100 mg /100 mL NS	1mg/mL	mg/hr	10 – 80 mg/hr; Start 10 mg/hr; titrate by 5mg/hr every hour	Keep urine output GREATER than 20ml/hr
Insulin	100 units / 100 mL NS	1 unit/mL	units/hr	0.5 – 20 units/hr	Titrate per protocol
Isoproterenol (Isuprel)	1 mg / 250 mL D5W	4 mcg/mL	mcg/min	2 – 10 mcg/min; Start 1 mcg/min; titrate by 1mcg/min every 10 min	Keep Heart rate GREATER than 60bpm
Labetalol (Normodyne)	200 mg / 200 mL D5W	1 mg/mL	mg/min	0.5 – 2 mg/min; Start 2 mg/min; titrate by 0.5 mg/min every 15 min up to 300mg in 24 hours	Keep Heart rate LESS than120bpm and/or systolic blood pressure LESS than165mmHg
Lorazepam (Ativan)	50mg/50 ml D5W	0.2 mg/mL	mg/hr	1 – 10 mg/hr; Start 2mg/hr titrate by 1 mg every ~~30~~ ~~5~~ **20** min	Titrate to RASS 0 to -2
Midazolam (Versed)	50 mg / 50 ml D5W	1 mg/mL	mg/hr	1 – 10 mg/hr; Start 2mg/hr; titrate by 1 mg every ~~15~~ ~~5~~ **15** min	Titrate to RASS 0 to -2
Milrinone (Primacor) (Premix)	20 mg / 100 mL D5W	200 mcg/mL	mcg/kg/min	0.25 - 0.75 mcg/kg/min Start 0.25 mcg/kg/min; titrate by 0.25 mcg/kg/min every hour	Keep Cardiac Index GREATER than 2.2 L/min per square meter
Morphine	100 mg / 100 mL NS	1 mg/mL	mg/hr	1 - 20 mg/hr; Start 2 mg/hr; titrate by ~~0.5~~ 1 mg every ~~30~~ ~~5~~ **30** min	Keep Goal pain scale at less than or equal to 2 or at or lower than patient reported acceptable pain level.
Nicardipine (Cardene)	20mg/200 ml NS	0.1 mg/mL	mg/hr	2.5 – 15 mg/hr; Start 5mg/hr; titrate by 2.5 mg/hr every 15 min	Keep Systolic blood pressure LESS than 165mmHg

DRUG	STANDARD CONCENTRATION	YIELDS	CHART IN	USUAL DOSE RANGE	Titration Parameter
Nitroglycerin (Tridil)	50 mg / 250 mL D5W	200 mcg/mL	mcg/min	5 – 400 mcg/min; Start 5 mcg/min; titrate by 5 mcg/min every 5 min up to 20 mcg/min. If no response at 20 mcg/min, may increase by 10 mcg/min every 5 min	Keep Systolic blood pressure LESS than 165mmHg and/or titrate for chest pain relief
*Nitroprusside (Nipride)	50 mg / 250 mL D5W	200 mcg/mL	mcg/kg/min	0.25 – 10 mcg/kg/min; Start 0.25 mcg/kg/min; titrate by 0.25 mcg/kg/min every 5 min	Keep Systolic blood pressure LESS than 165 mmHg
*Norepinephrine (Levophed)	4 mg / 250 mL NS	16 mcg/mL	mcg/min	0.5 – 30 mcg/min; Start 2 mcg/min; titrate by 2 mcg/min every 5 min	Keep Systolic blood pressure GREATER than 90mmHg and/or Mean arterial pressure GREATER than 65mmHg
Oxytocin (Pitocin)	20 units / 1000 ml NS	20,000 milli units/ml	milliunit/min	1 milliunit/min-10 milliunit/min; Max dose 20 milliunit/min	Titrate per protocol-see Women and Newborn Services Unit Specific Procedure
*Phenylephrine (Neosynephrine)	50 mg / 250 mL NS	200 mcg/mL	mcg/min	5 – 180 mcg/min; Start 10mcg/min;titrate by 20 mcg/min every 5 min	Keep Systolic blood pressure GREATER than 90mmHg and/or Mean arterial pressure GREATER than 65mmHg
Propofol (Diprivan)	1000 mg / 100 mL (10 mg/mL)	10 mg/mL	mcg/kg/min	5 - **60** ~~80~~ mcg/kg/min ;Start at 10 mcg/kg/min; titrate by 5 mcg/kg/min every ~~10~~ 5 min	Titrate to RASS 0 to -2
Vecuronium (Norcuron)	100 mg / 100 mL NS	1 mg/mL	mcg/kg/min	Normal range 0.8 - 1.7 mcg/kg/ min; Start 0.8 mcg/kg/min; titrate by 0.1 mcg/kg/hr every ~~10~~ **5 10** min	Goal train-of-four 2:4 or Bedside Shivering Assessment Scale Score of 0

Rev 11/2016

* Indicates that these drug infusions can be mixed in a higher concentration strength for fluid restricted patients

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

A. **DEFINITION(S):**

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

B. **POLICY:**

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

Patient Care services Content Expert	Operating Room Committee	Clinical Policies & Procedures Committee	Nurse Executive Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
10/08, 01/09, 09/09, 06/10, 07/12, 03/13, 09/14, 02/17, 05/18	10/14, 05/17, 10/18	08/12, 07/13, 04/14, 10/14, 06/17, 12/18	08/12, 04/14, 10/14, 07/17, 12/18	10/12, 06/14, 11/14, 08/17, 02/19	03/19	11/12,07/14, 01/15, 09/17, n/a	12/12, 07/14, 01/15, 09/17

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

C. **SITE MARKING:**

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

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

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

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

D. **SCHEDULING:**

1. Scheduling for the procedure must include the following information:
a. Patient name and second patient identifier (DOB, MRN, or FIN). Cases cannot be scheduled unless this information is available (with the exception of an emergency, when a delay procuring information could adversely affect the patient).

b. Entire procedure, exact site, level, digit and side/ laterality. No abbreviations may be used.
c. See department specific scheduling procedures for additional scheduling requirements.

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

1. Upon admission, the patient's identity is verified by the person admitting the patient. An appropriate identification band is affixed to the patient's arm (or leg). See Patient Care Services Policy Identification, Patient.
2. Before the patient leaves the unit/floor the Registered Nurse (RN):
   a. Reviews the medical record to verify the following items are available, accurately matched to the patient and are all in agreement for the procedure/site/side to be performed:
      i. H&P **(must be electronic or printed~~written~~ within 30 days prior to surgery/procedure)– review the** plan for surgery
      ii. Electronic H&P update completed day of surgery/procedure (i.e., Physician Pre-Procedure Documentation form in the Electronic Health Record)
      ~~ii.~~**iii.** Orders for consent
      ~~iii.~~**iv.** Consent form
      ~~iv.~~**v.** Surgery/procedural schedule
      ~~v.~~**vi.** ~~Radiologic~~**Imaging** studies report (as applicable)
   b. Completes the pre-operative/pre-procedure checklist (as applicable).
   c. Ensures site marking is completed if patient is going directly to the operating room.
   d. Any discrepancies identified during the pre-procedure verification process shall require a "hard stop" and a "huddle" to be called at the patient's bedside to resolve the discrepancy.
3. In Pre-Op Hold/pre-procedure area the pre-procedural RN/HCP:
   a. Reviews the medical record to verify the following items are available, accurately matched to the patient and are all in agreement for the procedure/site/side to be performed:
      i. H&P **(must be electronic or printed~~written~~ within 30 days prior to surgery/procedure)– review the** –plan for surgery
      ii. Electronic H&P update completed day of surgery/procedure (i.e., Physician Pre-Procedure Documentation form in the Electronic Health Record)
      ~~ii.~~**iii.** Orders for consent
      ~~iii.~~**iv.** Consent form
      ~~iv.~~**v.** Surgery/procedural schedule
      ~~v.~~**vi.** ~~Radiologic~~**Imaging** report and images, as ordered
   b. Reviews the Pre-Operative Checklist to ensure accuracy and completeness.
   c. Ensures site marking is completed.
   d. Any discrepancies identified during the pre-procedure verification process, shall require a "hard stop" and a "huddle" to be called at the patient's bedside to resolve the discrepancy.
4. Prior to transferring the patient to the operating room/procedural area the OR/Procedural RN:
   a. Reviews the medical record to verify the following items are available, accurately matched to the patient and are all in agreement for the procedure/site/side to be performed:
      i. H&P **(must be electronic or printed~~written~~ within 30 days prior to surgery/procedure)– review the** plan for surgery
      ii. Electronic H&P update completed day of surgery/procedure (i.e., Physician Pre-Procedure Documentation form in the Electronic Health Record)
      ~~ii.~~**iii.** Orders for consent
      ~~iii.~~**iv.** Consent form
      ~~iv.~~**v.** Surgery/procedural schedule
      ~~v.~~**vi.** ~~Radiologic~~**Imaging** report and images, as ordered

b. Reviews the Pre-Operative Checklist to ensure accuracy and completeness.
c. Ensures necessary implants or special equipment are available.
d. Ensures site marking is completed.
e. Any discrepancies identified during the pre-procedure verification process, shall require a "hard stop" and a "huddle" to be called at the patient's bedside to resolve the discrepancy.

F. **TIME-OUT:**

1. The Time Out is conducted immediately before starting the procedure.
2. During the Time Out, all other noise and activities in the room are suspended (to the extent possible, without compromising patient safety).
3. Use the medical record and patient armband to verify:
   a. Patients' identity verified using two patient identifiers per Patient Care Services: Identification of Patients Policy and comparing two sources of identification (patient's armband, if visible, and medical record). If the armband is not visible during the Time Out, one of the following alternatives must be used:
      i. A patient identification band is placed on an exposed extremity (alterative wrist, ankle) and this band is used to confirm two patient identifiers during the Time Out.
      ii. Two team members confirm the patient identity (two identifiers) upon arrival to the surgical/procedural area. One of the team members must remain with the patient during the entire pre-procedural phase and confirm the patient identity during the Time Out.
      iii. Two team members confirm patient identity (two identifiers) upon arrival to the surgical/procedural area. The two patient identifiers are written on the white board in the procedure room and confirmed by the two team members. During the final Time Out, the team confirms patient identity against the information on the white board.
         1) This patient identification process shall be used in surgical services.
   b. Physician/AHP calls for the Time Out after the patient is prepped and draped.
   c. The circulating RN/assistive HCP (such as Emergency Medical Technician, Respiratory Care Practitioner, Radiology Technician, Anesthesia Technician):
      i. Uses the consent form to read the patient's name, approved second identifier, and procedure.
      ii. Verifies the **following precautions were taken when using** alcohol-based prep **solutions:**
         1) ~~was allowed a~~**At** least 3 minutes **passed for prep** to dry and fumes dissipated before draping **or using surgical equipment**~~.~~**.**
         2) Prep solution is not pooled.
         ~~ii.~~**3) Prep solution-soaked materials are removed from the field prior to draping or using surgical equipment.**
   d. The anesthesiologist (if applicable, or circulating RN if no anesthesiologist present) states antibiotic administered, dose and time.
   e. The circulating RN/assistive HCP:
      i. Verifies antibiotic selection is appropriate to procedure
      ii. States antibiotic re-dosing interval
      iii. Sets a timer for 30 minutes less than the re-dosing interval (i.e., if the re-dosing interval is 2 hours, set the timer for 1 hour and 30 minutes)
   f. The physician/AHP states the intended procedure, verifies the site is marked (if applicable) and asks if all agree.
   g. The scrubbed person states agreement and readiness for consented procedure.
   h. All Staff members in the OR at the time of the time out must state "I Agree" or state their concern/discrepancy.
4. Initiation of the Time Out is the responsibility of the physician/AHP performing the procedure.

5. The Time Out is conducted in a fail-safe mode:
   a. The surgery/invasive procedure is not started until all questions are resolved.
6. The time out includes all members of the procedural team who will be participating in the procedure at its inception.
7. The circulating RN or healthcare provider assisting the physician/AHP is responsible for documentation of the Time Out in the patient's medical record.
8. If two or more procedures are being performed on the same patient, a Time Out is performed to confirm each subsequent procedure before it is initiated.

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

1. Patient Care Services: Identification of Patients Policy

H. **REFERENCE(S):**

1. JAMA Surgery (2017). Centers for disease control and prevention guideline for the prevention of surgical site infection, 2017. *JAMA Surgery*, E1-E8. doi: 10.1001/jamasurg.2017.0904
2. The Joint Commission (2017). *Hospital Accreditation Standards*. Illinois: Joint Commission Resources.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**VENTRICULAR ASSIST DEVICE: IMPELLA NURSING CARE OF THE PATIENT**
Purpose:	To provide guidelines for the safe nursing care and monitoring of the patient with an Impella device in place outside of the Cath Lab (CCL) or Operating Room (OR).
Supportive Data:	**ABIOMED Impella Protocol and Tools**
Equipment:	**Impella_2.5/CP_5.0/LD_RP**

A. **DEFINITION(S):**

1. Left Sided Impella: Impella 2.5,/CP,/5.0/**LD**
   a. The Impella 2.5/CP/5.0 are percutaneously inserted temporary ventricular assist device (~~VAO~~**VAD**) which provides hemodynamic support by using a small microaxial blood pump housed inside a catheter to pull blood from the left ventricle into the aorta, unloading up to five liters of blood. This action effectively decreases left ventricular preload, increases mean arterial pressure and forward flow, increases end-organ perfusion and protects the myocardium by decreasing oxygen demand and increasing oxygen supply. They are recommended for short-term use (Impella 2.5 and Impella CP < 4 days~~P~~ and Impella 5.0 <6 days or per MD order)
   b. Impella 2.5 is inserted percutaneously via an introducer sheath and Is capable of unloading up to 2.5 liters of blood per minute.
   c. Impella CP is inserted percutaneously via an introducer sheath and is capable of unloading 2.5-3.5 liters of blood.
   d. Impella 5.0/**LD** assist device is inserted peripherally via arterial cut down and is capable of unloading up to 5.0 liters of blood per minute.
2. Right Sided Impella: Impella RP System
   a. The Impella RP System is a percutaneously inserted temporary ventricular assist device (VAD) with an intracardiac microaxial blood pump that supports a patient's pulmonary circulation. It is inserted percutaneously through the femoral vein and into the pulmonary artery (PA). It delivers blood from the inlet are which sits in the inferior vena cava (IVC), through the cannula, to the outlet in the pulmonary artery.

B. **POLICY:**

1. The Impella device will be placed in the **Cardiac Catheterization Lab** (CCL) or **Operating Room** (OR) and may or may not be removed prior to leaving the CCL or OR.
2. The patient with an Impella device in place outside of CCL or OR must be cared for in the **Intensive Care Unit** (ICU) by an Impella-trained **Registered Nurse** (RN).
3. Nurse to patient ratio will be at least 1:1
4. Left Sided Impella: Impella 2.5,/CP,/5.0/**LD**
   a. The Left-sided Impella device provides left heart support. Monitor patient for signs of right heart failure and assess need for **bi-ventricular implantable cardiac defibrillator** (BIV**ICD**~~AO~~) if necessary. Signs of right heart failure may include:
      i. Reduced output from Impella.
      ii. Suction alarms on Impella console.
      iii. Elevated CVP.
      iv. Signs of liver failure
      v. Elevated PA pressures.
   b. Indications:
      i. Stable Patients with **high**~~hlah~~-risk coronary disease scheduled for revascularization.
      ii. Cardiogenic shock patients in need of left ventricular support.
      iii. Patients with reduced ventricular function, e.g., post-cardiotomy, low output

Patient Care Services Content Expert	Division of Cardiology	Clinical Policies & Procedures Committee	Nurse Executive Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
NEW, 11/18	11/18	12/18	12/18	01/19	02/19	03/19	n/a	

syndrome, post-MI, and peri/post **percutaneous coronary intervention** (PCI).

c. Contraindications:

~~i. Mechanical aortic valves.~~
~~ii. Moderate to severe aortic stenosis or regurgitation.~~
~~iii. Left ventricular thrombus.~~
~~iv. Moderate to severe peripheral arterial disease.~~

i. Mural Thrombus in the left ventricle
ii. Presence of mechanical aortic valve or heat constrictive device
iii. Aortic valve stenosis/calcification (equivalent to an orifice area of 0.6cm2 or less)
iv. Moderate to severe aortic insufficiency (echocardiographic assessment graded as > +2)
v. Severe peripheral arterial disease precluding placement of the Impella system
vi. Significant right heart failure
vii. Combined cardiorespiratory failure
viii. Presence of an atrial or ventricular septal defect (including post-infarct VSD)
ix. Left ventricular rupture
x. Cardiac Tamponade (Cardiogenic shock indication only)

5. -Right-Sided Impella - Impella RP

a. Indications:

i. The Right-Sided Impella device provides right heart support **for patients** such as ~~patients~~ **those** who develop acute right heart failure or decompensation following left ventricular assist device implantation, myocardial infarction, heart transplant or open-heart surgery.

b. Contraindications:

i. Disorders of the pulmonary artery wall that would preclude placement or correct position of the Impella RP device
ii. Mechanical valves
iii. Severe valvular stenosis or regurgitation of the tricuspid valve (TV) or pulmonary valve (PV)
iv. Mural thrombus of the right atrium (RA) or vena cava
v. Anatomic conditions precluding insertion of the pump
~~vi. Other illnesses or therapy requirement precooling use of the pump~~
vi. Presence of a vena cava filter or caval interruption device~~, unless there is a clear access from the femoral vein to the right atrium that is large enough to accommodate a 22Fr catheter~~.

C. **PROCEDURE:**

1. General considerations:

a. Ensure the Impella console is always plugged in; device can function for one hour without AC power. It may take up to 10 hours to fully re-charge the Impella.
b. Do not raise HOB greater than 30 degrees if patient is temporally cannulated.
c. Obtain order for knee immobilizer if patient unable to maintain straight-leg position and is femorally cannulated.
d. Perform dressing changes to insertion site per hospital policy or **as needed (prn**~~pm~~**)** using aseptic technique and transparent dressing.
e. Refer to the infection prevention guidelines in relation to hand hygiene and possible **person protection equipment** (PPE) when applicable.
f. Assess insertion site every one hour for bleeding, hematoma or infection.
g. Monitor pedal pulses ~~X~~**every 15 minutes times 4, every 30 minutes times**~~X~~ **4 then** ~~and~~ assess for limb ischemia every one hour.

h. Turn~~m~~ patient according to implanting cardiologist/cardiac surgeon's order. Patient positioning order must be reviewed daily with implanting cardiologist/cardiac surgeon.
i. Use care when turning, repositioning, or performing bed-to-gumey or bed-to-bed transfers to ensure the device is not pulled on or pulled out.
j. Do not allow red Impella plug (left-sided Impella) or blue Impella plug (right- sided Impella) to hang freely from catheter and avoid bending catheter near red (or blue) Impella plug to avoid kinking.
k. Impella may cause ECG interference,- set ~~HP~~ Bedside monitor to "filter" status for ECG interference.
l. Patient will be anticoagulated **with**~~due to~~ **a** heparin infusion, monitor ~~ACT~~/PTT per physician orders **for Pharmacy to dose**. (Goal: ~~ACT 160-180sec or~~ PTT ~~60-S65-870~~sec ~~or~~)
m. Obtain daily transthoracic echocardiography or portable chest X-ray to determine Impella catheter placement per physician order. Implanting cardiologist to review Impella catheter placement daily with the nurse.
n. The catheter of the Impella 2.5,/CP,/5.0**/LD, and** /RP is to be removed only by a Physician or Physician Assistant.
o. The performance level indicates the performance level at which the catheter is operating (how much it is unloading) and is determined by physician order and is set to achieve desired hemodynamics.
p. If the patient with an Impella device in place needs CPR, place performance level at "P2" and perform CPR with device in place and running.
q. Change NS arterial flush/tubing daily for 2.5 and CP devices. For 5.0**/LD or**/RP device no arterial flush is required.
r. Purge fluid and purge tubing change per hospital's protocol on fluid and tubing change.
s. Wean per physician orders.

2. On Admission to critical care:
   a. Order echocardiogram (left-sided Impella) or Chest X-ray (right-sided Impella) to verify placement on arrival to critical care unit as soon as possible.
   b. Verify that Tuohy-Borst valve on Impella catheter is locked to prevent catheter migration.
   c. Switch to P-level mode and disable P-level suction control.
   d. If the purge system has not been transferred to the standard configuration, follow the steps below:
      i. Press "PURGE SYSTEM" to select "Transfer to Standard Configuration" from the menu.
      ii. Do not use saline. Use Heparin/Dextrose purge solution as recommended by pharmacy
      iii. Select OK to deliver a bolus to the pressure reservoir so that the reservoir can maintain purge pressure during the change. A progress bar shows the progress of the bolus. After the bolus is delivered, the controller automatically proceeds to the next screen.
      iv. Disconnect the yellow luer from the Impella Catheter and remove the used purge cassette.
      v. Insert the new purge cassette into the controller. Be sure to slide the purge pressure transmitter into place and extend the purge tubing through the gap in the purge cassette door when you close the door.
      vi. The system automatically primes the purge cassette. A progress bar shows the progress of the priming. Once the priming is complete, you are prompted to connect the purge tubing to the Impella catheter.
      vii. Connect the yellow luer on the end of the purge tubing to the yellow luer on the Impella catheter.

viii. Purge system change is complete. Enter the purge fluid information and select OK.
1) To select the default purge fluid values displayed on the screen, scroll to and select OK. This will select those values and automatically advance to the next screen.
2) To change the purge fluid information, scroll to the appropriate item and push the selector knob to select it. Then scroll through the values and push the selector knob to make a new selection.

e. Assess and chart the centimeter marker on the Impella catheter closest to the sheath.
f. Ensure roller clamp is completely open on the line to the pressure bag.
g. Verify that the pressure bag is inflated to 300-350 mmHg.
h. It is recommended that **central venous pressure** (CVP) be monitored and that a level of 12 mmHg be maintained.

3. Monitoring of catheter position:
a. The position of the Impella device is monitored by the RN continuously via placement signal and motor current displays and the placement monitoring illustration display on the Impella console.
b. Obtain physician order for daily transthoracic echocardiography or portable chest x-ray to monitor position.
c. The ideal position of the Impella catheter is:
i. For Impella 2.5,/CP,/5.0/**LD**, the catheter inlet lies in the left ventricle and the catheter outlet in the aorta,- the placement signal and motor current displays will be pulsatile and the Impella catheter icon will be displayed with the valve symbol in the middle of the catheter.
ii. For Impella RP, the catheter inlet lies in the inferior vena cava (at the level of the diaphragm or apex of the heart away from RA and TV) and the catheter outlet in the PA (bifurcation of the right and left PA branch),- the placement signal and motor current displays will be similar to a PA waveform
d. Note and document catheter position markings after placement and hourly.
e. Ensure device is secured to leg with tape.
f. If the device migrates, the following warnings will appear on the Impella console: "Impella position wrong" or "Impella in Ventricle"
i. If the pump console alarms that the device is not positioned properly, reduce performance level to "P2" and notify the physician immediately- only a physician may reposition the device. The physician may request echocardiography or fluoroscopy for guidance.
g. Low native heart pulsatility: In a patient with poor native ventricular function, the placement signal may remain pulsatile however, the amplitude will be dampened
h. If the device is out of position, the patient may be at risk for hemolysis. Monitor **the** patient for and notify physician of signs of hemolysis including:
i. Decreased hemoglobin level.
ii. Dark or blood-colored urine.
iii. Acute renal failure.
i. For "Placement Signal Lumen Blocked" alarm
i. Ensure roller clamp on pressure bag is fully open
ii. Check pressure in the pressure bag (300-350mmHg)
iii. Close roller clamp and disconnect IV from the red luer,- do not grip the white flush valve when trying to disconnect IV from luer
iv. Attach 20 cc syringe to red luer, squeeze white flush valve, and aspirate 1-2 cc of blood into syringe
v. Remove syringe and open roller clamp
vi. **Hold**~~Cold~~ the clear luer upright and flood with saline from the pressurized bag
vii. Reconnect IV to the red luer and ensure roller clamp still open

viii. Squeeze or pinch white flush valve side-to-side and flush the aspirated blood from the lumen
ix. If still unable to get placement signal notify MD and utilize motor current waveform to ensure positioning across the aortic valve.

4. **Normal saline** (NS) arterial flush solution (2.5 and CP devices only):
   a. ~~To c~~**C**hange flush solution daily and pm
   b. Perform hand hygiene and don gloves.
   c. Prime the new NS flush solution set-up and close the roller clamp.
   d. Place the NS bag in a pressure bag and inflate to between 350-400 mmHg.
   e. Close the roller clamp and disconnect the old flush solution connected at the red sidearm port.
   f. Open the roller clamp on the new flush solution set-up to start a slow drip.
   g. Position the male luer connector over the female luer connector and fill to overflow, displacing any air.
   h. Connect and secure luer fittings.
   i. Open the roller clamp all the way and squeeze the white wings for 5 to 10 seconds to complete the internal prime- the final prime should eliminate any risk of lost or dampened pressure caused by blood tracking into the pressure lumen during the pressure tubing change.
   j. To maintain a good pressure signal: periodically fast-flush catheter lumen for 15-20 seconds, maintain pressure bag at 350-400 mmHg.
   k. Remove gloves and perform hand hygiene.
5. Suction Alarm:
   a. Suction alarm may occur if the circulating blood volume is inadequate or if blood return is restricted.
   b. Suction will limit the amount of support the device can provide and will result in decreased blood pressure, cardiac output, and dysrhythmia.
   c. Suction can cause hemolysis by damaging the red blood cells.
   d. Suction can be caused by:
      i. Left-sided Impella:
         1) Right ventricular failure - consider RV support
         2) Improper catheter position - check catheter position
         3) Hypovolemia - correct volume deficits
      ii. Right-sided Impella
         1) Inadequate preload - correct volume deficits
         2) Malposition - check device position (Chest X-ray, fluoroscopy, or echo)
   e. Assess for and correct the above conditions if a suction alarm occurs.
   f. While running in auto-mode if the controller detects suction it will alarm "Impella Flow Reduced" and will automatically reduce motor speed to reduce the flow rate.
   g. While running in P-Level mode, if the controller detects suction it will alarm "Suction".
   h. Recommended actions:
      i. Impella 2.5/CP:
         1) Check the device position
         2) Confirm RV function by assessing CVP or right side function with echocardiography or fluoroscopy. If CVP is not an option, check the pulmonary artery diastolic pressure (if PA is present) to assess the patient volume status.
         3) Assess patient's fluid intake and output to confirm adequate volume status.
         4) Return P-level to pre-alarm setting.
      ii. Impella 5.0/**LD** Catheter:
         1) Reduce P-level by 1 or 2 levels to reduce the effects of suction.
         2) Check the device position

3) Assess patient's fluid intake and output to confirm adequate volume status.
4) Confirm RV function by assessing CVP or right side function with echocardiography. If CVP is not an option, check the pulmonary artery diastolic pressure (if PA is present) to assess the patient volume status.
5) Return the P-level to pre-alarm setting Q.

iii. Impella RP:
1) If suction is an issue, the flow displayed on the controller maybe higher than the actual Impella RP flow rate.
2) If the suction alarm appears on the controller when the Impella RP is running at P-levels between P7 and P9, decrease the P-level to P6, or to P5, or to P4 as needed, to resolve suction. If suction alarm continues when P- level is between P4 and P6, momentarily stop the Impella RP to resolve the suction issue and then restart it immediately.
3) Evaluate patient volume status; maintain a positive CVP
4) Check device position
5) Return to previous P-level when suction alarm is resolved when appropriate

6. Differential pressure sensor:
   a. Impella 2.5 & CP
      i. Not Applicable
   b. Impella 5.0/**LD** or RP
      i. The Impella 5.0**LD,**/RP has an electronic differential pressure sensor at the proximal end of the cannula which generates the placement signal,- the placement signal is equal to the difference. The sensor generates an electrical signal proportional to the difference between the pressure outside the inlet area and the pressure inside the cannula. This signal is displayed on the Automated Impella Controller as the placement signal.
      ii. If the waveform shifts up or down on the y-axis or if the flow rate does not match the performance level setting, the differential pressure sensor is experiencing "drift" and may require zeroing.
         1) Press the MENU key and select "Start Manual Zero."
         2) Select OK to confirm the decrease in P-level- 3.
         3) The controller displays "Wait until the new P-level is reached" and then "Calculation is running".
         4) Select OK to accept the new setting when the controller displays the "Placement Signal Offset Adjust finished!" message.
         5) The Impella will automatically be reset to the previous P- level.
7. Purge pressure management:
   a. The purge system prevents blood from entering the microaxial motor by providing a pressure barrier via the flow of purge fluid through the motor in the opposite direction of the blood flow.
   b. Purge pressure must be greater than the patient's peak blood pressure.
   c. Increasing the flow of the purge fluid will increase the pressure, decreasing the flow of purge fluid will decrease the purge pressure
   d. The AIC console that accompanies the Impella device is used to adjust the purge fluid flow rate.
   e. Purge pressure is displayed on the Impella console.
   f. Purge fluid flow rate is not to be less and 2 ml/hour or greater than 30 ml/hour.
   g. Purge fluid and purge tubing change per hospital policy
      i. Perform hand hygiene and don gloves.
      ii. Open PURGE SYSTEM menu and select "Change Purge Cassette"
      iii. Follow the instructions on the screen to change the purge cassette.
   h. Standard Purge Solution: The Heparin/Dextrose solution provided by the pharmacy is

Heparin 25,000 units in Dextrose 5%, 500 ml (concentration 50units/ml) and is for intra-arterial flush. The amount of heparin and dextrose in purge fluid may be changed per physician order. Note: for Impella RP, the Heparin/Dextrose solution is started in Cardiovascular Lab rather than in the critical care unit.

i. "Low Purge Pressure" alarm (purge pressure less than 300 mmHg and purge flow greater than or equal to 30 mL/hr.:
   i. Check for leaks and loose connections in or on the purge cassette, yellow luer connection to the clear sidearm, the clear sidearm and the red luer connection (if the Y connector being used)
   ii. Change purge cassette if leaking **or every 72 hours**.
   iii. If there are no leaks, change to a purge fluid with a higher dextrose concentration. To do this, open the Purge System menu and select "Change Purge Fluid." Follow the instructions on the screen.
   iv. If the pressure stabilizes, no other action is required.
   v. If the purge pressure is not stable and the low purge pressure alarm remains unresolved for more than 20 minutes, there may be a problem with the purge cassette. Replace the purge cassette. (Follow the instructions on the screen "Change Purge Cassette".)
   vi. If the low purge pressure alarm still remains unresolved for more than 20 minutes, this may be a sign of Impella catheter damage. Inform MD.

j. High purge pressure will result in one of two alarms- "Purge Flow Low" or "Purge System Blocked"

k. For high purge pressure (purge pressure greater than or equal to 1100 mmHg and purge flow less than 2 ml/hour):
   i. Check for kinks in the purge tubing, clear sidearm, catheter shaft and Y connector (if being used)
   ii. Ensure plastic clip on pressure reservoir of the clear sidearm is snapped into connector cable
   iii. Decrease dextrose concentration (must obtain physician order)
   iv. Monitor motor currents and note any upward trend, consider replacing catheter if a rise in motor current is seen.

l. For in-depth troubleshooting of purge pressure alarms, refer to Impella user manual located on the unit.

D. **DOCUMENTATION AND ASSESSMENT:**

1. In **electronic health record (EHR)**~~SCM or on appropriate paper flowsheet~~ document:
   a. Vital signs per ~~unit protocol~~**standards of care**.
   b. **Intake and output** (I&O) every hour.
   c. Daily weights.
   d. Positioning/repositioning as ordered.
   e. Dressing change per hospital policy.
   f. Head of bed elevation hourly.
   g. If femorally cannulated, assessment of pulses and signs of limb ischemia hourly.
   h. If femorally cannulated, perform neurovascular checks of the extremity with the Impella device every hour and prn Notify the physician immediately if signs and symptoms are present (6Ps - pain, pallor, paresthesia, paralysis, pulselessness, poikilothermia).
   i. Subjective patient complaints:
      i. Deep throbbing feeling of pressure in affected extremity.
      ii. Calf pain with dorsal flexion of foot. (homan's sign).
      iii. Loss of lower leg sensation or function.
   j. Objective finding (for unconscious patient or patient unable to communicate):
      i. Ankle/arm index: Ankle systolic divided by brachial systolic, (radial/brachial arterial line systolic okay).

ii. Normal ankle/arm index value = 0.8 - 1.2.
iii. Post- insertion ankle/arm index < 0.8 have 8 times the risk of limb ischemia.

k. Assessment of access site hourly.

l. **Monitor and document upon arrival, every hour and with repositioning:**
   - i. **Pump performance (P Level)(P0-P8 or Auto)**
   - ii. **Flow (L/min)(0.0-5.0)**
   - iii. **Placement Signal (mmHg) [(2.5/CP = Sys/Dia) (5.0: (30-60/+15)]**
   - iv. **Purge Pressure (300-1100mmHg)**
   - v. **Motor Current**
   - ~~**Pump position**~~
   - vi. **Purge Fluid Infusion Rate (mL/hr)**
   - vii. **Power AC Battery (60 minute battery life)**
   - ~~**Catheter Depth (cm)**~~
   - viii. **Distal Pulses**

~~l. Catheter position markings after placement and hourly~~

~~m. Impella performance level, flow, placement signal, motor current, pump position, motor RPM, and purge pressure hourly.~~

E. **TROUBLESHOOTING:**

1. For an in-depth description of troubleshooting and operation and description of all possible alarms, refer to Impella reference guide and user manual located on unit.
2. Impella 24-hour support 1-800-422-8666.

F. **REFERENCE(S):**

1. Abiomed Corporation (2016). Impella 5.0 with the Impella automated controller: Instructions for use & clinical reference manual. Danvers, MA Abiomed Corporation (2016). Impella 2.5/CP with the Impella automated controller: Instructions for use & clinical reference manual. Danvers, MA Abiomed Corporation (2016). Impella RP with the Impella automated controller: Instructions for use & clinical reference manual. Danvers, MA Hoag Hospital Cath Lab Policy 3.1. (2008). Abiomed Impella 2.5 Percutaneous Cardiac Assist Device.
2. McCulloch,B. (2011) Use of the Impella 2.5 in High-risk Percuataneous Coronary Intervention. Critical Care Nurse, 31(1), e1-e16.
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Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: ~~NEW~~12/13 **SUBJECT:** Wearable Cardioverter-Defibrillator (LifeVest)

REVISION DATE(S):

Patient Care Services Content Expert Approval:	**08/18**
Clinical Policies & Procedures Committee Approval:	**~~09/13~~09/~~18~~11/18**
Nurse Executive Committee Approval:	**~~09/13~~11/18**
Division of Cardiology:	**12/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~10/13~~02/19**
Administration Approval:	**03/19**
Professional Affairs Committee Approval:	**~~11/13~~ n/a**
Board of Directors Approval:	**12/13**

A. **DEFINITIONS:**

1. **Life Vest** Wearable **Cardioverter**–Defibrillator **(WCD)** ~~(LifeVest®)~~ is a **"wearable defibrillator that is worn by patients at risk** ~~non-invasive device worn by outpatients at~~ risk for sudden cardiac arrest (SCA). It is an optional treatment for SCA designed to detect life-threatening arrhythmias and deliver shock treatment to restore a normal heart rhythm and heart rate.
   a. The **WCD (i.e.,** LifeVest)® allows physicians time to assess patient's long-term arrhythmica risk and make appropriate treatment plans.
   b. The LifeVest® is a patient interactive device **and thus requires a patient is able to respond to alertsman**.
2. The LifeVest®-is programmed to perform the following major functions:
   a. Detect life-threating arrhythmias.
   b. Alert asymptomatic patients if a life-threating heart rate/rhythm is detected.
   c. Allow patients to self-administer treatment based on their tolerance to the arrhythmia or initiate treatment i.e., defibrillation.
   d. Deliver shock (defibrillation) treatment to unconscious patients or symptomatic patients that do not halt treatment.

B. **PURPOSE:**

1. **To identify the inpatient nursing units that may provide care for patients admitted wearing a LifeVest or have a LifeVest applied during their hospital stay.**
2. **To identify ~~the~~ inpatient Registered Nurse's (RN)'s responsibilities when providing care for patients admitted wearing a LifeVest or when an order is received to apply a LifeVest during a hospital stay.**
3. **To identify the RN's responsibilities when a patient is transferred to TCMC outpatient rehabilitation unit.**

~~1. To ensure patients requiring an outpatient LifeVest® are adequately monitored in the Emergency Department, Intensive Care Unit (ICU), or Telemetry when the device is removed.~~
~~2. To prevent patient complications from discontinuation of a LifeVest®.~~
~~3. To clarify the Registered Nurse (RN) s' responsibilities for providing education to patients requiring a LifeVest® post discharge.~~

~~B. PROCEDURE:~~
~~1. Removal of a LifeVest®.~~

~~a. Do not cut the LifeVest® off of patient, cardiac electrodes may be worn with the LifeVest® if unable to remove in the event of an emergency~~
~~b. Remove the battery from the monitor~~
~~i. Unfasten garment clips/snaps and remove~~
~~ii. Do not remove garment belt or sensors~~
~~c. Place intact garment in Patient Belonging Bag. Secure the device as outlined in this policy.~~

C. **POLICY:**

1. Patient must be alert and oriented to implement the care management routine for the LifeVest and able to identify when LifeVest therapies are not required.
2. Patients should wear the LifeVest at all times, including while sleeping.
3. Ensure patient changes and charges the reserve battery every 24 hours.
4. The LifeVest should only be removed when the patient is showering or bathing with a physician's order. See the patient manual if required to assist patient for additional information.
5. Staff should not intervene or touch patient when the device delivers a treatment~~shock~~. The LiveVest has three types of alerts that the patient must respond to, they are as follows:
   a. Vibration alert – informs the patient "you're about to receive a siren alert". The vibration alert also alarms when the battery is changed.
   b. Siren alert – a high-pitched two-tone sound that means an abnormal rhythm has been detected.
      i. If the patient is alert they must: depress the response buttons to stop the treatment
      ii. If the patient is unconscious or does not response within 60 seconds a treatment will be provided.
         1) Prior to delivering a treatment the siren alert will stop and a voice will prompt bystanders not to touch the patient. The voice also alerts bystanders to call for help after the patient receives the treatment.
   ~~2.~~c. Gong alert – low-pitched gong sound that repeats about once a second. The alert is accompanied by a message stating a problem that needs the patient's attention. The patient must read the message to identify the appropriate action.

D. **REHABILIATION UNIT**

1. Patients admitted to Tri-City Medical Center (TCMC) Rehabilitation unit with a LifeVest shall be able to properly manage the alarms and to press the response buttons to stop shock activation.
2. Ensure patient is admitted wearing the LifeVest and has the following supplies (extra garment [{vest}], electrode belts, battery and battery charger, cell phone with charger, and patient manual ~~handbook~~)
3. The following shall be implemented by the primary RN in the event a patient:
   a. Receives a shock and is responsive
      i. Assess vital signs (blood pressure, heart rate, respiratory rate, and oxygen saturation percent)
      ii. Call the Rapid Response Team (RRT), if indicated
      iii. Notify physician
   b. Receives a shock and has a change in level of consciousness
      i. Assess vital signs
      ii. Call the RRT
   c. Receives a shock and is unresponsive
      i. Assess vital signs, identify the presence of a pulse and assess breathing.
      ii. Call a Code Blue, if indicated and start basic life support (BLS)

d. Document events in the medical record

~~C.~~E. ~~POLICY:~~ INPATIENT NURSING UNITS

1. Inpatients~~Patients~~ requiring a LifeVest shall be admitted or transferred to Telemetry, Progressive Care Unit (PCU) or the Intensive Care Unit (ICU) for continuous cardiac monitoring until discharge.
   a. ~~The p~~Patients will have the care provided by a core Telemetry, PCU, or ICU RN
2. RNs shall assess patient's ability to properly manage the alarms and to press the response buttons to stop shock activation. Assess the patient's ability to state or locate the following:
   a. Why they need a LifeVest?
   b. Three types of alarm alerts
      i. Audible, visual, and tactile
   c. How to stop a shock.
      i. Ask patient to point to the buttons they must depress?
   d. Time of day or night the battery should be changed.
   e. How to change the battery and ensure the spare battery is charging?
   f. How to download the device data
   g. How they are alerted?
   h. When to change the vest?
   ~~a.~~i. When to notify the nurse or when would they call 911 if at home?
3. If the patient is able to properly manage and comply with the LifeVest therapy instructions, do not remove the LifeVest without a physician's order~~vest.~~
4. If a patient is unable to properly manage or comply with the ~~The~~ LifeVest® therapy instructions or requires procedures or test requiring the LifeVest be removed:
   a. Ensure a visible continuous cardiac rhythm is displayed, apply defibrillator pads per hospital ~~the~~procedure, ~~defibrillator pads and ensure continuous cardiac monitoring is implemented~~ and then remove the LifeVest
   ~~3. Continuous cardiac monitoring will be implemented and the patient will be transported to procedures or test with a RN and a monitor capable of defibrillating until the WCD is reapplied or an implantable cardioverter defibrillated in implanted or if ordered by a physician. will be removed by the patient or a caregiver on arrival to the ED, ICU, or Telemetry.~~
   b. After removing the LifeVest perform the following:
      i. Place the device in the patient's closet
      ii. Ensure the battery is charging
      iii. If the family request, give the LifeVest and battery with the charger to family~~If the patient is unable to remove the LifeVest® and~~
      ~~a.~~iv. Document disposition per ~~family or caregivers are not available, a TCMC RN will remove the device and follow the~~ Administrative Policy: Valuables, Liability, and Control. ~~The RN will ensure continuous cardiac monitoring is implemented prior to removal of the device.~~
         ~~b. The RN removing the device will document the LifeVest® disposition on the Valuables and Belongings PowerForm and document the removal of the device in the Electronic Medical Record (EMR).~~
         1) Continuous cardiac monitoring will be implemented during transport to procedures or test with a RN and a monitor capable of defibrillating until the LifeVest~~WCD~~ is reapplied or an implantable cardioverter defibrillated in implanted
   ~~4. Once the LifeVest® is removed, the patient will be transported with an RN and a monitor capable of defibrillating. This should be for the duration of stay or until an implantable cardioverter defibrillatort (ICD) is placed.~~
5. See Online~~Elsevier~~ Skill: LifeVest Wearable Cardioverter-Defibrillator procedure for instructions on the following:

a. **Overview of the WCD e.g., LifeVest**
b. **Patient education**
c. **Assessment and preparation for patients with new orders for a LifeVest**
d. **Monitoring and care**
e. **Expected and unexpected outcomes**
f. **General documentation requirements**

6. **Battery and Garment~~Vest~~ Management**
   a. **Ensure patient's battery charger is plugged, reserve battery is charging, patient changes battery per the instruction provided by manufacturer,**
   b. **Ensures patient has extra LifeVest supplies**

~~a. ED Admission~~~~Once the LifeVest® is removed implement the following:~~
~~i. Ensure the patient or caregiver assumes responsibility for the LifeVest®.~~
~~ii. The ED RN will strongly encourage the patient to send the LifeVest® home with their family/friend or caregiver. (See Patient Valuables, Liability, and Control Administrative Policy).~~
~~iii. If sending the LifeVest® home is unacceptable to the patient, the ED RN will call security personnel who will witness the valuables with the RN, obtain patient signature on the valuables envelope, and place the envelope in the safe located in the ED Registration area.~~
~~iv. Document removal of the LifeVest® and the disposition of the device in the EMR.~~
~~v. The ED RN or ED Technician will document in the Valuables and Belongings PowerForm the disposition of the device.~~
~~vi. Communicate the location of the LifeVest® during hand-off.~~
~~5. Inpatient Direct Admission to Telemetry or ICU~~
~~a. If patient is wearing a LifeVest®, remove the LifeVest®~~
~~i. Do not cut the LifeVest® off of patient, cardiac electrodes may be worn with the LifeVest® if unable to remove in the event of an emergency~~
~~ii. Remove the battery from the monitor~~
~~a) Unfasten garment clips/snaps and remove~~
~~a) Do not remove garment belt or sensors~~
~~iii. Place intact garment in Patient Belonging Bag. Secure the device as outlined in this policy.~~
~~iv. Once the LifeVest® is removed, the admitting unit RN will strongly suggest the patient send the device home with family or caregiver. If the patient refuses to send the device home, the admitting unit RN will follow the Patient Valuables, Liability, and Control Administrative Policy: Accepting Valuables from a Patient/Guardian during the Admitting Process.~~
~~b. Document removal of the LifeVest® in the EMR.~~
~~c. Document in the Valuables and Belongings PowerForm the disposition of the device.~~
~~d. Communicate the disposition of the LifeVest® during hand-off.~~

~~2.~~7. Discharging a Patient Requiring a LifeVest®
   a. Prior to discharge (24-48 hours) ensure patient, if not contraindicated, has ambulated and a cardiac tracing is placed in the medical record. Document patient's tolerance to ambulation in the medical record and **complete a focus** assessment ~~patient per~~ **per** the Standards of Care **for Adults.**
   b. Prior to discharge (24-48 hours) ensure the following is initiated and implemented:
      i. Request patient notify family to bring the LifeVest® and battery charger to TCMC **if taken home.** Once received, update the Valuables and Belongings **Checklist in the medical record.**~~PowerForm and~~ **Instruct patient to** ~~have patient~~ **apply the LifeVest**~~vest with battery~~**. Ensure patient charges the reserve battery.**

~~i. Notify ZOLL's Territory Manager at 760-330-6307. A ZOLL Patient Service Representative (PSR) will be assigned to review discharge instructions for home use of the LifeVest®.~~

ii. RNs will reinforce discharge instructions as outlined by TCMC and suggested by the LifeVest® manufacturer **for patients admitted wearing a LifeVest. For patients receiving a LifeVest during the current admission, review the instructions provided by the LifeVest technician, and patient is discharged with the LifeVest kit provided by the manufacture.**

~~ii. On the day of discharge ensure patient applies the LifeVest®. The patient's family/caregiver should be encouraged to assist patient if needed to apply the LifeVest®.~~

~~iii. TCMC RNs will ensure the device is on the patient prior to patient leaving the facility and document patient/family application of the LifeVest® in the EMR.~~

~~iv. Discontinue cardiac monitoring when transport arrives to patient's room.~~

iii. A physician's order is required to discharge the patient without wearing a LifeVest®.

~~Discharging Patients with a New Order for a LifeVest®~~

~~Prior to discharge (24-48 hours) ensure patient, if not contraindicated, has ambulated and a cardiac tracing is placed in the medical record. Document patient's tolerance to ambulation in the medical record and **complete a focus assessment** assess patient per the Standards of Care **for Adults.**~~

~~**Reinforce discharge instructions per physician orders and as outlined in Elsevier Skill: LifeVest Wearable Cardioverter-Defibrillator**~~

~~**Ensure patient is discharged with the LifeVest supplies and patient manual**~~

~~**RNs will reinforce discharge instructions as outlined by TCMC and suggested by the manufacturer.**~~

~~b.~~

~~c. Prior to discharge ensure the following is initiated and implemented for patients with new orders for a wearing a LifeVest®:~~

~~i. Contact Case Management to ensure appropriate arrangements are implemented.~~

~~ii. Case Management will make the arrangements for the LifeVest®.~~

~~iii. Zoll's PSR will provide instructions to the patient on use of the device.~~

~~iv. If the patient is not scheduled for discharge on the day the PSR provides instructions, the primary RN will implement the following:~~

~~1. Instruct PSR to have patient remove theLifeVest®.~~

~~2. Document on the Valuables and Belongings PowerForm the disposition of the device.~~

~~3. Document in the EMR removal of the LifeVest® by patient or PSR.~~

~~4. Educate the patient/family/caregiver on the rationale for removal of the device until discharge.~~

~~v. TCMC RNs will ensure the patient or their family/caregiver has applied the device prior to the patient leaving the facility. Document patient/family application of the LifeVest® in the EMR.~~

~~iv. Discontinue cardiac monitoring when transport arrives to the patient room.~~

~~vi. A physician's order is required to discharge the patient without wearing a LifeVest®.~~

~~8. Removal of the LifeVest®)by TCMC RNs.~~

~~a. Ensure continuous cardiac monitoring is implemented.~~

~~b. Remove battery from device.~~

~~i. Battery should be place in charger if available.~~

~~c. Remove the vest and follow the instructions for ED Admission or Inpatient Direct Admission to Telemetry or ICU.~~

~~D.~~**F. RELATED DOCUMENT(S):**

1. Patient Care Services (PCS) **Policy:** Discharge of Patients and Discharge Against Medical Advice Policy
2. PCS **Policy:** Discharge Planning ~~Policy~~
3. ~~Admission- Mosby's Procedure Manual~~
4. ~~3.~~ PCS **Policy:** Patient and Family Education ~~Policy~~
4. ~~Administrative~~ **PCS Policy:** Patient Valuables, Liability, and Control ~~Policy~~

G. EXTERNAL LINK(S):

~~5.~~1. **Online~~Elsevier~~ Skill: LifeVest Wearable Cardioverter-Defibrillator Procedure**

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

1. **Zoll.** (n.d.). ***LifeVest: Operator's Manual LifeVest 4000***
2. **Zoll.** (n.d.). ***LifeVest: Patient's Manual LifeVest 4000***
6. ~~Mosby's Online Procedure Manual. (2066-2013). Admission. Retrieved from TCMC Intranet~~
~~Zoll Medical Corporation.(2009-2012). *Lifevest model 4000 patient manual.*~~
2. ~~Zoll Medical Corporation. (2013). Lifevest questions and answers. Retrieved from http://www.lifevest.zoll.com/medical-professionals/~~
3. ~~Zoll Medical Corporation. (2011). Lifevest wearable defibrillator emergency patient management. Retrieved from http://www.lifevest.zoll.com/medical-professionals/~~
7. ~~ZOLL Medical Corporation. (2009-2012). Lifevest 4000: Patient Manual.~~

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE ~~POLICY~~
HUMAN RESOURCES

ISSUE DATE: 12/02 **SUBJECT:** Confidentiality

REVISION DATE: 02/03, 10/05, 10/08, 05/11, 04/15 **POLICY NUMBER:** 8610-455

Administrative Human Resources Content Expert Approval~~Department Review:~~	**~~12/17~~01/19**
Administrative Policies & Procedures Committee Approval:	**~~01/18~~01/19**
Medical Executive Committee Approval:	**~~n/a~~02/19**
~~Organizational Compliance Committee Approval:~~	**~~n/a~~**
~~Human Resources Committee Approval:~~	**~~04/18~~**
Administration Approval:	**03/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/18**

A. **PURPOSE:**

1. To ensure confidential patient and employee information is protected in accordance with Tri-City Healthcare District's ("TCHD") legal and ethical responsibilities.

B. **SCOPE:**

1. This policy applies to all of TCHD's Workforce Members~~.to whom TCHD Confidential Information is disclosed and whose conduct in the performance of work for TCHD is under the direct control of TCHD or its employees, whether or not they are paid by TCHD~~.

C. **DEFINITION(S):**

1. Business Associate: Non-employee relationships where a person or entity performs duties, functions or any other activity on behalf of TCHD, that will or may involve the access and use of any Confidential Information. This agreement will provide for protection of Confidential Information in accordance with State and Federal law.
2. ~~Confidential~~ **Protected** ~~Patient~~ **Health** Information **(PHI): Individually identifiable health information transmitted or maintained in paper or electronic form that is created or received by TCHD AND**
   - **a. Relates to the past, present, or future physical or mental health or condition of an individual; OR**
   - **b. Relates to the provision of health care to an individual; OR**
   - **c. Relates to the past, present, or future payment, AND**
   - **d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.**

~~2.~~3. ~~Any information about a patient including medical treatment, medical condition, and diagnoses, any demographic information, collected from an individual that (a) is created or received by a health care provider, health plan, employer or health care clearinghouse; and (b) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual and that identifies the individual or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. Confidential Patient Information includes patient identifiable information.~~

~~3.~~4. Confidential ~~Personnel~~ **Employee** Information: Any information related to an employee, including social security number, home address, telephone numbers, emergency contacts, life insurance coverage and beneficiaries, benefits, salary or wages, resumes and applications for employment,

reviews, warnings, and/or disciplinary action, and any other form or document found in an employee's personnel file.

~~4.~~5. Confidential Employee Medical Information: Any medical information relating to an employee including health insurance application form, life insurance application form, requests for medical leave, personal accident reports, worker's compensation reports, OSHA injury or illness reports, and any other form or document which contains private medical information related to a specific employee, and any other form or document found in an employee's personnel file.

~~5.~~6. TCHD Proprietary and Confidential Information: Information and physical material not generally known or available outside TCHD and information and physical material entrusted to TCHD in confidence by third parties. Examples includes, but are not limited to ~~Confidential Patient Information~~**PHI**, Confidential Employee Information, Confidential Employee Medical Information, TCHD's financial information, company competitive information, TCHD-developed intellectual property, business e-mail messages, and information about TCHD's affiliates, vendors and suppliers.

~~6.~~7. Confidential Information: ~~Confidential Patient Information~~**PHI**, Confidential ~~Personnel~~ **Employee** Information, Confidential Employee Medical Information, and TCHD Proprietary and Confidential Information shall be collectively referred to as "Confidential Information" for the purposes of this policy.

~~7.~~8. Workforce Members: **Eemployees, volunteers, trainees, and other persons whose conduct, in the performance of work for TCHD is under the direct control of TCHD whether or not they are paid by TCHD.** ~~Includes employees, non-employees (volunteers, contractors, students, and vendors), physicians (including residents and physician assistants), and physician's employees providing services at TCHD~~.

D. **POLICY:**

1. Workforce Member Responsibility: TCHD's Workforce Members shall be responsible for maintaining the confidentiality of all Confidential Information entrusted to it and for reporting known or suspected unauthorized use, access or disclosure of Confidential Information. Minimum responsibilities include:
   a. Understanding and following policies and department specific procedures appropriate to individual role and responsibilities.
   b. Protecting information from unauthorized access, use, disclosure and transmission.
   c. Maintaining safeguards for protection of information.
   d. Reporting and/or securing Confidential Information found unattended or unsecured.
   e. Reporting individuals who share passwords or who use other's passwords and/or access codes.
2. Confidentiality Statement: Access to TCHD's information systems and any Confidential Information is contingent upon execution of a Confidentiality Acknowledgement Agreement Form (CAAF) upon hire, appointment or initiation of service. The CAAF, which may be amended at TCHD's discretion, is available on the shared drive and its terms are fully incorporated as if set forth separately herein.
3. Minimum Disclosures Necessary: When using, disclosing or requesting Confidential Information, reasonable efforts must be made to limit the amount of ~~protected health information (PHI)~~ **information** disclosed to be the minimum amount of information necessary to accomplish the requestor's intended purpose. This restriction does not apply to disclosing medical records for treatment. This requirement will be incorporated into all policies and processes that are established for access, use and/or disclosure of Confidential Information.
4. Business Associate Agreements: A Business Associate Agreement is required in non-employee relationships where a person or entity performs duties, functions, or any other activity on behalf of TCHD~~,~~ that will or may involve the access and use of any Confidential Information. This agreement will provide for protection of Confidential Information in accordance with State and Federal law. The TCHD leader (for purposes of this policy, defined as manager or higher) that oversees the work of the Business Associate must ensure that a Business Associate Agreement has been executed.

5. Safeguarding of Information: Confidential Information collected, generated, and/or stored by TCHD shall be maintained in such a manner as to prevent its unauthorized disclosure. Disclosure of Confidential Information shall be restricted to those who possess a need to know, ~~those~~ who have been authorized to know, or as may be required by State and/or Federal Law.
6. Prohibited Uses/Disclosures of Confidential Information:
   a. Not Meeting Minimum Use Necessary Standard: Viewing or obtaining information not needed for job completion (regardless of the medium of storage) constitutes unauthorized disclosure of that information and a violation of this policy.
   b. Examples of Prohibited Uses/Disclosures: TCHD characterizes as unacceptable any activity through which an individual:
      i. Allows or participates in access, use or disclosure of Confidential Information not needed for his or her job.
      ii. Removes Confidential Information, including medical records.
      iii. Without authorization, deletes, shreds, destroys, alters, dismantles, disfigures, prevents rightful access to or otherwise interferes with the integrity of Confidential Information and/or information resources.
      iv. Obtains information outside of approved channels without obtaining documented authorization to access such information.
      v. Accesses one's own medical record in the electronic medical record. Use of the patient portal is the acceptable way to review one's medical record; other access is considered a breach.
         1) The individual may visit the Registration or Medical Records department to sign up for the patient portal.
      vi. Discloses Confidential Information, regardless of intent, in any form, including verbal, written or electronic, to:
         1) Individuals not involved in the care or treatment of TCHD patients;
         2) Individuals who are involved or know the patient but have no need to know the information~~; or~~.
      vii. Discloses Confidential Information in a setting where that information could be overheard by individuals who have no need to know, for example in elevators, lobbies, waiting rooms, hallways, dining rooms, etc.
      viii. Discloses Confidential Personnel and/or Employee Medical Information to any third party~~, whether or not a TCHD employee~~, who does not have a legitimate need to know such information.
         1) A legitimate need to know such information may arise in connection with, and including but not limited to disciplinary actions to be taken against a~~n~~**Workforce Member** ~~employee~~, a~~n~~ **Workforce Member's** ~~employee's~~ own emergency, and/or efforts to obtain treatment or care for a~~n~~**Workforce Member** ~~employee~~.
      ix. Allows the use or disclosure of Confidential Information in a setting where information can be read or transferred from an unattended computer monitor or in violation with TCHD's ~~Acceptable Use of Information and Computing Resources Policy.~~**Administrative Compliance Policy: Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment and Health Care Operations (TPO)** ~~policy (8610-592)~~
7. Termination of Employment: Individuals whose relationship with TCHD terminates (whether voluntarily or involuntarily) will continue to be obligated to maintain confidentiality as defined in this policy and as provided for in the CAAF. Individuals must surrender all of the following in their custody or control no later than the last day of employment or other affiliation with TCHD:
   a. Access keys
   b. Access codes
   c. Originals or copies of documents containing Confidential Information

E. **PROCEDURE:**

1. Supervisor Responsibility:
   a. Determine appropriate levels of access to Confidential Information for all of TCHD's Workforce **Members reporting to him/her** to ensure adequate performance of duties while ensuring the minimum disclosures necessary to achieve this objective.
   b. Establish safeguards to protect privacy and security of information.
   c. Evaluate the need for Business Associate Agreements, as appropriate.
   d. Know and follow procedures to report unauthorized disclosures of Confidential Information and other violations.
   e. Adhere to Human Resource policies for disciplinary action.
   f. Establish consistent procedures for appropriate disposal of documents or items containing Confidential Information.
   g. **Conduct** ~~P~~periodic monitoring of compliance with TCHD policies pertaining to confidentiality, privacy and security.
   h. Provide on-going education and training on privacy and security policies and procedures.
   i. Notify the appropriate departments of the termination of employment or relationship of any Workforce ~~m~~**M**ember.
2. Workforce Member Responsibility:
   a. Completion of CAAF: Each ~~member of~~ TCHD's Workforce **Member** shall execute the CAAF as follows:
      i. Upon hire/credentialing/initiation of service (volunteers and contracted).
      ii. With each ~~employee~~ performance evaluation or credentialing renewal.
   b. CAAF Document Retention: Executed CAAFs shall be maintained in files in either Human Resources Department or Medical Staff Services, as appropriate.
      i. CAAFs for students shall be maintained ~~in~~ **by** the Education Department.
      ii. CAAFs for volunteers shall be maintained ~~in~~ **by** the Auxiliary Department.
   c. Reporting of Suspected Violations: All ~~members of~~ TCHD's Workforce **Members** must report suspected violations of confidentiality through the existing compliance reporting channels:
      i. Supervisor;
      ii. ~~Quality Review (QRR) Report~~;
      ~~iii. Patient Representative;~~
      ~~iv.~~**iii.** TCHD Values Line;
      ~~v.~~**iv.** TCHD **Chief Compliance and** Privacy Officer; and/or
      ~~vi.~~**v.** Human Resources
   d. Application of Standard Safeguards: All ~~members of~~ TCHD's Workforce **Members** must apply standard safeguards to work processes, including:
      i. Limiting unauthorized persons from viewing, accessing or having access to Confidential Information whether in hard copy, electronic form or in any other format.
      ii. Limiting the display of patient names to first and last initials or first name and last initials on white boards used for patient tracking, in public view.
      iii. Limiting exposure of patient's name and other Confidential Information to public view.
      iv. Preventing Confidential Information from being left unattended in public areas.
      v. Limiting viewing of computer screens containing patient identifiable information to the public.
      vi. Preventing disposal of documents or other items containing Confidential Information in the regular trash and disposing of such items in accordance with TCHD policy (i.e. shred or medical waste systems.)
      vii. Limiting discussions of Confidential Information to those necessary to the performance of one's duties or in order to provide patient care and ensuring that such discussions take place in private areas. Discussing any Confidential

Information in public areas, hallways, elevators, cafeterias, restrooms etc. is strictly prohibited.

viii. Maintaining strict confidentiality of passwords/access codes.

ix. Establishing and/or maintaining the physical security of Confidential Information, utilizing access controls, and locking storage cabinets.

x. Confidential Information may not be transmitted or removed from the premises, either physically or electronically, without authorization from Department Director/Designee.

F. **VIOLATIONS OF POLICY:**

1. Violators of this Policy shall be subject to disciplinary action by TCHD and reporting to the Licensing Board up to, and including, loss of privileges and/or termination. Individuals, who access, use or disclose Confidential Information without proper authorization, will be subject to disciplinary action by TCHD and may, under certain circumstances, incur personal liability in connection with such unauthorized conduct.

G. **FORM(S):**

1. **Business Associate Agreement**
2. **Tri-City Healthcare District** Confidentiality Acknowledgement & /Agreement Form

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

1. Administrative Policy: 237 Hospital Records Retention
2. Administrative Policy: 427 Fair Treatment for Supervisory and Management Employees
3. Administrative Policy: 428 Fair Treatment for Non-Management
4. Administrative Policy: 511 Business Associate Agreement
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I. **REFERENCE(S):**

1. 1974 Federal Privacy Act
2. California Code of Regulations, Title 22, Section 70707(b)(8)
3. California State Confidentiality of Medical Information Act (CMIA)
4. ~~3.~~ **California Code of Regulations Section 56798 (17 CCR § 56798)**
5. ~~4. Health & Safety Code 199.20~~
6. Health Insurance Portability and Accountability Act of 1996 (HIPAA)
7. **The** Joint Commission

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (the "Agreement") is entered into by and between Tri-City Healthcare District, a health care district organized under the Local Health Care District Law of the State of California ("HOSPITAL"), and _____ ("CONTRACTOR") (the HOSPITAL and CONTRACTOR may be referred to individually as a "Party" and collectively as the "Parties"), and is effective, as detailed within, when signed by authorized representatives of both Parties.

RECITALS

A. HOSPITAL and CONTRACTOR wish to form or have already formed a business relationship, under which CONTRACTOR may perform certain functions for or on behalf of HOSPITAL involving either or both of the Disclosure of Protected Health Information (hereafter "PHI") by HOSPITAL to CONTRACTOR and/or the creation or Use of PHI by CONTRACTOR on behalf of HOSPITAL.

B. HOSPITAL and CONTRACTOR intend to protect the privacy and provide for the security of PHI Disclosed to or Used by CONTRACTOR pursuant to this Agreement, in compliance with the Health Insurance Portability and Accountability Act of 1996 (Public Law 104.191; commonly referred to as "HIPAA"), the regulations promulgated thereunder, and other applicable laws, including without limitation the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (Public Law 111-005; commonly referred to as the "HITECH Act"), the HIPAA Final Omnibus Rule of January 2013, the California Medical Information Act ("CMIA") (CA Civil Code §§ 56-56.37), the California Information Practices Act (CA Civil Code §§ 198-1798.78), California Health & Safety Code § 1280.15, California Health & Safety Code §§ 123100-123149.5, and any statutes and regulations adopted or to be adopted in conjunction with or pursuant thereto (hereinafter, collectively referred to as the "HIPAA Rules").

C. HOSPITAL may engage in one or more enterprises governed by HIPAA regulation 45 C.F.R. § 160.103, and may require services from CONTRACTOR, the nature of which may require that PHI be Used or generated by CONTRACTOR on behalf of HOSPITAL.

D. This Agreement sets forth the terms and conditions pursuant to which PHI that is created, received, maintained, or transmitted by CONTRACTOR, from or on behalf of HOSPITAL, shall be managed. This Agreement supplements and/or amends each of the Contractual Agreements with respect to CONTRACTOR's creation, receipt, Use, and transmission of PHI thereunder, so as to allow HOSPITAL and CONTRACTOR to comply with the HIPAA Rules.

In consideration of the mutual promises below, in contemplation of the exchange of information under this or other contractual arrangements and in order to comply with legal requirements for the protection of this information, the parties agree as follows:

1. DEFINITION OF TERMS

1.1 Catch-all definition. The following terms (and any other capitalized terms not specified here), if used in this Agreement, shall have the same meaning as those terms in the HIPAA Rules: Accounting of Disclosures, Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

1.2 **Agreement** means this Business Associate Agreement.

1.3 **Contractual Arrangements** shall refer to all other contracts, memoranda of understanding or agreement, or any similar instruments or oral arrangements establishing the exchange of goods or services between HOSPITAL and CONTRACTOR.

1.4 **De-identified** shall have the meaning set forth in 45 C.F.R. § 164.514(b). This definition, and the related section of the HIPAA Rules, specifies that all 18 of the PHI identifiers shall be removed. De-identified information does not constitute Protected Health Information and is not subject to the terms of this Agreement so long as the information remains separated from any information by which the Record Subject may be identified.

1.5 **HOSPITAL** shall mean the Party so named above, and shall include any members of its workforce, officers, agents, representatives and contractors.

1.6 **CONTRACTOR** shall mean the Party so named above, and any members of its workforce, officers, agents, subcontractors, representatives and affiliated contractors.

1.7 **Record Subject** shall mean the Individual who may be identified by, and who is the subject of, any record or records containing PHI.

2. RIGHTS OF CONTRACTOR

2.1 **Data Ownership:** CONTRACTOR acknowledges that he or she has no ownership interest in PHI received from HOSPITAL or created on HOSPITAL's

behalf. CONTRACTOR will take no actions and make no representations that contradict this acknowledgment.

2.2 **Services:** Except as otherwise specified in this Agreement or by law, CONTRACTOR may make any and all Uses or Disclosures of PHI necessary to perform its obligations to HOSPITAL under existing or future Contractual Arrangements. All other Uses or Disclosures are prohibited. CONTRACTOR may Use or Disclose PHI for the purposes made necessary under its Contractual Arrangements with HOSPITAL only (i) to members of its workforce, contractors, and agents, in accordance with this Agreement; or (ii) as directed by the HOSPITAL.

3. OBLIGATIONS AND ACTIVITIES OF CONTRACTOR

With regard to his or her Use and/or Disclosure of PHI, CONTRACTOR agrees to:

3.1 Use or Disclose the Minimum Necessary PHI that it receives from or creates for HOSPITAL only as permitted or required by this Agreement or as otherwise Required by Law. [164.502(a)(4)(i) and (ii); 164.504(e)(2)(i); 164.504(e)(2)(ii)(A)] This includes, but is not limited to, CONTRACTOR being able to:

a. Disclose PHI when required by the Secretary to investigate or determine the CONTRACTOR's compliance with the HIPAA Rules.

b. Disclose PHI to the HOSPITAL, Individual, or Individual's designee, as necessary to satisfy a HOSPITAL's obligations under § 164.524(c)(2)(ii) and (3)(ii) with respect to an Individual's request for an electronic copy of PHI.

c. Use the PHI in its possession for its own normal management and administration, and to fulfill any present or future legal responsibilities of CONTRACTOR, provided that such Uses are permitted under California and federal confidentiality laws.

d. Disclose the PHI in its possession to third parties for the purpose of its own normal management and administration, or to fulfill any present or future legal responsibilities of CONTRACTOR, provided that:

i. the Disclosures are Required by Law; or

ii. CONTRACTOR has received from the third party reasonable assurances that that entity will treat PHI as CONTRACTOR would under this Agreement including, where applicable, via written contract as required in 45 C.F.R. § 164.504(e)(5).

e. provide Data Aggregation services relating to the Health Care Operations of HOSPITAL. Under no circumstances may

CONTRACTOR Disclose PHI of HOSPITAL to another Covered Entity absent the explicit authorization of HOSPITAL.

f. request PHI in the form of a Limited Data Set, to be used for limited research, public health or health care operations purposes.

g. De-identify PHI obtained by CONTRACTOR under this Agreement and use such De-identified data, provided that such use is in accordance with the De-identification requirements of the HIPAA Rules.

3.2 report to HOSPITAL's designated Privacy Officer any Use or Disclosure of PHI that is not permitted or required by this Agreement, and in addition, report to HOSPITAL's designated Privacy Officer any Security Incident, or any Breach (as defined in the HITECH Act or applicable state law, including without limitation section 1280.15 of the California Health & Safety Code), **within 1 day** of CONTRACTOR's discovery of such Breach, Security Incident, and/or unauthorized Use or Disclosure, with pertinent detail as this information is collected and to include the Risk Assessment performed by CONTRACTOR (and any necessary supporting information) in accordance with the HIPAA Rules included or following as soon thereafter as may be possible and mutually agreed by the Parties. [164.314(a)(2)(i)(C); 164.504(e)(2)(ii)(C); 164.410(b); 164.410(c)]

3.3 establish and act upon policies and procedures for protecting the privacy and security of PHI, including, but not limited to, contingency planning/backup and periodic security training, as required by the HIPAA Rules, and to the extent the CONTRACTOR is to carry out HOSPITAL's obligations the CONTRACTOR will comply with the requirements of 45 C.F.R., Part 164, Subpart C and Subpart E. [164.314(a)(2)(i)(A); 164.504(e)(2)(ii)(B); 164.504(e)(2)(ii)(H)]

3.4 implement administrative, physical, and technical safeguards that meet or exceed industry-standards and appropriately protect the confidentiality, integrity, and availability of the PHI that it creates, receives, maintains, or transmits on behalf of HOSPITAL, as required by the HIPAA Rules, covering at a minimum those elements of the HIPAA Rules made directly applicable to CONTRACTOR or any of CONTRACTOR's contractors. [164.504(e)(2)(ii)(B)]

3.5 ensure, through written contract or similar vehicle, that any subcontractor that creates, receives, maintains or transmits PHI on behalf of CONTRACTOR or HOSPITAL, agrees to the same restrictions and conditions that apply through this Agreement to CONTRACTOR with respect to such information. [164.314(a)(2)(i)(B); 164.504(e)(2)(ii)(D)]

3.6 make available its internal practices, books and records relating to any Use or Disclosure of PHI to the Department of Health and Human Services for purposes of determining HOSPITAL's and/or CONTRACTOR's compliance with the HIPAA Rules. [164.504(e)(2)(ii)(I)]

3.7 provide HOSPITAL any information requested by HOSPITAL, in writing, that is needed to permit HOSPITAL to respond under the HIPAA Rules to a request by a Record Subject for an Accounting of the Disclosures of PHI of the individual, **within 10 business days** of the request; the response shall be in electronic format if so required by the HITECH Act and requested by HOSPITAL, and shall cover the lesser of the timeframe specifically requested or the maximum timeframe that over which such information must be retained by HOSPITAL and/or CONTRACTOR under the applicable portion of the HIPAA Rules, in accordance with 45 C.F.R. § 164.528. [164.504(e)(2)(ii)(G)]

3.8 return to HOSPITAL or destroy, **within 20 business days** of the termination of this Agreement, all PHI in CONTRACTOR's possession and retain no copies, transcripts or backups thereof. In the event that it is infeasible to return or destroy some PHI, CONTRACTOR agrees to inform HOSPITAL in writing **within 10 business days**, and to limit further Use or Disclosure of the PHI to those purposes that make return or destruction infeasible, and to maintain the protections specified in this Agreement for any retained information, for as long as the information is retained by CONTRACTOR. [164.504(e)(2)(ii)(J)]

3.9 Use internally and/or Disclose to CONTRACTOR's contractors, agents or other third parties, and request from HOSPITAL, only the Minimum Necessary PHI to perform or fulfill a specific function permitted or Required by Law or CONTRACTOR's Contractual Arrangements with HOSPITAL, utilizing Limited Data Sets wherever feasible and practicable, as further specified in Section 3.13 of this Agreement and as required by the HIPAA Rules. [164.502(b); 164.514(d)]

3.10 defer to HOSPITAL with respect to any notifications that may be necessary, as specified in Sections 4.3 and 4.4 of this Agreement, in the event of a Breach.

3.11 allow HOSPITAL, within ten (10) business days of a written request to CONTRACTOR by HOSPITAL, to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies, and procedures of CONTRACTOR relating to the Use or Disclosure of PHI pursuant to this Agreement and the HIPAA Rule.

3.12 **With Respect to the Handling of Designated Record Sets,** CONTRACTOR further agrees to:

a. provide access to the PHI for HOSPITAL or the Record Subject to whom such PHI relates (or his or her authorized representative), at the request of, and within the timeframe designated by the HIPAA Rules and HOSPITAL, in order to meet a request by such Individual under the HIPAA Rules, in accordance with 45 C.F.R. § 164.524. [164.504(e)(2)(ii)(E)]

b. make any amendment(s) to the PHI required by the HIPAA Rules that HOSPITAL directs, at the request of and within the timeframe designated by the HIPAA Rules and HOSPITAL, in accordance with 45 C.F.R. § 164.526. [164.504(e)(2)(ii)(F)]

3.13 **With Respect to the Use or Disclosure of Limited Data Sets**, CONTRACTOR further agrees to:

a. limit the use of the Limited Data Set to the specific research, public health, or health care operations purposes for which the data was requested;

b. make no attempt to reconstruct the identity of the Record Subject from the Limited Data Set;

c. establish in advance what entities other than CONTRACTOR may be asked by CONTRACTOR to Use or Disclose the Limited Data Set, obtain agreements from such entities to abide by the specific restrictions applicable to CONTRACTOR with respect to Limited Data Sets (as set forth in this section 3.13), and certify compliance with this section to HOSPITAL in writing.

4. OBLIGATIONS OF HOSPITAL

4.1 HOSPITAL shall not request CONTRACTOR to Use or Disclose PHI in any manner that would violate this Agreement or the HIPAA Rules.

4.2 With regard to the Use or Disclosure of PHI by CONTRACTOR, HOSPITAL agrees to notify CONTRACTOR, in writing and in a timely manner, of any arrangements or limitations permitted or required of the HOSPITAL under the HIPAA Rules that will significantly impact the Use or Disclosure of PHI by CONTRACTOR under their Contractual Arrangements, including, but not limited to, restrictions on Use or Disclosure of PHI agreed to by the HOSPITAL pursuant to a Record Subject's approved request for additional privacy restrictions.

4.3 Notification to Individual. It is the sole responsibility of the HOSPITAL to notify Individuals of any Breach of PHI. At no time, is CONTRACTOR to contact or speak directly with any of HOSPITAL's Individuals who are the subject of any Breach of PHI. Any such inquiries should be directed to the HOSPITAL's Privacy Officer. CONTRACTOR shall cooperate with HOSPITAL as necessary to provide such notification and any details pertaining to any Breach of PHI.

4.4 Notification to Media. For a Breach of PHI involving more than 500 Individuals, it is solely the responsibility of HOSPITAL to notify the media and appropriate law enforcement and federal and state agencies as required by the HITECH Act, 45 C.F.R. § 164.406, and applicable state law. At no time is CONTRACTOR to contact or speak directly with the media without the prior

authorization of HOSPITAL. CONTRACTOR shall cooperate with HOSPITAL as necessary to gather information or provide such notification to the media.

5. WARRANTIES AND REPRESENTATIONS

Each Party represents and warrants to the other Party that all of its workforce members, officers, agents, representatives and contractors whose services may be used to fulfill obligations under this Agreement or other Contractual Arrangements are or shall be appropriately informed of their responsibilities and duties with respect to PHI and the HIPAA Rules, are qualified to render those services competently and in compliance with the HIPAA Rules, and are under legal obligation to each Party, respectively, to observe and comply with all applicable medical privacy and confidentiality requirements, by contract or otherwise, sufficient to enable each Party to fully comply with all provisions of this Agreement and all other standards set by applicable federal and California law.

6. TERM AND TERMINATION

6.1 **Term.** This Agreement shall become effective when signed by authorized representatives of both Parties and shall continue in effect, unless specifically terminated as provided in this Section. In addition, certain provisions and requirements of this Agreement may survive its expiration or other termination.

6.2 **Termination by HOSPITAL.** If HOSPITAL determines that CONTRACTOR has breached a material term of this Agreement, HOSPITAL shall provide CONTRACTOR with written notice of the existence of a breach and afford CONTRACTOR an opportunity to cure said breach upon mutually agreeable terms. CONTRACTOR must provide an acceptable and effective plan to cure said breach to the satisfaction of HOSPITAL **within 10 days of** receiving notice. Failure to cure will be grounds for the immediate termination of this Addendum. [164.504(e)(2)(iii)]

6.3 **Termination by CONTRACTOR.** If CONTRACTOR determines that HOSPITAL has breached a material term of this Agreement, or that a material condition of performance under this Agreement has so changed that CONTRACTOR finds it impossible to comply with the new condition, CONTRACTOR may provide **60 days' notice** of its intention to terminate this Agreement and any related Contractual Arrangements.

6.4 **Effect of Termination.** In the event of termination pursuant to this Section, CONTRACTOR agrees to return or destroy all PHI received from or created, transmitted, or maintained for HOSPITAL as specified in Section 3.8. Further, the obligation to indemnify the other party set forth in Section 7.1 shall survive the termination of this Agreement for any reason.

In the event that CONTRACTOR determines that returning or destroying a subset of the PHI is infeasible, CONTRACTOR shall provide to HOSPITAL notification of the conditions that make return or destruction infeasible. CONTRACTOR

shall extend the protections of this Agreement to such PHI and limit further Uses and Disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as CONTRACTOR maintains such PHI.

7. INDEMNIFICATION AND INSURANCE

7.1 **Indemnification.** The Parties agree to indemnify and hold harmless each other and each other's respective employees, agents and affiliated entities against any claim, damage or liability, including reasonable defense costs, that may result from any third party claim if and to the extent proximately caused by any breach of this Agreement by the other, as determined by a court, administrative body of competent jurisdiction, formal alternative dispute resolution process or good faith negotiated settlement, and provided that the party seeking indemnification furnishes to the other prompt written notice and requisite authority, information and assistance to defend, save that the Indemnifying Party may not make any admission of fault or liability on behalf of the other without the other Party's prior written permission.

7.2 **Insurance.** CONTRACTOR, at its sole cost and expense, shall insure its activities in connection with this Agreement. Specifically, CONTRACTOR shall obtain, keep in force, and maintain insurance or equivalent programs of self-insurance with appropriate limits that shall cover losses that may arise from breach of this Agreement, breach of CONTRACTOR's security, or other unauthorized Use or Disclosure of PHI by CONTRACTOR. At HOSPITAL's request, CONTRACTOR shall provide copies of Certificates of Insurance, or other similar documentation satisfactory to HOSPITAL, prior to the effective date of this Agreement, and in such cases shall continue to update HOSPITAL with regard to changes in CONTRACTOR's chosen insurance carriers or coverage limits. It should be expressly understood, however, that the limits and coverage expressed therein shall in no way limit the liability of CONTRACTOR.

8. MISCELLANEOUS

8.1 **Amendments.** The Parties acknowledge that technology, best industry practices, and state and federal law regarding the privacy of PHI are rapidly evolving, and that amendment of this Agreement may be required to reflect such developments. Upon HOSPITAL's request, CONTRACTOR agrees to promptly enter into the negotiations with HOSPITAL concerning the terms of any necessary changes to this Agreement consistent with these developments, in order to maintain optimal privacy and confidentiality for the PHI that CONTRACTOR receives from or creates for HOSPITAL. This Agreement may not be modified, nor any provision hereof waived or amended, except in a writing duly signed by authorized representatives of the Parties.

8.2 **Assignments/Subcontracting.** This Agreement shall inure to the benefit of and be binding upon the Parties hereto and their respective legal representatives, affiliated entities, successors and assigns. CONTRACTOR may not assign the rights or obligations under this Agreement without the express written consent of HOSPITAL.

8.3 **Assistance in Litigation/Administrative Proceedings.** Upon written request of either Party, and upon making arrangement to pay reasonable expenses incurred, the Parties agree to provide good-faith assistance, in the form of records, witness testimony, and other evidence as the requesting Party may reasonably deem necessary in order to defend against a third party judicial or administrative action or investigation, provided that such assistance would not unfairly prejudice the ability of that Party to defend itself in any pending or expected legal or administrative proceeding or investigation. This clause shall not have effect in cases of adversarial proceedings between the Parties, and under such circumstances the normal rules of discovery shall instead apply.

8.4 **Attorneys' Fees.** If any legal action, suit or proceeding, including mediation, arbitration or other non-judicial proceeding, is commenced between CONTRACTOR and HOSPITAL regarding their respective rights and obligations under this Agreement, the prevailing Party shall be entitled to recover, in addition to damages or other relief, all costs and expenses, attorneys' fees and court costs (including, without limitation, expert witness fees). As used herein, the term "prevailing Party" shall mean the Party that obtains the principal relief that it has sought by judgment. If the Party that commenced or instituted the action, suit or proceeding shall dismiss or discontinue it without the concurrence of the other Party, such other party shall be deemed the prevailing Party.

8.5 **Dispute Resolution.** The Parties agree to attempt, in good faith, to resolve any breach or alleged breach that does not result in summary termination under Section 6.2 of this Agreement. Should such attempts fail to produce a mutually agreeable result within a reasonable period of time, the Parties agree to seek mediation before a mediator approved by, and in a process conducted under the applicable rules of, the American Arbitration Association before filing a lawsuit over the unresolved matters. Notwithstanding the foregoing, the Parties waive all rights to, and agree not to assert any right to, any trial by jury on any issues or disputes arising under or related to this Agreement.

8.6 **General Interpretation.** The Parties have negotiated the terms of this Agreement and the language used in this Agreement shall be deemed to be the language chosen by the Parties to express their mutual intent. This Agreement shall be construed without regard to any presumption or rule requiring construction against the Party causing such instrument or any portion thereof to be drafted, or in favor of the Party receiving a particular benefit under the

Agreement. In addition, any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

8.7 **Governing Law.** This Agreement shall be governed by the laws of the State of California. All disputes arising hereunder shall be adjudicated before the courts of the County of San Diego, California. The Parties hereby waive all objections to the exercise of personal jurisdiction or venue of said courts.

8.8 **Merger.** This Agreement and the respective Contractual Arrangements comprise the entire agreement between the Parties, with respect to the privacy of PHI and the ordering and termination of relationships that impact such concerns, and supersedes all prior discussions, negotiations, and arrangements.

8.9 **Notice.** Any notice to be given under this Agreement shall be in writing and delivered personally or sent by certified or registered mail or overnight delivery

(for HOSPITAL): Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056
Attn: Chief Executive Officer

(for CONTRACTOR):_____
_____
_____

8.10 **Remedies.** The right to any redress, cure, indemnification, termination, or any other right conferred under this Agreement is not intended to be exclusive and exists in addition to any other rights or remedies available to either Party at law or in equity.

8.11 **Severance.** The invalidity or unenforceability of any part of this Agreement shall not affect the remaining provisions, and the Agreement shall be construed as if the invalid provisions were omitted.

8.12 **Survival.** The respective rights and obligations of the Parties under the provisions of this Agreement, solely with respect to PHI that CONTRACTOR retains in accordance with Sections 3.10, shall survive termination of this Agreement indefinitely. All of Section 3 shall survive termination of this Agreement with respect to retained PHI that comprises some or all of a Designated Record Set.

8.13 **Third Party Beneficiaries.** Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the Parties and their respective affiliated entities, successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

8.14 **Waiver.** All rights and obligations created under this Agreement shall survive any attempt, other than through a valid Amendment as per Section 8.1, to remove or modify them. No action or failure to act by either Party, other than the execution of a valid written Amendment, may waive any right or obligation to subsequently act,

refrain from acting, or command the action or inaction of the other Party, as applicable, as provided within this Agreement.

IN WITNESS WHEREOF, the Parties have executed this Agreement to be effective when signed by authorized representatives of both Parties.

For HOSPITAL		**For CONTRACTOR**	
By:	_____	By:	_____
Name:	Steve Dietlin	Name:	_____
Title:	Chief Executive Officer	Title:	_____
Date:	_____	Date:	_____

TRI-CITY HEALTHCARE DISTRICT
CONFIDENTIALITY ACKNOWLEDGEMENT & AGREEMENT FORM

PRINT NAME: _____

DEPARTMENT: _____ POSITION: _____

During the course of your activity at Tri-City Healthcare District (TCHD) and its affiliates, you may have access to information which is confidential and may not be disclosed except as permitted or required by law and in accord with TCHD's policies and procedures. In order for TCHD to properly care for patients and engage in successful business planning, certain information must remain confidential. Improper disclosure of confidential information can cause irreparable damage to TCHD. Confidential information includes, but is not limited to:

1. Medical and certain other personal information about patients.
2. Medical and certain other personal information about employees.
3. Medical Staff records and committee proceedings.
4. Personnel records and employee information.
5. Work Place Investigations
6. Reports, policies and procedures, marketing or financial information, and other information related to the business of services of TCHD and its affiliates which has not previously been released to the public at large by a duly authorized representative of TCHD.

If you have any questions at any time concerning the confidentiality or disclosure of information, you should contact the Values Line at ~~1-800-273-8452~~**1-844-521-7862 or https://tchd.ethicspoint.com.**~~:~~

By reviewing each section and signing this Confidentiality Acknowledgment, I acknowledge and agree that:

1. I will only access business information for which I have a legitimate business purpose. I will not disclose TCHD proprietary, operational, or employee information except when expressly authorized to do so by TCHD.

2. Medical Information is confidential and my access is restricted to my legitimate medical need to know for diagnosis, treatment and care of a particular patient.

3. I am obligated to hold confidential information in the strictest confidence and not to disclose the information to any person or in any manner which is inconsistent with applicable policies and procedures of TCHD.

4. I will print information from any hospital information system only when necessary for a legitimate business purpose. I understand that patient medical information may only be stored in authorized locations such as the hard copy medical record jacket located in the Health Information Department. Exceptions may be incorporated into departmental policy when the exception is approved in writing by Tri-City Healthcare District's Director of Legal Services.

5. I will shred or dispose of all patient or employee identifiable information in a designated locked, confidential disposal bin.

6. Patient medical information available from any hospital information system may not be in final form. Therefore, I will not release printed hard copy to third parties, including parents/guardians, but will refer them to the Medical Records/Health Information Department for assistance. Exceptions may be incorporated into departmental policy so long as the exception is approved in writing by Tri-City Healthcare District's Director of Legal Services. Third parties or employees requesting copies of personnel and employee records will be referred to Human Resources.

7. My access and use of any hospital information system information is subject to routine, random, and undisclosed surveillance by the hospital.

8. Failure to comply with my confidentiality obligation may result in disciplinary action or termination of my employment/educational affiliation by Tri-City Healthcare District and its affiliates, or corrective action in conformance with current medical staff bylaws, rules and regulations.

9. Impermissible disclosure of confidential information about a person may result in legal action being taken against me by or on behalf of that person.

10. I understand that licensed health care providers are subject to sanctions for impermissible disclosure under numerous statutes and regulations including revocation, suspension, probation, public reprimand, and arrest.

11. If I am issued a unique password, it is my responsibility to maintain this code in a confidential manner. This password is my signature for accessing authorized on line computer systems. My password will ensure that the data for which I am responsible will not be available to anyone else; therefore, it is mandatory that my password and access data be kept strictly confidential.

12. My confidentiality obligation shall continue indefinitely, including at all times after my association with Tri-City Healthcare District and its affiliates, such as termination of my employment or affiliation with Tri-City Healthcare District and its affiliates.

I HAVE READ AND UNDERSTAND THIS CONFIDENTIALITY AGREEMENT, HAVE HAD MY QUESTIONS FULLY ADDRESSED, AND HAVE RECEIVED A COPY FOR MY PERMANENT PERSONAL RECORDS.

_____ _____

Employee Signature Date/Time

_____

Print Name

Tri-City Healthcare District

Code of Conduct

Table of Contents

About Our Code and Your Responsibilities

Our Commitment to Quality Care - Our Values

Quality
Caring
Safety
Integrity
Innovation
Stewardship

Tri-City Healthcare District exists to serve the healthcare needs of its community. We are committed to furnishing each and every patient with high quality, compassionate care. To achieve this, we must all adopt a strong and deep commitment to embracing and living our values: quality, caring, safety, integrity, innovation, and stewardship.

Our values must be more than words on paper. Each of us has a responsibility to think about and be guided by the Tri-City values in everything we do, especially when faced with difficult decisions. Our values, as embodied in this Code of Conduct, applicable Policies and Procedures, and the support we provide to one another, will help guide us and ensure that we meet our ethics and compliance responsibilities and aspirations.

To Whom this Code Applies

The Code of Conduct provides the ethical guidelines and expectations for conducting business for, or on behalf of Tri-City Healthcare District. It applies to all District officers and employees, at every level, and to our Board of Directors. It also applies to the District's medical staff, as well as vendors, consultants, contractors, and temporary employees, who often serve as an extension of the District.

Compliance with the Law and Regulations

This Code of Conduct reflects our commitment to conduct business consistent with fundamental ethical standards and to comply with applicable laws and regulations, including all applicable federal health care program laws, regulations, and program requirements.

Each of us is responsible for knowing and upholding the rules that apply to our jobs, including, as applicable, the requirements of Medicare, Medicaid, the Emergency Medical Treatment and Active Labor Act (EMTALA), the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), the False Claims Act, California's Confidentiality of Medical Information Act (CMIA), and all other applicable state and federal healthcare laws and regulations.

We are also required to seek advice from a manager, the Chief Compliance Officer, or the Legal Department if we are in doubt about the appropriateness and/or legality of an action. To help us understand and meet these obligations, this Code defines expectations, provides guidance, and identifies resources to help us address concerns.

RESPONSIBILITIES

Everyone is responsible for maintaining our reputation as a quality healthcare provider that practices legally and ethically. Meeting these responsibilities is critical to the District's success today and in the future. We need to act with integrity.

Without integrity, we fail our patients, our community, our coworkers, and ourselves. We must strive to maintain the highest ethical standards:

- **Be honest** in all you do.
- **Always obey** the law and all District policies and procedures, and act in a professional, honest, and ethical manner when acting on behalf of the District. Seek advice if in doubt about the appropriateness and/or legality of an action.
- **Know** the information contained in this Code and the related District policies and procedures, paying particular attention to the policies and procedures that pertain to your job responsibilities.
- **Complete** all required training in a timely manner.
- **Promptly report** concerns about possible violations of laws, regulations, this Code, or any District policies or procedures in accordance with the District's policies.
- **Cooperate** and tell the whole truth when responding to a compliance review or investigation. Never alter or destroy any records.
- **No excuses!** No reason, including the need to meet job responsibilities or organizational goals, is an excuse for violating laws, regulations, this Code, or District policies and procedures.

ADDITIONAL RESPONSIBILITIES OF DISTRICT LEADERSHIP

Individuals who manage others or are otherwise in a position of authority have these additional responsibilities:

- **Lead by example.** Managers are expected to exemplify the highest standards of ethical conduct.
- **Create a positive working environment** where everyone feels comfortable asking questions and reporting potential violations of this Code and its underlying policies and procedures. Never retaliate or seek retribution against those who raise issues or concerns.
- **Never ask or pressure anyone** to do something that you would be prohibited from doing yourself.
- Be aware of the **limits of your authority** and do not take any action that exceeds those limits. Never delegate authority to any individual whom you believe may engage in unlawful or unethical conduct.
- If you **supervise contractors** working on our behalf, ensure that they understand our expectations that they comply with applicable law, regulations and our Code.

As a manager, you need to monitor what is happening with those whom you supervise. If you become aware of conduct that may violate applicable law, regulations, our Code, or our policies and procedures, you **MUST** report it immediately. Not reporting a violation when you know or should have known about it may result in discipline up to and including termination of your employment.

Managers should not consider ethics concerns as threats or challenges to their authority. We want open, honest, and truthful dialogue to become a natural part of our daily work.

Q: I'm a manager, and I'm not clear what my obligations are if someone comes to me with an allegation – and what if it involves a senior leader?

A: No matter who the allegation involves, you must report it. See the next section of this Code for more detail on how to report it.

Asking Questions and Reporting Suspected Violations

In today's complex healthcare environment, legal and ethical concerns routinely occur. When they do, employees must report the issues so that they can be addressed quickly and appropriately, minimizing the damage to the District and any involved parties. The sooner we know about possible problems, the sooner we can address them and find solutions. And of course, employees **MUST** report misconduct which they commit, witness, or hear about.

For reporting, employees have several options:

- Bring matters involving employee relations and discipline, work safety, job duties, harassment, and employee health to the attention of your manager or the Human Resources Department.

- Ask your manager or the Legal Department questions regarding handling legal documents, responding to regulatory inquiries, and how to determine and interpret the laws that apply to your job.

- Concerns regarding noncompliance with applicable laws and regulatory requirements must be reported to your manager, the Chief Compliance Officer, or by calling the **Values Line (800) 273-8452**.

The Values Line is available 24 hours per day, 365 days per year. Translators are available to speak in your native language, all calls are kept confidential, **and you can make your report anonymously, if you so choose**. If you make a report through the Values Line, you will receive an identification number so you can follow up on the concern. This is especially important if you have submitted a report anonymously, because it will enable you to provide additional information, and track the resolution of the matter.

Tri-City Healthcare District has an opportunity to improve every time an employee asks a question or raises a concern. When employees take action, speak up, and report questionable conduct, they are protecting their colleagues and our reputation. Remember, an issue cannot be addressed unless it is brought to someone's attention.

Protection from Retaliation

To build trust, we must listen openly to concerns about misconduct, respond appropriately, and never retaliate or seek retribution against those who raise issues or participate in investigations.

We take claims of retaliation and retribution seriously. All such claims will be thoroughly investigated. If they are substantiated, retaliators will be disciplined, up to and including dismissal from the District. If an employee believes he or she has experienced retaliation, the individual should report it using any of the methods described in the above section on *Asking Questions and Reporting Suspected Violations*.

Accountability and Discipline

All employees of Tri-City Healthcare District are required to obey all federal, state, and local laws and to abide by the rules set forth in this Code of Conduct and all District policies and procedures. Any individual who fails to do so is subject to penalties up to and including dismissal from the District along with criminal and/or civil prosecution.

Amendments and Waivers

On rare occasions, Tri-City Healthcare District may amend or waive certain provisions of this Code. Anyone who believes that a waiver may be appropriate should discuss the matter with the Chief Compliance Officer or the CEO.

Any proposed waiver or exception must be approved by the Chief Compliance Officer and CEO in writing, per policy 8750-566.

Our Ethics and Compliance Resources

This Code and District policies serve as resources for employees to help guide their actions.

Employees also should be alert to changes in the law or new requirements that may affect their work as well as new District services that may be subject to special legal requirements.

In addition to the Code, it is important to remember that District leaders are a good resource when it comes to ethical business conduct, as are the Chief Compliance Officer, the Legal Department, the Human Resources Department, and the Values Line (800) 273-8452. Employees should feel free to take advantage of any of the resources provided.

Making the Right Decision

Pressure often clouds our judgment, and occasionally, the right choice is not clear. Remember, support is available for employees facing a tough call. Our colleagues and managers can help us think through our options. Employees also may rely on this Code for help, or contact the Values Line (800) 273-8452.

When making a difficult decision, employees should ask three simple questions:

- **Is it legal?** If it isn't, don't do it.
- **Is it right?** How do you feel about the choice? Does your conscience give you pause? Would a close, trusted friend be okay with it?
- **How would I feel if the conduct appeared on YouTube or in the newspaper?** If someone posted a video of (or a blog entry about) what you had done and individuals around the world saw it, would it hurt your reputation or the reputation of Tri-City Healthcare District? If so, it is the wrong choice – don't do it!

Our Commitment to Our Patients

Providing Quality Medical Care

The only acceptable standard of care at Tri-City Healthcare District is that of the highest quality. We provide care that is compassionate and that advances the health and wellness of all the people we serve. Our commitment in this regard is more fully set forth in the District's *Patient Handbook*, Policy 8610-302, and the Joint Commission's National Patient Safety Goals.

Caring for Our Patients and Their Rights

The District adheres to the highest standards in the realm of patients' rights and respecting patients' privacy, safety, and sovereignty over their own bodies. We communicate clearly with our patients about their rights and their options, and we make sure that they are empowered while availing themselves of our services and care.

District employees must be mindful that each of our patients has specific rights including:

- Considerate and respectful care, personal dignity, and comfort.
- To receive information about his or her health status, diagnosis, prognosis, and treatment.
- Free interpreter services available.
- To make decisions regarding medical care and to receive needed information.
- To request or refuse treatment, to the extent permitted by law.
- To have personal privacy respected.
- To receive care in a safe setting, free from abuse, neglect, or exploitation.

Patient Safety

No patient care goal is more important than that of ensuring patient safety. Employees of the District work diligently to correctly identify our patients, promptly communicate key care information to correct staff, properly use medications, and identify and manage other patient safety risks.

The Joint Commission provides certain patient safety goals, generally including:

- Identifying patients correctly.
- Maintaining and communicating accurate patient medication information.
- Preventing infection of all types, making use of all appropriate guidelines.
- Identify patient safety risks, including suicide risk.
- Complying with current CDC and WHO hand hygiene guidelines.

Safeguarding Patient Privacy and Confidentiality

Our commitment to upholding the law includes patient information privacy and security. Employees should disclose confidential patient information only as permitted by law to those with a need to know. We will hold our contractors and care partners to the same standards.

Our Commitment to One Another

Respect in the Workplace

We are committed to fair and respectful treatment and equal opportunity in our employment interactions and decisions. Our colleagues and job applicants are entitled to respect and should be judged only on the basis of their qualifications, demonstrated skills, and achievements.

Remember:

- Treat others as you wish to be treated.
- Review your own decisions to ensure that only objective merit and healthcare considerations drive your actions.
- If you supervise others, judge them on performance. Avoid introducing unrelated considerations into your decisions.

Equal Employment Opportunity

We believe every employee deserves to work and grow in an environment free of unlawful discrimination, harassment, intimidation, and abuse. We understand that the District is best served when all perspectives are considered fairly and without prejudice. We prohibit any form of discrimination on the basis of a characteristic protected by state and federal law, and our policies. For more detailed information, please consult Policy 8610-418, or ask Human Resources.

Harassment

The District is committed to providing a harassment-free environment. The District's anti-harassment policy applies to all persons involved in the operation of the District and prohibits unlawful harassment by any employee of the District, including supervisors and managers, as well as vendors and customers. For more specific information regarding harassment, please consult Policy 8610-403, or ask Human Resources.

Remember:

- Treat coworkers with respect. Do not discriminate or harass anyone. Be open to different points of view, backgrounds, and experiences and recognize the value that diversity brings to our work.
- Let people know if you find their behavior to be demeaning or disrespectful of you or others. Don't tolerate discrimination or harassment in any form.
- Be professional. Do not visit inappropriate internet sites or display sexually explicit or offensive pictures. This prohibition does not include internet sites or pictures legitimately used in connection with your work for the District.
- Report all incidents of harassment and discrimination that may compromise our ability to work together in an appropriate environment.

Q: ***One of my co-workers sends e-mails and text messages containing jokes and comments that make fun of certain nationalities. They make me uncomfortable, but no one else has spoken up about them. What should I do?***

A: ***You should notify your manager or the Human Resources Department. Jokes that demean or stereotype people's national origin, or any other protected characteristic, are inappropriate. Raise the issue now, so that it does not continue or even escalate.***

Q: ***While attending an educational program with some coworkers at a local hotel, a colleague repeatedly asked me out for drinks and made comments about my appearance that made me uncomfortable. I asked him to stop, but he wouldn't. We weren't in the office and it was "after hours" so I wasn't sure what I should do. Does this violate our Code?***

A: ***Yes. This type of conduct will not be tolerated, not only during working hours but in all work-related situations. Tell your colleague such actions are inappropriate. If they do not stop immediately, or if you don't feel comfortable confronting your colleague, report the issue.***

Safe Working Environment

The District is committed to providing a safe and healthy workplace for our employees, as well as for patients and visitors to our facilities. We need to protect ourselves and others in our everyday actions. Situations that may pose a health, safety, or environmental hazard must be immediately fixed or reported to management. We can only achieve our goal of a safe and healthy workplace through the active participation and support of everyone. **The more we communicate, the better we can respond to any unsafe or unhealthy working conditions.**

Remember:

- Comply with all applicable health and safety laws, policies, and procedures. If you don't know what the safe thing to do is, ask someone who knows.
- Understand your job fully and follow instructions. Wear personal protective equipment in accordance with the job you are performing. Use, adjust, and repair equipment only if you are trained and qualified.
- If an unsafe condition cannot be immediately fixed, notify your manager or Human Resources immediately.

Q: I've noticed some practices in my area that don't seem safe. Who can I speak to? I'm new here, and don't want to be considered a troublemaker.

A: Discuss your concerns with your manager. There may be very good reasons for the practices. On the other hand, sometimes new eyes see things that more experienced eyes have missed. Raising a concern about safety is not making trouble; it is being responsible.

Abuse of Drugs and Alcohol

Part of maintaining a safe working environment is being certain that every employee is fully awake, aware, and able to do his or her job carefully and safely. We must be mindful of how others might be affected by our actions. We also should be mindful of our intake of alcohol at work-related events.

Remember:

- While at work or on District business, you should be alert, never impaired, and always ready to carry out your work duties.
- The use of alcoholic beverages or illegal substances during working hours will not be tolerated. The possession of alcoholic beverages or illegal substances on District property is forbidden.
- If you have a medical condition that requires you to use medication while working, and that medication could impair your mental or physical capabilities, you must notify Employee Health.

Workplace Violence

The District has a zero tolerance for acts and threats of violence. All such acts and threats, even those made in apparent jest, will be taken seriously, and will lead to discipline up to and including termination.

It is every employee's responsibility to assist in establishing and maintaining a violence-free work environment. Therefore, each employee is expected and encouraged to report any incident which may be threatening to you or your co-workers or any event which you reasonably believe is threatening or violent.

Threats include any indication of intent to harm a person or damage District property. Threats may be direct or indirect, and they may be communicated verbally or nonverbally.

Q: Are visiting physicians, medical personnel, and contractors expected to follow the same health, safety, and security policies and procedures as employees?

A: Absolutely. Managers and supervisors are responsible for ensuring that anyone working on District premises understands and complies with all applicable laws, regulations and policies.

Protecting District Assets

It is our responsibility to care for, properly use, and protect our assets and resources. We must each use our best judgment to make sure District assets are not lost, stolen, or wasted, and are used only for legitimate business purposes. We must never use District assets for personal gain.

Our assets include:

- Our physical facilities;
- Computers, files, documents, and passwords;
- Confidential information;
- Employee time; and
- Machines, equipment, materials, and supplies.

Remember:

- Ask your manager before you take hospital property, such as files or personal computers, off District premises.
- Be aware that Tri-City Healthcare District reserves the right to search all our property, as well as anything brought onto or taken from District premises (including employee personal possessions).
- Do not use our equipment or systems, including email and the internet, to download, create, store, or send content that others might find offensive or that is illegal.
- Do not share passwords or allow others to use District assets.

Confidential Information

One of the District's most valuable assets is its confidential information. Confidential information includes information not publicly released such as patient information, personnel information, staffing changes, trade secrets, business plans, and employee medical information. The obligation to preserve and protect District confidential information is ongoing, even after employment ends.

Remember:

- Use confidential information only for legitimate operational purposes.
- Share confidential information only with people who need to know it.
- Forward all requests for information regarding a current or former employee's position/compensation with the District to the Human Resources Department.
- Avoid discussing confidential information when others might be able to overhear what is being said.
- Never use confidential information for personal financial gain or to compete with Tri-City Healthcare District.

Employee Privacy

Tri-City Healthcare District is committed to respecting the confidentiality of employees' personal information, such as personal records, photos, social security numbers, medical information, and home addresses. Only such personal data as is necessary will be acquired and retained by the District.

Employees authorized to have access to personal employee data are expected to ensure the security of the information and share it only with authorized persons on a "need-to-know" basis. We must make sure such information is stored securely and we should refrain from holding the information longer than is necessary to meet the legal or business reason for which it was acquired.

Q: Are the emails I send from my computer protected by the District's privacy policy?

A: Tri-City Healthcare District respects the confidentiality of the personal information of employees; however, it is important to remember that employees have no expectation of privacy with regard to workplace communication, including emails, texts, and voicemails. Even communications with your personal attorney will not be privileged if the District email system or computers are used.

Confidential Information – Business partners

Everyone with necessary access to District confidential information who is not employed by the District, including visiting physicians and medical personnel, contractors, and consultants, is expected to adhere to the District's specific policies and procedures with regard to information protection. Managers are responsible for ensuring that our business partners are duly authorized to handle our confidential information and are appropriately cautious with it.

Accurate Coding, Billing, and Records

Trustees, patients, insurance companies, government officials, and others need to be able to rely on the accuracy and completeness of our business records and invoices. We must be honest in what we say, what we write and what we do. Accurate information is also essential within the District so that we can make good business decisions. This is why our coding, billing, and records must be accurate, timely, complete, and understandable.

Each of us is responsible for helping to ensure that invoices we submit are legitimate and appropriate, and that the codes and information we record are accurate, complete, and maintained in a manner consistent with our system of internal controls.

Remember:

- Always code and bill accurately, only for services rendered and documented properly. Ensure that any bills submitted are consistent with federal billing standards and federal medical program requirements.
- Make sure that financial entries are clear and complete and do not hide or disguise the true nature of any transaction.
- Do not record, understate, or overstate known liabilities and assets, or defer the recording of items which should be expensed.
- Do not maintain undisclosed or unrecorded funds, assets, or liabilities.
- Do not back date documents.
- Never make false claims on an expense report, time sheet, or in billing a health care program.
- If you are uncertain about the validity of an entry or process consult with your manager, or contact Human Resources.
- Only sign documents that you are authorized to sign and that you are certain are accurate and truthful. This includes approving invoices and journal entries as well as 'signing off' on financial statements.
- Bring any evidence of fraud in accounting, financial reporting, or internal controls to the attention of your manager, the Chief Compliance Officer, or the Values Line (800) 273-8452.

Proper Use of Electronic Media

Electronic media includes everything from the content of CDs to email and text messages to websites, television, and radio broadcasts. We should all exercise discretion when using electronic media. These tools should never be used in a way that interferes with the conduct of District business. We also should avoid any usage that might lead to loss or damage, such as the introduction of viruses or a breach of our firewalls. We also must be aware of software licensing rules and never use unauthorized copies of software on District computers, or use District software on our personal computers in a way not intended by the license.

Remember, do not use District equipment:

- To download, save, send, or access any defamatory, discriminatory, obscene or illegal material.
- To gain or attempt to gain unauthorized or unlawful access to computers, equipment, networks, or systems of Tri-City Healthcare District or any other person or entity.
- In connection with any infringement of intellectual property rights, including but not limited to copyrights.
- In connection with the violation or attempted violation of any law.

Use of Social Media

District employees who choose to use social media should do so on their own time, be careful to comply with Policy 8610-479, and avoid discussing any District confidential or work information. Employees also should be careful when posting online to avoid giving the impression that they are speaking on behalf of the District unless authorized to do so.

Think carefully before hitting the 'send' button. These types of communications live forever. Remember, if you are not authorized to speak publically on behalf of the District, you should not do so.

Retention and Disposal of Documents and Records

Medical and business documents and records must be maintained in accordance with procedures and time frames established by applicable laws, accreditation standards, and the District's document retention policies. Medical and business documents include paper documents, such as letters and memoranda; computer-based information, such as e-mail or computer files on disk or tape; and any other medium that contains information about the District or its business activities.

We will not tamper with records, nor remove or destroy them before the time period specified in the District's document retention policies, and we will not destroy any records we know relate to pending litigation or government investigation.

Meeting the Letter and the Spirit of Laws and Regulatory Requirements

Compliance and Transparency

We are obligated to follow all relevant local, state, and federal laws and regulations. Each of us is responsible for knowing which of these apply to our respective jobs. An employee who is unclear about a law is responsible for asking questions of his or her manager, the Legal Department, or Human Resources. Failure to comply with the laws and regulations which govern our services undermines our mission and will ultimately lead to serious consequences for the District and its employees.

Transparency is key to maintaining a culture of compliance with healthcare laws and regulations. When we are open and clear about our actions we can more readily demonstrate our compliance, and we can more easily spot and remedy any errors or confusion about a law or regulation.

Conflicts of Interest

A conflict of interest occurs whenever an employee has a competing interest that may interfere with his or her ability to make a sound, objective decision for the District. We must never use our positions with Tri-City Healthcare District, or with any of its patients or vendors, for private gain, to advance personal interests, or to obtain favors or benefits for ourselves, members of our families, or any other individuals or entities. Each of us is expected to use good judgment and avoid situations that can lead to even the appearance of a conflict.

It is impossible to describe every potential conflict. Therefore, the District relies on each of us to uphold the highest standards of integrity and to seek advice when needed. Please consult Policy 8610-462 or Human Resources for more specific information.

Remember:

- If you believe a conflict or potential conflict exists, you must disclose it to your manager, or Human Resources.
- Any situation that creates, or even appears to create, a conflict of interest between your personal interests and the interests of the District and our patients should be avoided.

Personal Relationships

We must not let personal relationships with friends or family members influence our work-related decisions in a way that causes us to act against the best interests of Tri-City Healthcare District. This includes decisions made about hiring employees, selecting vendors, and billing. Employees should obtain management approval before becoming involved in such decisions.

Financial Incentives to Provide Care

We should be especially careful to avoid even the appearance of any conflicts of interest in our dealings with physicians and other healthcare providers. We must never offer or provide anything of value to encourage or reward referrals from other healthcare professionals, and we also must not accept them. These types of gifts are typically viewed as bribes or kickbacks, which are illegal.

Remember:

- Do not offer, pay, or accept bribes or kickbacks.
- Do not tie compensation to volume or value of referrals.
- If you are aware of a District employee who is offering, paying, or receiving kickbacks or bribes, or if you suspect such behavior is occurring, report your concern to your manager, the Chief Compliance Officer, or the Values Line (800) 273-8452.

Outside Business or Employment

Tri-City Healthcare District employees occasionally take on additional, outside employment. This could constitute a conflict of interest if that outside work interferes with the employee's ability to fulfill his or her responsibilities to the District, or if there is a risk that the outside employment may cause the employee to disclose District confidential information.

An employee who plans to take on outside employment or who already has an outside job or consulting arrangement that is related in any way to the healthcare industry must disclose it to Human Resources. Please see Policy 8610-462 for more detailed information.

Personal Investments or Transactions

Ownership by a District employee of an investment in a vendor, competitor or business partner could influence decisions made by that employee. For those employees who are not already required to annually disclose such interests under the District Conflict of Interest Code, such ownership interests in companies not publicly traded on a national stock exchange must be reported to Human Resources.

Additionally, any District employee who holds an ownership stake in any other healthcare entities (e.g., labs, outpatient imaging centers, rehabilitation facilities, etc.) must be careful about how this ownership affects any decisions made on behalf of the District. Referring Tri-City patients to such entities is called self-referral and may implicate and violate various anti-self-referral and anti-inducement laws and regulations. In addition, such interests are reportable by employees designated in the District Conflict of Interest Code, and may result in disqualification from some decision-making.

Boards, Panels, Foundations, Consulting Arrangements

Memberships or participation in outside organizations, especially those which oversee, approve actions by, receive grants from, or have contracts with the District, should be disclosed in advance to Human Resources. Examples of such arrangements are municipal Board memberships; focus groups, discussion panels and advisory boards for makers of healthcare products; community health clinic boards; and participation in a Foundation that distributes financial support to research or healthcare entities. You may be directed to manage such conflicts by removing yourself from any decision making that will impact Tri-City Healthcare District. In some instances in which a conflict of interest precludes you from carrying out your responsibilities to the District, resignation may be necessary.

Accepting Gifts and Entertainment

District employees are not allowed to accept gifts or gratuities that are inconsistent with Policy 8610-425, 8610-462, this Code, or that could influence decisions regarding patient care or business. We have one excellent standard of care for all patients, and that standard should not be affected in any way by gifts.

Providing Gifts, Meals and Entertainment

Gifts, meals or entertainment may only be given to others if they are reasonable complements to business relationships, are of modest value, and are not against the law or the policy of the District or the recipient's organization. While it is a legitimate business activity to entertain our business partners and prospects ancillary to our business with them, no such activity should involve behavior that would otherwise violate policies or reflect poorly on our reputation. In addition, these activities may implicate the federal health care program anti-kickback law (the "Anti-Kickback Law"), 42 U.S.C. § 1320a-7b(b), and the federal physician self-referral law (the "Stark Law"), 42 U.S.C. § 1395nn.

Remember:

- Before you provide gifts or entertainment, be sure it is consistent with both District policy and the policies of the recipient's employer.
- Never provide gifts to government officials without prior Legal Department approval.

Compliance with Government Healthcare Regulations

Tri-City Healthcare District complies with all federal, state, and local laws that govern our healthcare practices. We operate in full cooperation with the Federal False Claims Act and the Deficit Reduction Act, which are intended to protect government programs including Medicare, Medicaid, and TRICARE from fraud, waste and abuse. Our policies promote accuracy and transparency in our coding and billing practices for both government and private payers, and we offer protection for whistleblowers.

We comply fully with EMTALA, which protects patients seeking emergency care, and are committed to providing all necessary care to any patients who come to us requiring emergency medical treatment. We adhere to all laws governing improper payments, such as the Federal Anti-Kickback Law, which prohibits offering, giving, or accepting anything of value to motivate or reward referrals.

Working with Regulatory Authorities

Tri-City Healthcare District and its employees are committed to cooperate with all regulatory authorities. We will provide any information required by state and federal audits and investigations promptly, fully, and honestly. We will not alter, withhold, or destroy any records related to an investigation.

Employees should notify the Legal Department before responding to a subpoena, search warrant, request for an interview or other non-routine request for access to information related to District matters.

Our Commitment to the Community

Tri-City Healthcare District – In the Community

We have a responsibility, as a healthcare provider, to be a good corporate citizen. We encourage participation in, and strive for the improvement of, the communities in which we live and work. We support giving and volunteering in our communities, and we understand the value of our good reputation to our communities.

While employees are encouraged to be involved in community organizations and projects of their choice, we should never present our personal views or actions as if they represent Tri-City Healthcare District's position. Any charitable contributions or donations on behalf of the District must be approved by the Board of Directors.

Outside activities must not interfere with job performance. Employees should not exert improper influence in business decisions regarding a charity or other organization where they volunteer.

Q: My manager often asks me to buy candy bars as part of fund raising activities for his children's schools. He also encourages us to support his favorite charities and sponsor him in fundraising walks and races. Sometimes I feel I don't have a choice. What can I do?

A: Selling, soliciting, or collecting contributions for any purpose on the District's premises is prohibited. The only exception is for District-approved fundraisers such as March of Dimes. In addition, pressuring others to contribute to or join charities, groups, or political activities is not allowed. Your manager may not view his actions as 'pressure' and may not be aware of our policy. If you are comfortable doing so, talk to him about the problem. As an alternative, you can contact Human Resources.

Environmental Compliance

The District actively seeks opportunities to improve the quality of life in our communities and to improve the environment that sustains us all. We recognize the need to provide our services in a way that protects and improves the state of the environment for future generations.

We are committed to meeting or exceeding applicable environmental laws and regulations and to continuously improving our environmental performance through resource conservation, waste minimization, and water and energy efficiency.

Remember, we must:

- Comply with all applicable environmental laws, regulations, and District policies.
- Be proactive and help identify opportunities for improving our environmental performance, including, for example, additional ways that we can conserve and recycle.
- Support waste reduction and recycling efforts at the District and in our communities.
- Comply with medical waste disposal protocols.

Communicating with the Public

Tri-City Healthcare District needs a clear, consistent voice when providing information to the public and the media. For this reason, it is important that only authorized persons speak on behalf of the District. Employees should never give the impression that they are speaking on behalf of the District in any communication that may become public if they are not authorized to do so.

Remember:

- If you receive an inquiry regarding District activities, results, or plans, or its position on public issues, and are not specifically authorized by District leadership to respond, refer the request to your manager.
- Obtain approval from the Legal Department, Chief Executive Officer, or Director of Public Relations before making public speeches, writing articles for professional journals, or engaging in other public communications on behalf of the District.

POLITICAL CONTRIBUTIONS AND POLITICAL ACTIVITY

As a responsible healthcare provider and member of our community, we respect the rights of employees to voluntarily participate in the political process outside of work hours and beyond District premises.

We also are committed to following the rules and requirements set forth by the Political Reform Act of 1974 in its most current form.

Employees must always make it clear that their views and actions are their own and not those of Tri-City Healthcare District. Employees must not use the District's resources to support their personal choice of political parties, causes, or candidates.

Remember:

- Lobbying activities or government contacts on behalf of the District must be coordinated with management, and be consistent with Board-adopted policies, as well as local and state registration laws.
- The District may not engage in any political spending, including donating products, services, transportation, or facilities to politicians or political organizations.
- Holding or campaigning for political office must not create, or appear to create, a conflict of interest or incompatibility with your duties at the District.

Q: ***What types of expenditures are covered by the prohibition on political contributions by the District?***

A: ***Political contributions include monetary spending, as well as indirect contributions such as the purchase of tickets to a political fundraiser. The prohibition also applies to "in-kind" contributions such as the use of District personnel or facilities, telephones, email systems, or payment for services.***

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: 07/85 **SUBJECT:** Doctor Strong

REVISION DATE(S): 05/88, 10/96, 10/98, 10/99, 04/02, 05/03, 04/06, 06/09, 06/11, 06/12, 05/15~~, 11/18~~ **POLICY NUMBER:** 8610-221

Administrative District Operations Content Expert Approval:	11/18
Administrative Policies & Procedures Committee Approval:	~~03/15~~12/18
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~04/15~~02/19
Administration Approval:	03/19
Professional Affairs Committee Approval:	~~05/15~~ n/a
Board of Directors Approval:	05/15

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

1. ~~To provide for safe management of the violent patient or visitor by Tri-City Healthcare District Staff.~~ To assure a timely response to situations involving an actual or potential physical threat to patients, Workforce Members~~volunteers, students, physicians, employees~~, visitors or property. It is the purpose of this Hospital's security program that when dealing with a confrontational and/or combative patient, personnel and/or visitor with or without a weapon, the Security Department will be notified.
2. All personnel will be encouraged to recognize activities leading to actual or potential physical threats to patients, physicians, volunteers, students, personnel, visitors or property.
~~1.~~3. Prompt action will be taken to secure assistance needed to stabilize situations that could leave bodily harm and/or property damage.

B. **DEFINITIONS:**

1. **Workforce Member:** Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for TCHD, is under the direct control of TCHD whether or not they are paid by TCHD. ~~Response Team – All on-duty designated staff from the Security Department and Lift Team.~~

C. **~~POLICY:~~ PROCEDURES**

1. When any employee, volunteer or physician perceives that the situation may/or has become threatening verbally or physically, they should notify the hospital operator at ext. 66 and state Dr. Strong, then give their location. The operator will page overhead three times "Dr. Strong" with the location. The operator will repeat the Dr. Strong announcement on the hand-held two-way radios as well. Security Officers will respond to the location on a "stat" basis.
2. Employees at all off-site facilities will call 911 first and inform the Local ~~Oceanside~~ Police Department of the situation. The off-site facilities will contact the hospital Security Department after the Dr. Strong has concluded to inform of the situation.
3. When the Security Department personnel arrive at the scene, they will obtain information regarding the incident from the person who has initial contact with the individual(s) who are causing the actual or potential threat. Security Department personnel will assess the situation to see if it can be handled appropriately and safely with the number of personnel

at the scene. If assistance is required, Security will contact the Engineering Department to their location.

4. Security Department personnel may take additional action, which may be to call Local ~~Oceanside~~ Police Department to respond and assist in restraining the individual or arrest if the involved persons and/or property is at risk

~~1.~~5. Staff will follow Administrative Human Resources Policy: Workplace Violence 8610-463 ~~Guidelines~~ and complete the Workplace Violence Incident Report ~~WPV form~~ to document the situation per Occupational Safety and Health Administration (OSHA) guidelines.

~~2. Security Stat is used by the Behavioral Health Unit (BHU) to notify security of dangerous behavior in progress.~~

~~3. When a Medical Center employee observes, detects or is notified of any person who may place staff, patients or visitors at risk for harm, then he/she will evaluate the situation, and if necessary call for Dr. Strong. (Dialing "66").~~

~~4. A "Dr. Strong" is paged overhead when an emergency situation arises involving persons who:~~

~~a. Become violent on the hospital premises.~~

~~b. Exhibit signs of drug or alcohol intoxication and volatile behavior.~~

~~c. Threaten violence to staff or others.~~

~~d. Threaten or exhibit self injurious behavior.~~

~~e. Are on a court hold and attempt to leave (including all holds).~~

~~5. A "Dr Strong" should NOT be paged for any of the following reasons:~~

~~a. Patient fell out of bed.~~

~~b. Assistance in lifting a patient.~~

~~c. Any other reasons that are not the product of violent or potentially violent behavior.~~

~~6. When possible, patients should not be restrained face down. In the event this is determined to be the only safe mode of restraint, the patient should be repositioned face up as soon as reasonably possible.~~

~~7. As soon as possible after a patient is restrained, a medical professional shall assess the patient to ensure vitals, no trauma or injuries.~~

~~D. **PROCESS:**~~

~~1. The staff member who initiates the distress call will dial "66" (District's emergency call line) and state to the PBX operator:~~

~~a. Dr. Strong on unit/dept/location provide name of caller.~~

~~b. Panic buttons are to be used when necessary in designated locations.~~

~~c. Each Dr. Strong call will be announced three (3) times over the paging system as well as over the Security Radio.~~

~~2. The staff member who initiates the Dr. Strong call will remain in the area where help was summoned, if his/her safety is not in jeopardy. This staff member will:~~

~~a. Brief team as to situation.~~

~~b. Direct team to exact location and person(s) involved.~~

~~c. Get necessary equipment.~~

~~d. Clear area of onlookers.~~

~~3. Response Team~~

~~a. All Response Team members will be required to attend hospital training on Non Violent Crisis Intervention (NVCI) for effective aggression management using the least amount of force necessary to maintain control.~~

~~b. There will be a designated leader of the Response Team. In the Emergency Department and BHU, a staff member of that Unit will take charge. In other areas, the Security Officer will take charge. (If a Security Officer is not present, the staff nurse of the Response Team will take charge).~~

~~c. When physical restraint has been deemed necessary and an order is given, the team leader will assign limb holds to members.~~

~~d. Physical restraint must be conducted with patient and staff safety in mind.~~

~~e. The team will not remove their hold from the person until instructed by the team leader.~~
~~f. It is the responsibility of the Security Officers to assess whether police force is needed; and, if necessary, to notify the Oceanside Police Department.~~

~~4. Facing someone with a weapon~~
~~a. Any situation involving a person with a weapon becomes the responsibility of Security and the local police.~~
~~b. The use of the panic button is not advised due to the large number of staff required to respond to this signal. This could escalate a violent situation.~~
~~c. A staff member not in immediate danger may attempt to dial "66" for Security.~~
~~d. It is the responsibility of the staff to evacuate patients and themselves from the area.~~
~~e. No confrontation of the violent patient should be made except by members of the security staff or by law enforcement officers.~~
~~f.~~ ~~When calling the police for assistance because a patient has a "weapon", tell the police dispatcher what kind of weapon (gun, knife, explosive, etc).~~

D. FORM(S):

~~g.~~**1. Workplace Violence Incident Report**

~~h.~~**E. RELATED DOCUMENT(S)~~~~REFERENCES~~:**

1. Administrative Human Resources Policy: ~~/ Human Resources – Workplace~~ Violence 8610-463

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
- ☐ Cardiac rehabilitation
- ☐ Surgical services
- ☐ 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

WORKPLACE VIOLENCE INCIDENT REPORT

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

ADMINISTRATIVE POLICY
PATIENT CARE

ISSUE DATE: 06/83

SUBJECT: Patients Injured by a Deadly Weapon or Criminal Act, Proper Handling of Evidence

REVISION DATE: 05/88, 09/91, 06/97, 06/03, 08/06, 06/09, 08/12

POLICY NUMBER: 8610-315

Department Approval:	07/18
Administrative Policies & Procedures Committee Approval:	~~08/12~~08/18
Organizational Compliance Committee Approval:	n/a
Medical Executive Committee Approval:	~~n/a~~02/19
Administration Approval:	~~01/19~~03/19
Professional Affairs Committee Approval:	~~11/12~~ n/a
Board of Directors Approval:	11/12

A. **PURPOSE:**

1. To ensure proper handling and preservation of evidence from a victim injured by a deadly weapon or criminal act. This includes maintaining chain-of-custody and storage and retrieval of any foreign objects removed from the patient.

B. **DEFINITION:**

1. Foreign Object: Any object, such as a knife or bullet that was used to inflict harm on or in a person.
2. Chain-of-Custody: A series of documented transfers of **an evidentiary** object listing the date, time and signature of the individual who **has** physically released~~s~~ custody **of the object** and **of the individual** who **has** physically received~~s~~ custody of the object. **This d**~~D~~ocumentation of each successful~~ive~~ transfer **of the object** ~~creates an indisputable link in~~ **maintains** the **evidentiary** chain of custody.

C. **POLICY:**

1. Process any clothing articles from victim of a violent crime as follows:
   a. Bag different clothing articles in different paper bags.
   b. Cut off clothing without going through a bullet or stab wound hole.
   c. Allow law enforcement authorities in the patient's room (ED or OR) to collect evidence/take pictures from the victim.
   d. Allow law enforcement authorities (police or coroner) to complete picture taking and documentation prior to post mortem care.
2. Document wound size when doing assessment. Have a ruler available for measurements and for taking pictures.
3. Handling of Foreign objects; chain-of-custody:
   a. Bullets or other foreign objects removed from the victim may have legal consequences in the future.
   b. It is necessary that the chain of custody be maintained on these objects will be prepared, tagged and turned over to local law enforcement.
   c. All items will be placed in an envelope or other sealable container and labeled with the patient's name, medical record number, date and physician's name and will be accompanied by a **Property Custody Record**~~chain-of-custody form~~.

d. If law enforcement authority is not present, notify Security for collection and complete **Property Custody Record**~~Chain-of-Custody~~ and **After Action Incident Review**~~Security Incident Notification~~ forms.

e. The ~~person~~ **the staff member** who places the object in the envelope and seals it begins the chain-of-custody by logging on the form the date sealed and their signature. When passing on the envelope this person must sign, date the envelope and mark it "Released". The person who receives the envelope must sign, date and mark it "Received". Each ~~successive~~ transfer **of the object** must be logged in this way to create a chain-of-custody.

f. The object will be released to the custody of the law enforcement authority upon demand and proper identification. A business card or copy of photo ID of the officer receiving the object must be attached to the **Property Custody Record**~~Evidence Chain-of-Custody~~ form.

D. ~~**RELATED DOCUMENT(S)FORM(S) REFERENCED WHICH CAN BE LOCATED ON THE INTRANET:**~~

1. ~~**Security**~~**After Action Incident Review** ~~**Notification Form**~~
2. ~~**Chain of**~~ **Property Custody Record** ~~**Form**~~

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

~~2.~~1. **Security Policy: Seized Contraband or Evidence 231** ~~Evidence Chain-of-Custody~~
~~3.~~2. **Security Policy:** Security Incident Notification **208**

Tri-City Medical Center
Security Department

After Action Incident Review

The *After Action Incident Review* form is to be completed by Security Department personnel anytime a Security Officer feel that there is a process or incident that needs to be reviewed for the purposes of improvement within the Security Department.

Complete all applicable sections of this form and submit the completed *After Action Incident Review* with the completed Security Department Incident/Crime report. Use an additional continuation sheet if necessary.

1. Problem/Concern Identified including a Description of the Incident:

2. How was the Problem/Concern Identified:

3. Action Taken to resolve the Problem/Concern:

Recommendations:

Submitted By: _____ Date: _____ Received By: _____ Date: _____

Tri-City Medical Center
Security Department

Property Custody Record

Notice to Property Owner: Upon release from the Tri-City Medical Center it will be your responsibility to make arrangements to pick up the hereon-listed items from the Security Department. Any items not picked up within thirty(30) days will be destroyed.

Officer Receiving Property:	Date Received:	Time Received:

Property Received from:

❑ Owner: _____

❑ Other: _____

Location / Reason Property Obtained:

_____

_____

_____

❑ Property Received for Safekeeping

Item #	Qty	Description / Condition:	SN / Tag #

Property Disposition:

❑ Property Returned to Owner
❑ Property Returned to Other Reason: _____
❑ Property Destroyed After Thirty(30) Days
❑ Property Destroyed Before Thirty(30) Days Reason: _____

Property Returned By:		
Officer:	Badge:	Date:

Property Received By:	
Signature:	Date:

White: Security Department - Yellow: Person Receiving Property - Pink: Receipt

Tri-City Medical Center
Oceanside, California

Emergency Operations Procedure Manual
General Information

SUBJECT: Emergency Operations Plan

ISSUE DATE: 06/08 **POLICY NUMBER:** 4001
REVIEW DATE(S): 06/11
REVISION DATE(S): ~~06/15~~11/18

Department Approval Date(s):	**05/15, 06/16, 11/18**
Environmental Health and Safety Committee Approval Dates(s):	**06/15, 10/16, 12~~/~~18**
Medical Executive Committee Approval Dates(s):	**n/a**
Administration Approval:	**03/19**
Professional Affairs Committee Approval Date(s):	**06/15, 01/17, n/a**
Board of Directors Approval Date(s):	**06/15, 01/17**

A. **SCOPE OF SERVICES**:

1. The scope of Tri City Hospital District (TCHD) Emergency Operations Plan (EOP) is to provide a program that ensures effective mitigation, preparation, response and recovery to disasters or emergencies affecting the environment of care. The medical center has developed an "all hazards" approach that supports a level of preparedness sufficient to address a wide range of emergencies regardless of cause. The Emergency Operations Plan and associated Emergency Management Program extends to all inpatient and outpatient line programs, ancillary services, support services and facilities including patient care, business occupancies and temporary alternate care sites of Tri City Medical Center. The plan also affects all staff, volunteers, contract staff, medical staff and associates including contracted services of Tri City Hospital District.

B. **OBJECTIVE**:

1. The objective of the Emergency Operations Plan is to effectively prepare for, manage an emergency situation and restore the facility to the same operational capabilities as pre-emergency levels.
2. Six (6) critical areas of emergency response shall be managed in order to assess the medical center's needs and prepare personnel to respond to incidents. The six critical areas are:
   a. Communication
   b. Resources and Assets
   c. Safety and Security
   d. Personnel Responsibilities
   e. Utilities Management
   f. Patient Clinical and Support Activities

C. **OBJECTIVES:**

1. The objectives of the Emergency Operations Plan will include the following:
   a. Identifying procedures to prepare and respond to potential disasters or emergencies.
   b. Provide education to personnel on the elements of the Emergency Operations Plan.
   c. Establish and implement procedures in response to an assortment of disaster and emergency situations.
   d. Identify alternate sources for supplies and services in the event of a disaster or emergency through establishing mutual-aid agreements with neighboring hospitals and/or healthcare systems; public health departments; hazardous materials response teams; local fire department; local police department; area pharmacies; medical supply

vendors.

e. Identify recovery strategies and actions to be activated in the event of a disaster or emergency situation.

D. **RESPONSIBILITY**:

1. The Safety Officer, in conjunction with the Environmental Health and Safety Committee is responsible for developing, implementing and monitoring all aspects of the Emergency Operations Plan, including the hazard vulnerability analysis, mitigation, preparedness, response and recovery.
   a. The Safety Officer shall also track National Incident Management System (NIMS) implementation.
   b. The Safety Officer will have a working knowledge of emergency management, the medical centers operations (daily/emergency) and the Hospital Incident Command Center operations.
   c. It will be the responsibility of the medical centers leaders, as well as, medical personnel to actively participate in the organizations Emergency Operations Plan.
   d. The Emergency Operations Plan shall be developed in coordination with local community agencies. The medical center shall communicate its needs and vulnerabilities to community emergency response agencies and identify the capabilities of the community in meeting the needs of the medical center.

E. **SPECIFIC PROCEDURES IN RESPONSE TO A VARIETY OF EMERGENCIES BASED ON A HAZARD VULNERABILITY ANALYSIS PERFORMED BY THE MEDICAL CENTER**.

1. The medical center has developed specific procedures in response to potential disasters and emergencies that may occur. Additionally, the medical center will create a Hazard Vulnerability Analysis (HVA) to identify areas of vulnerability and to undertake provisions to lessen the severity and/or impact of a disaster or emergency that could affect the services provided by the medical center.
2. The HVA is evaluated on an annual basis and input from the local fire department and community agencies and will be obtained to assure the medical center is aware of hazards in the community to which an emergency response may be required.
3. The medical center has developed a Utilities Disruption Matrix designed to provide available operational hours prior to departmental shut down or commencing of evacuation procedures. The Utilities Disruption Matrix is based on the medical center having the capabilities of operating self-sufficiently for up to *96 hours* without the assistance of external agencies or resources.
4. For each emergency identified in the medical center's HVA as a high risk, the following shall be defined:
   a. Mitigation activities that are designed to reduce the risk of potential damage due to an emergency situation.
   b. Preparedness activities that organize and mobilize essential resources.
   c. Response strategies and actions to be activated during an emergency situation.
   d. Recovery strategies/actions that will help restore the systems that are critical to resuming normal operations of the medical center.
5. Will maintain a documented inventory of on-site assets and resources that will be needed during an emergency. At a minimum, this inventory should include:
   a. Personal Protection Equipment (PPE)
   b. Water
   c. Fuel
   d. Staffing
   e. Linen
   f. Cleaning Supplies
   g. Food
   h. Medical/Surgical Resources

i. Pharmaceutical Resources

6. The inventory of assets and resources shall be evaluated on an annual basis or as needed.
7. Methods shall be in place for the monitoring of the inventory of assets and resources during an emergency situation.

F. **DEFINE AND INTEGRATE THE MEDICAL CENTERS ROLE WITH THE COMMUNITYWIDE EMERGENCY OPERATIONS EFFORTS TO PROMOTE INTER-OPERABILITY BETWEEN THE FACILITY AND THE COMMUNITY:**

1. The Emergency Operations Plan shall be tested and exercises shall be developed based on the medical center's top scoring emergency situations within the Hazard Vulnerability Analysis. The exercise shall validate the effectiveness of the Emergency Operations Plan and will identify opportunities to improve.
2. The Emergency Operations Plan shall be tested and exercised a minimum of two (2) times per year, either in response to an actual emergency or in a planned exercise.
3. Only one (1) exercise per year shall include an influx of volunteer or simulated patients.
4. At least one (1) exercise per year shall be evaluated to see how effectively the hospital performs when the medical center cannot be supported by the local community for up to 96 hours. (Tabletop sessions are acceptable to meet the community portion of this exercise).
5. If applicable, the medical center will participate in at least one (1) communitywide exercise annually that is relevant to the priority of emergencies defined in the hazard vulnerability analysis. (Tabletop sessions are acceptable to meet the community portion of this exercise).
6. The ~~Director~~ **Manager** of Safety (Safety Officer) is identified as the designee whose sole responsibility during emergency response exercises is to monitor performance and document opportunities for improvement.
7. The medical center cooperates with all local, county and state emergency management exercises. The Safety Officer is a member of the countywide emergency management system and coordinates with other agencies on any large scale exercises. San Diego Department of Public Health and Human Services Agency/EMS and Statewide Disaster planning efforts, coordinate with local police, fire and ambulance services in conjunction with acute care facilities.

G. **COMMAND STRUCTURE**:

1. The command structure utilized by the medical center in coordination with the communitywide structure will be the Hospital Incident Command System (HICS).

H. **INITIATING THE PLAN, INCLUDING DESCRIPTION OF PLAN ACTIVATION**:

1. The Emergency Operations Plan will be activated when it has been determined that a disaster or emergency situation has occurred or has the potential of occurring.
2. The Joint Commission's definition of an emergency:
   a. *"a natural or man-made event that significantly disrupts the environment of care; that significantly disrupts care and treatment; or that results in sudden, significantly changed or increased demands for the organizations services. Some emergencies are called 'disasters' or 'potential injury creating events'."*
3. When the facility is notified of an emergency situation, the person receiving notification will immediately notify the Chief Executive Officer or his/her designee of the situation whether it be an external or internal emergency. The Nursing Administrative Supervisor will respond to the site of an internal emergency and report back to the Chief Executive Officer or his/her designee, the status of the situation.
4. The Chief Executive Officer or his/her designee will evaluate the emergency situation to determine whether the Emergency Operations Plan will be activated. If the Emergency Operations Plan is to be activated, the Chief Executive Officer or his/her designee will notify the Switchboard Operator to announce Code Orange External/Internal overhead.
5. The Chief Executive Officer or appointed designee will assume responsibility of the Hospital Incident Command center and activate the appropriate positions noted on the Incident

Management Team Chart as deemed necessary for the occurrence:

a. Until the Incident Command System is in place, the Chief Executive Officer or his/her designee will determine if the Labor Pool will be opened depending on the size of the emergency situation. If the Labor Pool is not opened, the Nursing Administrative Supervisor may assign additional assistance to the Emergency Area as needed. Additional personnel will be called in as needed via the staff call back system.

b. The Nursing Administrative Supervisor will notify additional outside agencies that may need to assist the medical center in the event of an internal emergency (*i.e. fire department, police department or other agencies).*

6. The recovery phase will be initiated after the emergency situation is over and the medical center has been evaluated. The recovery phase of the plan is to be initiated by the Chief Executive Officer or his/her designee.

I. **COMMUNICATION:**

1. Notification of External Authorities:
   a. The medical center shall have a communications system in place, including two-way radio equipment and operators who are familiar with the equipment's operation.
   b. The medical center will provide for alternate communication methods in the event of a failure. Two-way radio equipment and cell phones shall be available in the event of an emergency. In the event that cell phones are not working, microwave communications, satellite phones, ham radios or portable 800 MHZ radios may be used.
2. The Safety Officer will approve media access to the facility, with only the Public Information Officer (PIO) interacting with the media.
3. A medical record system will be used to meet the minimum requirements of emergency management operations.

J. **PERSONNEL RESPONSIBILITIES**:

1. Notification of Personnel When Emergency Operations Plan is initiated:
   a. In an emergency situation which is so wide spread to be considered an emergency and/or involving mass casualties, all medical center personnel, regardless of position, are expected to report to the medical center as soon as it is feasible to travel. Each department director maintains a current callback list of all personnel assigned to their department. Once the Emergency Operations Plan has been activated, the department director in cooperation with Human Resources will assign a staff member to initiate the call back list.
   b. In the event there are excess personnel, the Hospital Command Center will communicate with department directors regarding rescheduling of personnel future needs. The medical staff will report to the Chief of Medical Staff or Medical Specialist Officer for their assignments.
2. Alternate Roles and Responsibilities of Personnel during Emergencies:
   a. Personnel may not be assigned to their regular duties. Personnel will be asked to perform various jobs which will be considered vital to the effective operation of the hospital during the emergency situation. Personnel will be assigned duties based on the needs of the medical center. If personnel are not needed in their perspective units/departments, they will be sent to the Labor Pool for assignment.
3. Identification of Personnel in Emergencies:
   a. Personnel on duty during activation of the Emergency Operations Plan will be identified by their picture identification name badge, which is mandated to be worn at all times while on duty.
   b. Only persons wearing proper identification or possess valid credentials shall be allowed entrance into the medical center during an emergency situation.
4. Personnel Activities and Support:
   a. The medical center has made provisions for staff support that can be implemented in the event of a communitywide emergency. Such provisions may include but not limited

to:
   i. Temporary housing/lodging needs.
   ii. Transportation needs.
   iii. Family support needs, as necessary (including short term child care)
   iv. Incident stress debriefing and counseling.

5. Orientation and Training:
   a. Personnel will attend orientation upon hire and annually thereafter, reviewing their specific roles and responsibilities during an emergency/disaster situation.
   b. In-service education will be given to the specific staff on the backup communication system and obtaining supplies/equipment in the event of an emergency/disaster situation.
   c. The Safety Officer or designee is responsible for in-servicing personnel to the Emergency Operations Plan.
   d. The department directors are responsible for in-servicing their department personnel on the department specific responsibilities during an emergency/disaster situation.

K. **EMERGENCY CREDENTIALING OF CAREGIVERS**:

1. To provide a mechanism for emergency credentialing and granting privileges to volunteer/non-staff licensed independent practitioners in the event of a disaster.
2. The Chief Executive Officer or Chief of Staff or their designee(s), may grant emergency privileges upon presentation of a valid picture ID (issued by a state, federal or regulatory agency) e.g., driver's license or passport and at least one of the following:
   a. A current license to practice or primary source of verification of the license.
   b. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT)
   c. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity.
   d. Presentation by current facility or medical staff member with personal knowledge regarding practitioner's identity.
3. Verification of Information:
   a. Verification of the required information shall be done by the Medical Staff Office or designee as soon as feasible. A record of this information will be retained in the Medical Staff Office.
4. Conditions of Emergency Privileges:
   a. The emergency designee must practice under the direction and supervision of an existing member of the Tri City Hospital District.

L. **RESOURCES AND ASSETS**:

1. The medical center keeps a documented inventory of assets it has on site that would be needed in the event of an emergency or disaster situation. At a minimum, the inventory should include:
   a. Linen
   b. Cleaning Supplies
   c. Personal Protective Equipment (PPE)
   d. Water
   e. Food
   f. Fuel
   g. Staffing
   h. Medical Resources and Assets
   i. Surgical Resources and Assets
   j. Pharmaceutical Resources and Assets
2. Methods are established to monitor quantities of assets and resources during an emergency or disaster situation.

3. Arrange for emergency/disaster supporting services to be performed by local businesses, utility companies, government agencies and individuals. Emergency/ disaster supporting services may include:
   a. Transportation
   b. Communications
   c. Traffic Control
   d. Food Supplies
   e. Utility Maintenance
   f. Medical Supplies
4. These arrangements must be coordinated with the assistance of the Safety Officer, San Diego Department of Public Health or the local Office of Emergency Services (OES) whenever possible.
5. The medical center shall estimate its emergency needs for each kind of support and when feasible arrange to have supporting supplies, equipment and manpower pre-designated for medical center use.
6. Essential supplies, pharmaceuticals, medical supplies, equipment, food, water, linen, cleaning supplies and utilities shall be provided to meet shelter requirements for up to *96 hours* when the medical center cannot be supported by the community. Procedures are in place for the procurement of additional supplies in an emergency.
7. In the event that the medical center cannot be supported by the local community for at least *96 hours,* the Chief Executive Officer/Incident Commander, Incident Command Staff and in consultation with community leaders, will evaluate the following options and implement those options that best serve the medical center and community:
   a. Conservation of Resources
   b. Curtailment of Services
   c. Supplementing of resources from outside of the local community
   d. Staged Evacuation
   e. Total Evacuation

M. **SAFETY AND SECURITY**:

1. Efficient traffic flow must be established:
   a. Prepare floor plans which designate areas for specific patient care functions and ensure that personnel are familiar with these plans.
   b. Prepare and have available traffic control tools to show external and internal routing of casualties and other traffic.
   c. Assign and train volunteers to perform traffic control and security functions.
2. At the time the Emergency Operations Plan is activated, the Security Department personnel will be responsible for locking all exits and entrances with the exception of the ambulance entrance which will be manned. The Security Staff shall maintain control of entry and egress from the facility. Personnel of the medical center are required to wear badges identifying them as personnel. Only persons with proper identification shall be admitted to the medical center during an emergency situation.
3. Radioactive or Chemical Isolation and Decontamination:
   a. There is a designated decontamination room with separate ventilation system or ventilation shut off available for radioactive or chemical isolation and decontamination. Staff is trained in the response to radiological, biological, chemical or hazardous material contamination.
   b. Arrange with a local or State Emergency Management Agency Director (if applicable) for the training of staff who would perform the radiological monitoring of casualties and hospital areas and the acquisition of necessary radiological monitoring equipment. This equipment shall be stored in the medical center as part of its essential emergency supply equipment.

N. **UTILITIES MANAGEMENT:**

1. The medical center will provide for alternative sources of essential utilities, including:
   a. An emergency source of electrical power capable of operating all essential electrical equipment and plan for failure of back-up generators
   b. An alternate source for medical gas and vacuum delivery
   c. An alternate means of waste disposal in the vent of sewage system failure
   d. Sufficient fuel to last for at least *96 hours* of expanded operation

O. **PATIENT CLINICAL AND SUPPORT ACTIVITIES**:

1. Management of Patients during Emergencies (i.e. Scheduling, Modification or Discontinuation of Services, Control of Patient Information and Patient Transportation)
   a. Upon activation of the Emergency Operations Plan, normal admission requirements will be modified. Initially, admissions to the medical center will be limited to those whose survival depends upon services obtainable only through medical care.
   b. Outpatient care will be restricted to those whose lives may be ultimately depending upon the present expenditure of medical supplies and health manpower time.
2. All elective admissions and procedures will be canceled, including elective surgery, no emergent outpatient and transferring patients who are stable to be discharged.
   a. Patients may be transferred to other facilities so those emergency victims may be accommodated.
   b. Individuals may be redirected or relocated for a Medical Screening Exam in the event that the Emergency Operations Plan has been activated. (Section 1135(b) of the Social Security Act §489.24(a)(2)).
   c. In the event the Emergency Operations Plan is activated, persons may be transferred prior to being stabilized, if, based upon the circumstances of the emergency the medical center is unable to provide proper care or treatment of services. (Section 1135(b) of the Social Security Act §489.24(a)(2)).

P. **EVACUATION OF THE FACILITY:**

1. When an emergency situation arises requiring evacuation of patients from threatened or affected areas, the safety of lives at Tri City Hospital District is the primary concern. Authority to order an evacuation is vested only with the Chief Executive Officer, his/her designees, or the Safety Officer. Patients shall be evacuated to an area of safety by whatever means are available. Formal agreements are in place with ambulance services and alternate care sites to transfer patients as necessary.
2. All personnel have been trained in evacuation procedures. Evacuation routes are posted throughout the medical center.
3. Relocation to alternate health facility or place of safety (i.e., churches, schools)
   a. Prepare maps of routes to relocation site
   b. Confirm periodically the availability of the relocation site
   c. Establish lists of supplies and equipment, by priority, to be relocated
   d. Arrange adequate transportation for evacuation and relocation
4. Establishing an Alternate Care Site When the Environment Cannot Support Adequate Patient Care
5. Formal agreements should be in place so that patients may be transferred to a facility that can provide adequate patient care. The Liaison Officer will be responsible for the inter-facility communication between the medical center and the designated alternative care site, and for retaining records of which patients were transferred to and/or from an alternative care site. The patient care unit transferring the patient is responsible for obtaining copies of the patient's medical records, gathering personal belongings and ensuring the patient's medications are continued throughout the transfer. If a medical equipment is transferred with the patient, the patient care unit is responsible for documenting what equipment was transferred with the patient so that equipment may be retrieved during the recovery phase post emergency. The following agreements are in place:
   a. Ambulance contract agreements for transfer of patients between facilities

b. Transfer agreements will be made between neighboring facilities
c. Emergency acquisitions of medical supplies, pharmaceuticals, food, equipment, water, linen, emergency repair services, etc

Q. **CONTINUING AND/OR RE-ESTABLISHING OPERATIONS FOLLOWING AN EMERGENCY**:

1. The medical center has mechanisms in place to restore the operational capabilities of the facility to pre-emergency levels. Once the emergency is over, the Engineering Department, including the Director of Facilities, Safety Officer, Risk Manager and other administration representatives, will begin assessing the damage to the facility and the environmental concerns to determine whether the medical center can safely provide medical care to the community and proved a safe environment for patients, personnel and visitors.
   a. Picture and/or videos will be taken of all damages to the facility's buildings, grounds, equipment, etc., including all off campus facilities.
   b. Architects, building inspectors and structural engineers may be called in to determine if the buildings are safe for occupancy.
   c. All potential environmental concerns will be evaluated for proper function, i.e., hazardous waste, fuel tanks, to ensure there is no leakage into the local sewer or water system or any other impact on other environmental concerns.
   d. Ensure personnel support programs have been instituted, i.e., crisis counseling, flexible work hours, cash advances, day care, particularly if your personnel and the medical center have been directly impacted by the emergency.
   e. Clear debris and secure unsafe buildings as necessary.
   f. Restore internal and external communication devices
   g. Inventory equipment and supplies for damage and determine if additional supplies need to be obtained from suppliers. Picture/videos will be taken of all damaged supplies and equipment for insurance purposes. Damaged supplies and equipment will be retained until approval is received from insurance providers for disposal.
2. Notify the community through local media services regarding the services the medical center will be providing and the location they will be provided in the event that services are moved off-campus.
   a. Notify the medical center's insurance provider and contact third-party expert to prepare the claim.
   b. Ensure records and data have been protected and restore information as necessary from backup tapes.
   c. Keep detailed records.
3. A proactive process shall be developed and implemented to seek other federal funding to support preparedness that takes advantage of developing interoperability training with local and regional multi-disciplinary partners.

R. **PERFORMANCE STANDARDS**:

1. There is a planned, systematic, interdisciplinary approach to process design and performance measurement analysis and improvement related to organization wide safety. The Environmental Health and Safety Committee will develop and establish performance measures and related outcomes in a collaborative fashion, based on those priority issues known to be associated with the healthcare environment. Performance measures and outcomes will be prioritized based upon high risk; high volume, problem prone situations and potential or actual sentinel event related occurrences. Criteria for performance improvement measurement and outcome indicator selection will be based on the following:
   a. The measure can identify the events it was intended to identify
   b. The measurement has a documented numerator and denominator statement or description of the population to which the measure is applicable.
   c. The measure has defined data elements and allowable values
   d. The measure can detect changes in performance over time
   e. The measure allows for comparison over time within the organization or between the

organization and other entities.

f. The data intended for collection is available.

g. Results can be reported in a way that is useful to the organization and other interested stakeholders.

S. **NIMS PREPAREDNESS FUNDING**:

1. Tri City Hospital District shall establish a working relationship with State and San Diego County Department of Health and Human Services Agency/EMS and state associations to identify activities to obtain and appropriately allocate preparedness funding.
2. The Environmental Health and Safety Committee on an on-going basis monitors performance regarding actual or potential risk related to one or more of the following:
   a. Personnel knowledge and skills
   b. Level of personnel participation
   c. Monitoring and inspection activities
   d. Emergency and incident reporting
   e. Inspection, preventative maintenance and testing of safety equipment
   f. Other performance measures and outcomes will be established by the Environmental Health and Safety Committee based on the criterion listed above. Data sources, frequency of data collection, individual(s) responsible for data collection, aggregation and reporting will be determined by the Environmental Health and Safety Committee.
3. To identify opportunities for improvement/corrective action, the Environmental Health and Safety Committee will follow the organization's improvement methodology. The basic steps to this model will consistently be followed and include planning, designing, measuring, analyzing/assessing, improving and evaluating effectiveness. Should the Environmental Health and Safety Committee feel a team approach is necessary for performance and process improvement to occur, the Environmental Health and Safety Committee will follow the organization's performance improvement guidelines for improvement team member selection.
4. Determination of team necessity will be based on those priority issues listed (high-risk, volume and problem prone situations and sentinel event occurrence). The Environmental Health and Safety Committee will review the necessity of team development, requesting primarily, team participation only in those instances where it is felt the Environmental Health and Safety Committee's contributions toward improvement would be limited (due to specialty, limited scope and/or knowledge of the subject matter). Should team development be deemed necessary, team members will be selected on the basis of their knowledge of the subject identified for improvement and those individuals who are "closest" to the subject identified. The team will be interdisciplinary, as appropriate to the subject to be improved.
5. Performance Improvement monitoring and outcome activities will be presented to the Environmental Health and Safety Committee by the Safety Officer at least on a quarterly basis, with a report of performance outcome to the Quality Assurance Performance Improvement (QAPI) Committee.

T. **ANNUAL EVALUATION OF THE EMERGENCY OPERATIONS PLAN OBJECTIVES, SCOPE, PERFORMANCE AND EFFECTIVENESS**:

1. The annual evaluation of the Emergency Operations Plan will include a review of the scope according to Joint Commission standards and NIMS requirements to evaluate the degree in which the program meets accreditation standards, NIMS requirements and the current risk assessment of the medical center.
   a. A comparison of the expectations and actual results of the program will be evaluated to determine if the goals and objectives of the program were met.
   b. The overall performance of the program will be reviewed by evaluating the results of performance improvement outcomes. The overall effectiveness of the program will be evaluated by determining the degree that expectations were met.
   c. The Emergency Operations Plan shall be revised and updated based on the annual evaluation of the Emergency Operations Program, including the Hazard Vulnerability

Analysis.

2. The performance and effectiveness of the Emergency Operations Plan shall be reviewed by the Environmental Health and Safety Committee, the QAPI Committee, Administration and reported to the Board of Directors as well.

Tri-City Medical Center
Oceanside, California

ENGINEERING
OPERATIONS

SUBJECT: Emergency Generator Test & Failures

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

Department Approval Date(s):	**08/18**
Environmental Health and Safety Committee Approval Date(s):	**11/18**
Administration Approval:	**03/19**
Professional Affairs Committee Approval Date(s):	**n/a**
Board of Directors Approval Date(s):	

A. **PURPOSE:**
1. To establish and maintain a method of performing generator testing.

B. **POLICY:**
1. Tri-City Healthcare District performs generator tests at the following intervals.

C. **PROCEDURE:**
1. MONTHLY – each electrical generator providing emergency power to the life safety and critical power elements will be tested:
   a. 30 continuous minutes under hospital load
2. ANNUAL – each electrical generator providing emergency power to the life safety and critical power elements will be load bank tested for a total of 1 ½ continuous hours.
   a. 30 minutes at 25% of the load on the name plate
   b. 30 minutes at 50% of the load on the name plate
   c. 1 hour at 75% of the load on the name plate
3. TRIENNIAL – each electrical generator providing power to the life safety and critical power elements will be tested:
   a. For a duration of 4 continuous hours
   b. At least every 36 months (+/- 45 days)
   c. With a dynamic or static lead of at least 30% of nameplate rating of the generator.
4. If the emergency generator fails a required test, interim measures are implemented to protect patient, visitors, and staff until necessary repairs or corrective action is completed.
5. A complete retest will be conducted after necessary repairs or corrective action is completed.
6. The date and data of the tests for each emergency generator will be maintained by the Engineering Department.

Tri-City Medical Center
Oceanside, California

ENGINEERING
EMERGENCY PREPAREDNESS

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Failure of Fire Alarm System~~ ~~Policy Number: 8015 Page 1 of 1~~
~~Department: Hospital-Wide~~	~~EFFECTIVE: 11/17/94~~ ~~REVISED: 3/97; 5/00; 5/03, 5/06; 5/09; 6/12~~

SUBJECT: Failure of Fire Alarm System

ISSUE DATE: 11/94
REVIEW DATE(S):
REVISION DATE(S): 3/97, 5/00, 5/03, 5/06, 5/09, 6/12

Department Approval Date(s):	**09/18**
Environmental Health and Safety Committee Approval Date(s):	**11/18**
Administration Approval:	**03/19**
Professional Affairs Committee Approval Date(s):	**n/a**
Board of Directors Approval Date(s):	

A. **POLICY:**
1. In the event of fire alarm failure the following procedure will be followed.

B. **PROCEDURE:**
1. In the event that the fire alarm fails call **the preferred fire alarm vendor that is most familiar with our system.**~~: JJJ Alarm Co., (760) 747-3050~~ . Request that they come out immediately.~~ to repair system.~~
2. Call **the Oceanside** Fire Department~~: 966-8638.~~ Inform them that our fire alarm has failed.
3. ~~Call all hospital departments~~**Send out a hospital wide page to notify all staff.** Inform them that our fire alarm system has failed and they are to dial "66" in case of a fire.
4. Call the Director of Engineering or Facilities Manager. He will make arrangements with Security to implement a fire ~~guard~~ watch
5. After fire alarm system is repaired, notify all hospital departments and the Fire Department.
6. The duty engineer will generate the report and submit to the ~~Department Manger~~**Director of Engineering.** ~~and the EOC.~~ **After the report is reviewed and signed off, the Director of Engineering will submit the report to the Environmental Health & Safety Committee.**

Tri-City Medical Center
Oceanside, California

ENGINEERING
EMERGENCY PREPAREDNESS

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Guidelines for Procedure for Failure of Essential Equipment~~ ~~Policy Number: 8017 Page 1 of 1~~
~~Department: Engineering~~	~~EFFECTIVE: 9/94~~ ~~REVISED: 2/97; 5/00; 5/03, 5/06; 5/09; 6/12~~

SUBJECT: Guidelines for Procedure for Failure of Essential Equipment **or Utility**

ISSUE DATE: 9/94
REVIEW DATE(S):
REVISION DATE(S): 2/97, 5/00, 5/03, 5/06, 5/09, 6/12

Department Approval Date(s):	**09/18**
Environmental Health and Safety Committee Approval Date(s):	**11/18**
Administration Approval:	**03/19**
Professional Affairs Committee Approval Date(s):	**n/a**
Board of Directors Approval Date(s):	

A. **POLICY**:

1. The Director of Engineering is responsible for the proper and safe functioning of all equipment **and utilities under Engineering's responsibility**~~within the facility. and the condition of that facility generally.~~ –It is therefore, the Director of Engineering's responsibility to maintain awareness of the ~~activities within the facility~~**equipment and utility services status, reliability and preventive maintenance.**

B. **PROCEDURE:**

1. ~~The Joint Commission on Accreditation of Healthcare Organizations requires~~**Director of ~~Facilities~~Engineering or his/her designee develops** ~~and~~ **manage** ~~that written~~ procedures ~~shall be developed~~ that specify the action to be taken during the failure of essential equipment and ~~major~~ utility services. ~~The written~~**These** procedures shall include a call system for summoning essential personnel and outside assistance when required.
2. The following essential equipment and services shall be included:
   a. Major air conditioning equipment~~;~~
   b. Air handling systems (ventilation, filtration, quantitative exchanges, **pressures,** humidity)~~;~~
   c. Boilers~~;~~
   d. Electrical power services~~;~~
   e. Fire alarm and extinguishing systems~~;~~
   f. Water supply~~;~~
   g. All waste disposal systems~~; and~~
   h. Medical gas and vacuum systems~~.~~
   ~~h.~~**i. Any other equipment/utilities essential to operations.~~

3. Qualified engineering consultative advice shall be available as needed.
4. The Director of Engineering, **Administration, Administrative Supervisor and Department(s) affected should be notified immediately during a failure.** ~~shall always be notified first when a disruption of service occurs, but in the event of his/her absence this system gives Administration and other department directors a greater idea of who is best qualified to handle the situation.~~
5. In the event that the in-house personnel cannot correct the problem and restore the operation of the equipment, ~~then Administration,~~ the Director of Engineering or **his/her**~~their~~ design~~eated representative~~ shall ~~have full authorization to~~ call in an outside resource to correct the situation.

Tri-City Medical Center
Oceanside, California

ENGINEERING
EMERGENCY PREPAREDNESS

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: System Record Drawings~~ ~~Policy Number: 8019 Page 1 of 1~~
~~Department: Engineering~~	~~EFFECTIVE: 9/94~~ ~~REVISED: 2/97; 5/00; 5/03, 5/06; 5/09~~ ~~REVIEWED: 6/12~~

SUBJECT: System Record Drawings

ISSUE DATE: 9/94
REVIEW DATE(S): 6/12
REVISION DATE(S): 2/97, 5/00, 5/03, 5/06, 5/09

Department Approval Date(s):	**09/18**
Environmental Health and Safety Committee Approval Date(s):	**11/18**
Administration Approval:	**03/19**
Professional Affairs Committee Approval Date(s):	**n/a**
Board of Directors Approval Date(s):	

A. **POLICY:**

1. It is the policy of Tri-City Medical Center, Engineering Department to maintain current operational plans for major utility systems including, but not limited to, HVAC, plumbing, normal ~~electric~~**power**, emergency power, medical gas & vacuum, boiler & steam, natural gas, elevators, tube system and communication systems.
2. The plans (or as built drawings) of key utilities equipment location and controls are located in the Plans Room **or on the cloud**.
3. All construction projects utilize AIA (American Institute of Architects) certified Architects that specialize in Healthcare design. All plans are reviewed, approved and building permits are issued by Office of Statewide Health, Planning and Development (OSHPD). This ensures all projects comply with current Life Safety Codes, Building Codes, and **Americans with Disabilities Act** (ADA) requirements. All phases of construction **are**~~is~~ inspected by an Inspector of Record, OSHPD Compliance Officer, ~~and~~ OSHPD Fire Marshal**, and OSHPD District Structural Engineer** before occupancy is granted.

Tri-City Medical Center
Oceanside, California

ENGINEERING
EQUIPMENT

SUBJECT: Utility Management Plan
POLICY NUMBER: 4003

ISSUE DATE: 09/94
REVIEW DATE(S): 08/15
REVISION DATE(S): 02/97, 05/00, 05/03, 06/06, 05/09, 06/12, 06/15, 10/15, 01/17, 11/18

Department Approval:	**07/17, 11/18**
Environmental Health and Safety Committee Approval:	**08/17, 11/18**
Administration Approval:	**03/19**
Professional Affairs Committee Approval:	**11/17, n/a**
Board of Directors Approval:	**12/17**

A. **EXECUTIVE SUMMARY:**

1. The Environment of Care and the range of patient care services provided to the patients served by Tri-City Healthcare District (TCHD) present unique challenges. The specific utility system risks of the environment are identified by conducting and maintaining a proactive risk assessment. A Utility Systems Management Plan based on various risk criteria including risks identified by outside sources such as, The Joint Commission (TJC) is used to eliminate or reduce the probability of adverse patient outcomes.
2. The Utility Systems Management Plan describes the risk and daily management activities that TCHD has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people, coming to the organization's facilities. The management plan and the Utility Systems Management program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.
3. The program is applied to the TCHD and all outlying facilities operated and or owned by TCHD. The Utilities Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care and business occupancies of TCHD. The plan also affects all staff, volunteers, medical staff and associates including contracted services of TCHD.

B. **PRINCIPLES:**

1. Utility systems play a significant role in supporting complex medical equipment and in providing an appropriate environment for provision of patient care services.
2. Orientation, education, and training of operators, users, and maintainers of utility systems is an essential part of assuring safe effective care and treatment are rendered to persons receiving services.
3. Assessment of needs for continuing technical support of utility systems and design of appropriate calibration, inspection, maintenance, and repair services is an essential part of assuring that the systems are safe and reliable.

C. **OBJECTIVES:**

1. Design, operate and maintain utility systems serving the buildings that house the healthcare services of TCHD to provide a safe, comfortable, appropriate environment that supports patient care and business operations.

2. Perform recommended maintenance to maximize system service life and reliability.
3. Manage the Utility Systems Management program to assure compliance with The Joint Commission requirements.

D. **PROGRAM MANAGEMENT STRUCTURE:**

1. The Director of Engineering or Designee assures that an appropriate utility system maintenance program is implemented. The Director of Engineering or Designee also collaborates with the ~~Director~~ **Manager** of Safety/EOC to develop reports of Utility Systems Management performance for presentation to the Environmental Health and Safety Committee (EHSC) on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other utility systems issues.
2. The Hospital's Board of Directors receives an Annual Report of the activities of the Utility Systems Management program from the ~~Director~~ **Manager** of Safety/EOC unless other reports are requested. The Board of Directors reviews the Annual Report and, as appropriate, communicates concerns about identified issues back to the Director of Engineering and appropriate clinical staff. The Board of Directors collaborates with the Chief Executive Officer (CEO) and other senior managers to assure budget and staffing resources are available to support the Utility Systems Management program.
3. The Hospital's Chief Operating Officer (COO) or designee receives reports of the activities of the Utility Systems Management program as needed. The COO or designee collaborates with the Director of Engineering and other appropriate staff to address utility system issues and concerns. The COO or designee also collaborates with the Director of Engineering to develop a budget and operational objectives for the program.
4. The facility maintenance technicians and selected outside service company staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe reliable performance of utility systems in a timely manner. In addition, the technicians and service company staff perform necessary repairs.
5. Individual staff members are responsible for being familiar with the risks inherent in or present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

E. **PROCESSES OF THE UTILITY SYSTEMS PLAN:**

1. Plan for the Safe, Reliable, Effective Operation of Utility Systems
   a. The Utility Systems Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other individuals coming to the facilities of TCHD that may experience an adverse event while being monitored, diagnosed, or treated with any type of medical equipment or being housed in an environment supported by the utility systems of TCHD.
2. Design and Installation of Utility Systems
   a. The Director of Engineering or Designee works with qualified design professionals, project managers and the intended end users of the space of TCHD to plan, design, construct, and commission utility systems that meet codes and standards and the operational needs of the patient care and business activities of TCHD. The construction and commissioning procedures are designed to assure compliance with codes and standards and to meet the specific needs of the occupants of every space. In addition, the design process is intended to assure performance capability meets current needs and sufficient additional capacity is available to manage unusual demands and to help assure that future demands on utility systems can be met.
3. Determining System Risks and Developing and Inventory of Utility Systems and Equipment
   a. All utility systems components and equipment are included in a program of planned calibration, inspection, maintenance, and testing. The components and equipment are inventoried at the time of installation and acceptance testing. The inventory is maintained on an ongoing basis by the Plant Operations staff. The inventory includes

utility system equipment maintained by the Engineering and Maintenance staff and equipment maintained by vendors.

4. Maintenance Strategies
   a. The Director of Engineering or Designee evaluates all utility system equipment to determine the appropriate maintenance strategy for assuring safety and maximum useful life. The Director of Engineering or Designee uses manufacturer recommendations, applicable codes and standards, accreditation requirements, and local or reported field experience to determine the appropriate maintenance strategy for assuring safety and maximizing equipment availability and service life. The strategies may include fixed interval inspections, variable interval inspections, preemptive maintenance, predictive maintenance, and corrective maintenance.
5. Inspection, Testing, and Maintenance Intervals
   a. The Director of Engineering or Designee uses manufacturer recommendations, applicable codes and standards, accreditation requirements, and local or reported field experience to determine the appropriate maintenance intervals for assuring safety and maximizing equipment availability and service life.
   b. A maintenance management system is used to schedule and track timely completion of scheduled maintenance and service activities.
   c. The Director of Engineering or Designee is responsible for assuring that the rate of timely completion of scheduled maintenance and other service activities meets regulatory and accreditation requirements.
6. Management of Water Systems
   a. The Director of Engineering or Designee and Infection Control are responsible for identifying needs for procedures and controls to minimize the potential for the spread of infections through or by the utility systems.
   b. Each clinical care service and support service is evaluated to determine the potential for hospital-acquired illness. Each potential is further evaluated to determine what role physical barriers and utility systems can play in contributing to or minimizing the potential.
   c. The Director of Engineering or Designee and Infection Control are responsible for developing procedures and controls to manage any identified potential for growth and/or transmission of pathogenic organisms in the domestic hot water system, cooling tower water, and other potential sources of waterborne pathogens.
   d. The procedures may include periodic testing or treatment to control the risk and to inhibit the growth and spread of waterborne pathogens.
7. Management of Ventilation Systems
   a. The Director of Engineering or Designee and Infection Control are responsible for designing procedures and controls for monitoring the performance of air handling equipment. The procedures and controls address maintenance of air flow rates, air pressure differentials in critical areas, and managing the effectiveness of air filtration systems.
   b. Air handling and filtration equipment designed to control airborne contaminants including vapors, biological agents, dust, and fumes is monitored and maintained by Plant Operations.
   c. The performance of all new and altered air management systems is verified by a qualified service provider. At a minimum flow rates and pressure relationships are measured as part of the commissioning of all new building projects and major space renovations.
   d. Periodic measurements of air volume flow rates and pressure relationships are tested in sensitive areas throughout the hospital. When the measured system performance cannot be adjusted to meet code requirements or occupant needs, the Director of Engineering or Designee and Infection Control develop, when appropriate, a temporary Infection Control Risk Management plan to minimize the potential impact of the deficient performance.

8. Mapping of Utility Systems
   a. The Director of Engineering or Designee is responsible for maintaining up-to-date documentation of the distribution of all utility systems. The documents include as-built and record drawings, one line drawing's, valve charts, and similar documents. The documents include original construction documentation and documentation of renovations, alterations, additions, and modernizations. Hard copies of the documentation are maintained in the Plant Operations department. Documents that are available in electronic format are maintained on the Engineering Shared Drive.
9. Labeling of Controls for System Shutdown and Recovery
   a. The Director of Engineering or Designee is responsible for assuring that current documents showing the layout of utility systems and the locations of controls that must be activated to implement a partial or complete shut-down of each utility system are available at all times.
   b. The documents must include the original layout of the systems and all modifications, additions, and renovations that affect the process for implementing a partial or complete shutdown of a system. The documents must include information that can be used to identify specific controls. The controls must be identified by a label, numbered tag or other device that corresponds to the information on the documents.
10. Emergency Procedures
   a. The Director of Engineering or Designee and appropriate clinical caregivers collaborate to identify life-critical medical equipment supported by the utility systems. Life-critical equipment is defined as equipment, the failure or malfunction of which would cause immediate death or irreversible harm to the patient dependent on the function of the equipment.
   b. The Director of Engineering or Designee and the caregivers are responsible for developing appropriate resources to manage the response to the disruption of the function of the identified life-critical equipment. The resources are designed to minimize the probability of an adverse outcome of care.
   c. The resources must include but are not limited to information about the availability of spare or alternate equipment, procedures for communication with staff responsible for repair of the equipment, and specific emergency clinical procedures and the conditions under which they are to be implemented.
   d. Copies of applicable emergency procedures are included in the emergency operations manual of each clinical department. Training addressing the medical equipment emergency procedures is included in the department or job related orientation process. All utility systems emergency procedures are reviewed annually.
11. Inspection, Testing, and Maintenance of Emergency Power Systems
   a. The Director of Engineering or Designee is responsible for identifying all emergency power sources and for developing procedures and controls for inspection, maintenance, and testing to assure maximum service life and reliability. TCHD uses battery-powered lights, engine driven generators, and large UPS stored energy systems to provide power for emergency lighting, operation of critical systems, and operation of information systems equipment.
   b. Each required battery powered emergency lighting device is tested for 30 seconds each month and for 90 minutes annually.
   c. The Emergency Power Supply Systems (EPSS) supply power for emergency exits, patient ventilation, fire and life safety equipment, public safety, communications, data and processes that if disrupted would have serious life safety or health consequences. Each required EPSS system is tested in accordance with the code requirements for the class of device.
   d. The Director of Engineering or Designee is responsible for assuring that appropriate inspection, maintenance, and testing of the essential electrical system is done. Each motor/generator set serving the emergency power system is tested under connected load conditions 12 times a year. All automatic transfer switches are tested as part of

each scheduled generator load test.

e. Testing parameters are recorded and evaluated by the Plant Operations staff. All deficiencies are rectified immediately or a temporary secondary source of essential electrical service is put in place to serve the needs to critical departments or services until the primary system can be restored to full service.

f. If a failure during a planned test occurs, a full retest will be performed after appropriate repairs are made and essential electrical system is functional again.

g. Each diesel engine powered motor/generator not loaded to 30% or more of its nameplate capacity during connected load tests undergoes further evaluation to determine if the exhaust gas temperature reaches or exceeds the manufacturer's recommended temperature to prevent wet stacking. Each diesel engine failing to meet the temperature recommendation will be exercised annually by connecting it to a dynamic load bank and performing the three step test process specified by NFPA 99 and NFPA 110.

h. Batteries, fuel stored on site, controls, and other auxiliary emergency power equipment is inspected, maintained, and tested as required. The Director of Engineering or Designee Engineering staff and contracted service providers are responsible for assuring the reliability of each component part of the emergency power systems by performing all required calibration, inspection, maintenance, and testing in a timely manner.

12. Utility Systems Inventory and Initial Testing

a. The Director of Engineering or Designee establishes and maintains a current, accurate, and separate inventory of all utility systems equipment included in a program of planned inspection or maintenance. The inventory includes equipment owned by TCHD and leased or rented equipment.

b. The Director of Engineering or Designee is responsible for implementation of the program of planned inspection and maintenance. All utility systems equipment is tested for performance and safety prior to use.

13. Testing of Life Support Equipment

a. The Director of Engineering or Designee assures that scheduled testing of all utility systems that play a role in life support is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Director of Engineering or Designee will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

14. Testing of Infection Control Support Equipment

a. The Director of Engineering or Designee assures that scheduled testing of utility systems equipment that supports critical infection control processes is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Director of Engineering or Designee will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

15. Testing of Non-Life Support Equipment

a. The Director of Engineering or Designee assures that scheduled testing of all non-life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Facilities will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

16. Medical Gas System Testing

a. All medical gas systems are maintained and periodically tested to assure system performance. All testing and inspection is done in accordance with the requirements of the current edition of NFPA 99.

17. Modifying / Repairing Medical Gas Systems

a. When a new medical gas system is installed or an existing system is breached for any reason, the Director of Engineering or Designee coordinates certification of the system by a qualified service provider. The certification testing is done in accordance with the requirements of the current edition of NFPA 99. The Director of Engineering or Designee maintains a permanent record of all certification testing.

18. Labeling & Accessibility of Medical Gas Controls
    a. The Director of Engineering or Designee is responsible for assuring that all medical gas system control valves and monitoring stations are identified appropriately.
    b. In addition, the Director of Engineering or Designee is responsible for assuring that each monitoring station and valve is accessible. Accessibility is evaluated during scheduled tours.

F. **AFFECTED PERSONNEL/AREAS:**

1. Governing Board; Medical Staff; All Hospital Employees; Volunteers; Vendors; Contract Services and Staff.

G. **REFERENCE(S):**

1. The Joint Commission (2017). *Hospital Accreditation Standards*. Illinois: Joint Commission Resources.

Tri-City Medical Center
Oceanside, California

Environment of Care Manual
Life Safety Management

SUBJECT: ~~Fire Plan~~—Code Red Policy

ISSUE DATE:	**11/87**	**POLICY NUMBER: 3005**
REVIEW DATE(S):	**11/90, 11/93, 11/97, 4/06, 6/12, 8/15**	
REVISION DATE(S):	**11/94, 3/00, 4/03, 10/11, 4/13, 10/15, 11/18**	

Department Approval Date(s):	**08/15, 11/18**
Environmental Health and Safety Committee Approval Dates(s):	**09/15, 11/18**
Medical Executive Committee Approval Dates(s):	**n/a**
Administration Approval:	**03/19**
Professional Affairs Committee Approval Date(s):	**10/15, n/a**
Board of Directors Approval Date(s):	**10/15**

A. **PURPOSE:**

1. Tri-City Healthcare District's Code Red Policy will insure the protection of patients, employees, visitors and property from fire, smoke and other products of combustion.

B. **POLICY:**

1. All employees will be familiar with Tri-City Healthcare District's Fire Policy, and when applicable, the Department Specific Fire Policy for the area in which they work. All staff must know what to do in case of a fire, how to initiate an alarm, the location of the fire extinguishers and alarm pull stations in his or her department, and the operation of the fire extinguishers.
   a. Employees must be familiar with the acronym RACE:
      i. R: Rescue - remove anyone from immediate danger, closing fire and room doors and calling out for assistance.
      ii. A: Alarm - activate the nearest fire alarm (pull station) and call PBX operators by dialing "66" and notify them of the "Code Red" fire. All off campus locations dial "911".
      iii. C: Contain - close all remaining doors.
      iv. E: Extinguish - extinguish the fire if it can be done without endangering yourself or others.
   b. Supervisors are responsible for showing new employees the location of extinguishers and alarm pull stations during department orientation. . Remember the acronym **PASS** for extinguisher use:
      i. P: PULL the pin
      ii. A: AIM the nozzle at the base of the fire
      iii. S: SQUEEZE the handle
      iv. S: SWEEP back and forth across the base of the fire

C. **PROCEDURE:**

1. When a Fire Alarm Sounds:
   a. The hospital operator will announce on the overhead page system "Code Red" and give location of the fire. Do Not call the operator to obtain information about the fire.
   b. If you are away from your assigned area when the alarm sounds, stay where you are and wait for further instructions from the overhead page system.
   c. The hospital's Fire Response team will consist of designated personnel in Facilities Services, Environmental Services and Security Services. Upon hearing the alarm, these staff members are to stop their work and go immediately to the area indicated by the overhead page system.

d. The Senior Engineer will take immediate charge of the Fire Response Team. In his or her absence, the Engineer on duty will take command. This team is subject to the direction of the Administrator and/or City Fire Captain upon his or her arrival.
e. Patients are not to be evacuated from floors without the order of the Incident Commander or designee. If it is apparent to the Department Director/or designee that evacuation is absolutely necessary for patient safety, and if it is not possible to obtain the authoritative order, he or she may elect to evacuate patients.
f. Engineering will clear the fire alarm after the fire is secured.
g. Clinical personnel on other units should remain at their stations. All other personnel should remain in their work areas unless their assistance is requested.
h. The Hospital PBX Operator will announce on the overhead page system "Code Red All Clear" when fire is secure.

2. Code Red in Your Area:
   a. Avoid Panic: The greatest danger in most fires is panic. Do not alarm patients by excited motions. Never shout "Fire!" Patients look to you for protection. Appear calm and move with assurance.
   b. Remove patients and other persons from immediate danger.
   c. Go to the nearest fire alarm pull station and pull the handle to activate the alarm.
   d. Dial "66" to report "Code Red." Give location, size, extent of fire, and material burning, if known. Facilities off campus dial "911".
   e. Extinguish fire if possible - if it is safe, use a fire extinguisher to attempt to bring fire under control. If fire is out of control, close doors to room/area and shut off oxygen if possible. Move patients to the other side of the fire door away from the fire. Allow no one except the fire department to enter.
   f. Check for smoke and flames in other rooms then close all doors.
   g. Stand by to assist as needed.
3. Fire in Patient's Room:
   a. Patient's bed in flames: Remove the patient from bed to a safe place such as another bed, chair or hallway. Depress the nurse call button in the bathroom for immediate assistance. Do not take a smoldering bed out of the room.
   b. Close the patient's room door once the patient is out.
   c. Activate the fire alarm pull station nearest to the fire.
   d. Call PBX Operator, dial "66". Give exact location of the fire, including the room number.
4. Area Not Evacuated Under Fire Conditions:
   a. Provide maximum protection:
      i. Instruct people to stay in their rooms with the door closed.
      ii. Reassure patients of their safety.
      iii. Place a wet blanket or linens at the base of the doors of all occupied room to prevent smoke from entering room.
   b. If safe to do so one employee must remain in the corridor to assist fire department upon their arrival.
5. Evacuation: Always use stairs, never the elevator, during a fire.
   a. If evacuation is ordered for an area, the following are methods to be used:
      i. Blanket Carry
      ii. Two Person Carry
   b. Once a room has been evacuated, it should be marked "empty" by placing a pillow in front of the door. Only firefighters may enter the room after that.
   c. Remove Medical Records if possible.
   d. Evacuation plans are posted throughout the facility. They include evacuation routes and the location of alarms and firefighting equipment.
6. Be Alert For Fire Hazards:
   a. Never prop open fire doors.
   b. Hallways must be kept clear at all times.
   c. Never place flammable liquids or oxygen near an ignition source.

d. Do not use unapproved appliances - appliances brought from outside source must be cleared by Facilities Management.
e. Good housekeeping is the best guarantee against fire. Do all you can to maintain order and cleanliness in the interest of fire protection. Make it a habit to watch for fire hazards.
f. Do not allow stored items to obstruct sprinkler heads. (18" minimum clearance)
g. If you see or smell smoke, report it immediately for investigation. Early detection means prompt extinguishing of fire.

7. Duties of Personnel
   a. Be completely familiar with the Fire Safety Program and your responsibilities
   b. Participate in all fire drills and practice sessions as required.
   c. ~~Attend all fire training classes when assigned.~~
   d. Learn the fire alarm code and how to report a fire - Dial "66". All off campus locations dial "911".
   e. Learn the locations of and how to operate the fire alarm pull stations and fire extinguishers.
   f. Be acquainted with panic control and evacuation procedures.
   g. Observe the "No Smoking" rules.
   h. Never store flammable liquids in your desk or cabinet.
   i. Report any defective wiring - such as frayed cords, loose or broken plugs, blown fuses, etc.
   j. Properly dispose of waste or rags used with cleaning solvents.
   k. Do not use portable heating units. These units, particularly portable types are not permitted anywhere on the hospital premises unless approved by Engineering, No portable heaters are allowed in patient care areas.
   l. California Department of Corrections Rehabilitation Unit (CDCR) – 3 North South.
      i. If necessary, fire response will be coordinated via CDCR staff for custody patients evacuation.
   ~~m. Special Needs Unit – Behavioral Health Unit (BHU) due to special needs population (Psychiatric patients) emergency exit doors are locked for patient safety. BHU Department policy requires staff to have unit access keys with them at all times for emergency evacuation. In addition, when the BHU unit goes into a Code Red situation all electronic locks automatically "unlock" as part of the fire systems and staff are instructed to control BHU patient movement during emergent evacuation. All patient and staff will evacuate through the large yard area on the North East corner of the unit. In addition, if further evacuation is necessary they will continue with controlled evacuation of patients via exit gate towards pulmonary rehab gym parking area.~~
   ~~n.~~**m.** Switchboard personnel:
      i. If the fire is in the area of the PBX office you would follow the steps outlined in the general instructions section.
      ii. If the fire is not threatening the PBX office you would initiate the steps below:
         1) Upon receipt of a call notifying PBX of a Code Red/Fire, or when the fire alarm is activated, you will immediately:
            a) Notify the Fire Department, giving the address and location of the fire in the hospital.
            b) Notify all personnel through the use of the public address system. Use the following code:
               i) "Attention, Please – CODE RED and specific location." Repeat the page three (3) times.
         2) Prepare the Switchboard for emergency operations only, restricting calls.
         3) Notify:
            a) ~~Director~~ **Manager** of Safety/EOC

b) Administrator On-call
c) Administrative Supervisor on duty
d) Security ~~Manager~~ **Supervisor** or Lead
e) Director of Engineering
f) Emergency Department Charge Nurse
g) Other key personnel, as needed

4) Carry out administrative orders as directed.
5) If PBX system is inoperative, use the RED phones system or cell phones.

~~e.~~n. Practitioners, Allied Health Professionals, Volunteers & Non Staff Personnel:

i. Tri-City Healthcare District believes strongly in the principle of life safety. The organization recognizes as a practical matter that members of the medical staff/Allied Health Professionals and many volunteers and students are not present much of the time and are not likely to be a reliable resource during a fire response. Therefore, the medical staff, volunteers, and students do not have a specific defined role in the fire response plan. They are instructed to remain in the area they are located at the time an alarm sounds and to render assistance under the direction of the manager or employees of the area as needs arise.

Tri-City Medical Center
Oceanside, California

Environment of Care Manual
Hazardous Material Management

SUBJECT: Hazardous Material and Waste Management and Communication Plan

ISSUE DATE: 11/87 **POLICY NUMBER: 6000**
REVIEW DATE(S):
REVISION DATE(S): 09/94, 07/97, 09/00, 04/03, 12/10, 05/15

Department Approval:	**06/16, 11/18**
Environmental Health and Safety Committee Approval:	**09/16, 11/18**
Administration Approval:	**03/19**
Professional Affairs Committee Approval:	**01/17, n/a**
Board of Directors Approval:	**01/17**

A. **DEFINITIONS OF HAZARDOUS MATERIALS:**

1. Those materials that by their nature are a potential threat to the health and safety of persons coming into contact with them.
   a. Corrosives - having a pH less than or equal to 2 or greater than or equal to 12.5 and liquids that corrode steel at a rate of greater than .25 inch per year.
   b. Toxics (EP Toxicity) - a waste whose constitutes have a tendency to leach or migrate when disposed of in an improperly designed landfill; able to cause illness, death or restrict awareness enough to present a danger.
   c. Flammable liquids (ignitable) - flammable gases, oxidizers, liquids with a flash point of less than 140F, and solids that ignite spontaneously through absorption of moisture or friction.
   d. Reactive (Explosives) - substances that are unstable and readily undergo violent change, react violently with water, form potentially explosive mixtures with water, capable of detonation when exposed to a strong initiating source, generate significant quantities of toxic gas when exposed to water or in the case of cyanide or sulfide bearing waste, pH conditions between 2 and 12.5.
   e. Pharmaceutical waste and Expired Medications - Expired or unusable parenteral/oral liquids; dextrose/saline I.V. admixtures/solutions containing: antibiotics, multivitamins, dopamine, dobutamine, electrolytes epinephrine, epi-cal, heparin, insulin, lidocaine, lorazepam, magnesium sulfate, meperidine, midazolam, morphine, nitroglycerin, norepinephrine, oxytocin, theophylline, TPN; Maalox, Mylanta, alcohol containing liquids with less than 24% alcohol. Expired Unusable Pharmaceuticals: Intact expired or unusable medications.

B. **PURPOSE**

1. The purpose of the management plan is to define how hazardous materials and waste are identified, labeled, handled, whose responsibility they are, how training and communication is managed, and how monitoring occurs.

C. **POLICY**

1. Tri-City Healthcare District is committed to providing a safe and healthy environment for all employees, medical staff, patients and visitors by establishing ongoing mechanisms for controlling and monitoring the use of hazardous materials and waste in compliance with State and Federal regulations.
2. Right to Know Law

a. Employees and contractors are to be provided with information about the known and suspected health hazards that may result from working with Hazardous and Infectious Materials. While performing duties at Tri-City Healthcare District facilities, employees and contractors shall be informed so they can make a more knowledgeable and reasoned decision with respect to any associated personal health hazards.

b. General Orientation: New employees will be informed of "Right to Know Law" during the Safety portion of Employee Orientation.
   i. Employees have the right to refuse to work with a hazardous substance if they have not been provided with Safety Data Sheet information.
   ii. Employees, former employees, or applicants may not be terminated or discriminated against in any way for exercising any rights they are given under the law.

c. Instructional signs informing employees of their rights under the law are posted. Department Specific Orientation: At the time of initial assignment, all employees will receive training on any chemical which is known to be present in the workplace in such a manner that employees may be exposed under normal conditions of use or in a foreseeable emergency. If an employee is not ordinarily in a position to be exposed to hazardous chemicals, he or she need not be trained.

d. Contracting for Outside Services:
   i. Departments that obtain outside services through contracts or service agreements will insure that the contractor has been informed of all hazardous materials to which their employees may be exposed. The department will insure that the contracted employee has completed the Non-Tri-Healthcare District Employee Orientation Program.

D. **GUIDELINES:**

1. Method of Identification of Hazardous Material:
   a. Material is identified as hazardous by evaluation produced by Manufacturer, information disseminated from a reliable source, or by professional knowledge and experience.
   b. Directors of Engineering, Surgery, Nutrition, Laboratory, Pharmacy, and EVS, will submit a list of substances determined to be hazardous by this policy to the Safety Officer. This list will be updated as new products determined to be hazardous are introduced to the department.
   c. Labels are required on all hazardous substances to identify the hazardous material(s) contained therein and to provide warning about the type of hazard and the type of precautions required. This includes all containers with toxic substances in a concentration greater than or equal to 1% of the total composition, or 0.1% if carcinogens; unless specifically exempted.
2. Safety Data Sheets (SDS)-3 E Company Fax on Demand:
   a. Request an SDS when assistance is needed with medical emergencies, chemical spills, and employee
      i. Emergency Request – Immediate to 15 minutes: Poisoning, chemical exposure, chemical spill, human or environmental contamination, fire.
      ii. Immediate to 30 minutes: Regulatory Agency Request (OSHA, EPA, The Joint Commission).
      iii. Immediate to 3 hours: Employee request (non-emergency)
      iv. Standard Request – Immediate to 24 hours: Customer Request, Contractor Request.
      v. Mail Request – Rush: mailed within 24 hours – Standard: mailed within 3 business days: Request of 10 or more Safety Data Sheets.
   b. To initiate SDS request follow the following procedure:
      i. Call Toll Free: 1-800-451-8346 or 760-602-8703, to request up to nine SDS.

ii. Fax request to (760-602-8888 for orders and numbers on SDS of SDS sheets
iii. DO NOT FAX EMERGENCY SDS REQUESTS – CALL IMMEDIATELY

c. To request a SDS complete the attached request form then call, fax or mail to 3 E Company. Provide as much of the following information as possible:
   i. Product name.
   ii. Manufacturer name.
   iii. Product number.
   iv. UPC Code (if available).
   v. Be specific when request is for a product. Separate SDS are maintained for products that have even very minor differences from others (e.g. colors, aerosol vs. pourable, concentrated vs. ready – to use).

3. Employee Training:
   a. Department directors are responsible for providing training to employees on hazardous materials in their work area at the time of their initial assignment/ or reassignment and when a new hazard is introduced into their work area. All employees must complete the Annual Computer Based Learning (CBL's) modules which include a section on Hazardous Materials/Global Harmonization/Right-to-know training. The CBL instructions include the following items:
      i. Employee rights under the law.
      ii. Explanation of the (SDS)
      iii. Explanation of the labeling system and pictograms
      iv. Explanation of methods used to identify hazards and how to detect the presence of toxic substances in the work place, and routes of entry into the body.
      v. Safety and control devices to include personal protection.
      vi. Location of hazardous substance list.
      vii. Emergency procedures for spill control.
      viii. Review of blood-borne diseases and potential for transmission.
      ix. Types of protective equipment and proper use.
      x. Situations requiring use of protective equipment.
      xi. Review of concept of standard precautions as it applies to the employees specific work practices.
      xii. Review of methods to determine and designate infectious waste and linen along with instructions for proper disposal.
      xiii. Training in proper handling of needles and sharps along with proper disposal
      xiv. Training in completion of Employee Health Injury Report to indicate exposure to potential infectious agents.
      xv. Department Directors will ensure that all employees annually complete the Computer Based Learning module on Hazardous Materials. .

4. Hazardous Chemical Waste & Infectious Medical Waste Disposal
   a. General Disposal Guidelines:
      i. Disposal methods must comply with all federal, state and local regulations. Flammable materials are not to be disposed of into the drainage system.
      ii. Wear appropriate protective equipment (i.e. gloves, safety glasses, lab coat and respirator where applicable).
      iii. Date must be filled in on the substance's hazardous material storage label upon final use or disposal. All Chemical Waste will placed into the Chemical Waste Storage Shed for final disposal.
      iv. All empty discarded containers will be disposed of according to the manufacturer instructions and/or in accordance with Federal, State and local regulations.
      v. Tri-City Healthcare District is contracted with an outside company for the disposal of hazardous materials and waste in accordance with local, State and Federal regulations.

vi. Medical Infectious Waste will be placed into the RED Bio-Hazardous Container or Sharp Container and collected by the EVS Department and placed into the Bio-Hazardous Waste Storage shed until collected by the Waste Disposal Vendor final disposal (See Infection Control Manual).
vii. Waste Pharmaceuticals – Refer to AP&P # 276 Handling of Pharmaceutical Waste, Expired Medications & Expired IV Solutions.

b. Monitoring:
i. Waste Gas Levels (Surgical Suites):
ii. Waste gas levels in surgical areas are to be tested at least annually.
iii. Testing is to be conducted by an independent testing company contracted by Tri-City Healthcare District.
iv. Results of such testing are to be kept on file by the respective departments.
v. Results of the annual testing should be posted along with the maximum permitted levels of the gases tested for employee review.
vi. In the event levels exceed permitted levels, the Engineering Department and the Environment of Care/Safety Officer shall be notified in order that corrective measures can be taken.

c. Airflow Testing:
i. Airflow and air changing systems will be monitored and tested by the Engineering Department on an as needed basis. All new equipment is to be certified at the time of installation.
ii. Areas using or storing hazardous materials must have adequate ventilation in order to comply with room air change and flow standards as governed by the California Building Codes.
iii. Fume hoods should be utilized when using volatile or gaseous-forming hazardous materials to insure that gas levels remain at safe levels and do not affect air quality, fume hoods should remain running at all times.

d. Radiation
i. All monitoring of radiation levels will be conducted according to departmental policies per State regulations by the Radiation Safety Officer.

e. Formaldehyde Testing
i. Air monitoring for formaldehyde will be conducted annually. Methods will be in accordance with OSHA regulations and will be of two (2) types: 1) Personal and 2) Area.
ii. Engineering controls will be utilized to reduce airborne concentrations whenever feasible.
iii. Employees working with solutions of 1% or more formaldehyde will utilize protective equipment as follows:
1) Safety Glasses.
2) Gloves.
3) Disposable chemical resistant Lab coats.

f. Work Test Area:
i. Work areas suspected of containing airborne hazardous materials will be evaluated and tested immediately by Engineering Department and or the Environment of Care/Safety Officer.
ii. Levels exceeding permitted safe limits will be reported to the Safety Officer.
iii. A consultation with Administration, EOC/Safety Officer and the Director of the department involved will be made to determine whether or not work can continue in the affected area or to determine steps to be taken to insure employee safety.

g. Employee Monitoring and Medical Testing:
i. Appropriate medical testing will be conducted to determine the effects of the exposure and in order that an effective diagnosis and proper treatment can

be conducted.

ii. Testing will be done under the supervision of a licensed qualified physician.

h. Storage and Transportation:

i. A Flammable Storage Cabinet will be provided for flammable materials in order to prevent the spreading of fire. Further, flammable liquids will be stored away from flammable gases. Thus, in the event of fire the possibility of explosion is reduced and containment is readily achieved.

ii. All openings will be controlled with approved self-closing fire doors.

iii. Every inside storeroom will have a mechanical exhaust system that provides at least six complete air changes per hour. The Hazardous Material Storage Building has a switch that controls the ventilation system as well as the lights.

iv. Cylinders will be stored at least 20 feet from flammable and combustible liquids and other ignitable.

v. Cylinders will be stored separately (rooms) from flammable material

vi. Hazardous wastes/materials will not be stored with nonhazardous waste in order to prevent accidental contamination.

vii. Incompatible materials will be stored away from each other.

viii. Materials will be transported in approved safety containers or in their original shipping packages.

ix. No hazardous material will be transported to and stored in areas other than work or storage areas.

x. Materials will be transported in amounts comparable to regulated daily or weekly limits.

xi. Materials will not be transported and then stored in unapproved areas or in an unsafe manner.

xii. All materials packaged and shipped for outside disposal must comply with Department of Transportation (DOT) regulations.

xiii. Daily limits will be stored in approved safety cabinets.

i. Emergency Response Procedures:

i. Various hazardous chemicals are used throughout the hospital which could pose a threat of danger if a moderate or major spill should occur. The following procedure is outlined in the event that such a chemical spill occurs within the hospital environment. All personnel will be familiar with the proper procedure for handling these events to minimize the risk towards patients, visitors and staff members.

1) Areas of concern:

a) Laboratory - Large variety of chemicals.
b) Pharmacy - Large variety of chemicals.
c) Materials Management - Cleaning supplies and hospital chemical supplies.
d) Environmental Services - Cleaning supplies and solvents.
e) Radiology Radioactive material.
f) Food and Nutrition - Degreasers and cleaning supplies.
g) Respiratory –Disinfectants.
h) Facilities Management - Large variety of chemicals.
i) Sterile Processing Department – Disinfectants.
j) Surgical Services – Tissue Fixative.

j. Chemical Spills:

i. Immediately alert personnel in area.

ii. Dial "66" and tell PBX Operator that there is a chemical spill and the location.

iii. The PBX Operator will alert: The Environment of Care/Safety Officer, Manager of Environmental Services or Lead EVS, Manager of Security or Lead Officer, and Engineering.

iv. Evacuate and seal off areas from a safe distance; if flammable are involved,

eliminate ignition source if possible. Allow no one to enter area until Environmental Services, Security, and the Environment of Care/Safety Officer has been notified and arrives on scene.

v. Contact 3 E Company 1-800-451-8346 for Safety Data Sheet (SDS) information on how to handle the spill and what type of Personal Protective Equipment is needed. 3 E Company will fax the information within minutes to the closest fax machine number provided. Employees will need to know the name of the chemical to tell the 3 E Company operator.

vi. If at this time an evacuation is necessary the Hospital Evacuation Procedure will be implemented. The Environment of Care/Safety Officer will consult with Management and area personnel as to proper containment, identification, and disposal procedure as prescribed by the EPA or other written instructions that provide measures that are approved by law or ordinance.

vii. Notification of the fire department will depend on the type of the spill and the potential danger involved.

viii. If a minor spill of flammable, corrosives, toxics or reactive occurs and there is no immediate danger to employee(s) then:

1) Properly trained employees may clean-up the spill using approved spill kits/supplies/equipment that meet or exceed the PPE requirements listed on the SDS notice.
2) Contact Environmental Services (EVS) who will contain the spill, and clean the chemical up per SDS guidelines.
3) All collected chemicals must be handles per hazardous waste requirements and placed in an appropriate container, then labeled with the chemical name and other hazardous waste properties.
4) Contact the Environment of Care/Safety Officer with any questions.

k. Treatment of Contaminated Area:

i. Wash area immediately.

ii. Clothing contamination: Take item of clothing off immediately to prevent soaking through and contaminating skin. This includes all clothing affected.

iii. First Aid:

1) If skin/eye/mouth area(s) have been contaminated, flush affected area with large amounts of water for at least 15 minutes.
2) Do not try to neutralize.
   a) Go to the Emergency Department immediately after flushing affected area.

E. GOALS/OBJECTIVE FOR FY~~17~~19

1. Provide ~~face-to-face~~ training to all applicable Pharmacy ~~and~~, Engineering **and Lab** employees on how to properly respond to a chemical spill. Measurement will be number of applicable employees/number of employees receiving the spill management training. Goal is 100% of applicable employees.
2. ~~Complete the conversion over to Stericycle as the hazardous waste management provider and complete an assessment of new options related to disposable of controlled substances.~~
3. **Update and complete department specific hazardous material lists for all TCHD areas.**
~~2.~~ **Incorporate a First Responders hazardous material spill team to respond to larger than normal type spills within the hospital.**

F. REFERENCES

1. AP&P # 276 Handling of Pharmaceutical Waste, Expired Medications & Expired IV Solutions

Tri-City Medical Center
Oceanside, California

Environment of Care Manual
Life Safety Management

SUBJECT: **Life Safety Management Plan**

ISSUE DATE: **11/87**
REVISION DATE(S): **03/00, 04/06, 04/09, 04/13, 05/12, 06/15, 01/17, 11/18**

Department Approval:	**07/17, 11/18**
Environmental Health and Safety Committee Approval:	**08/17, 11/18**
Administration Approval:	**03/19**
Professional Affairs Committee Approval:	**11/17, n/a**
Board of Directors Approval:	**12/17**

A. **EXECUTIVE SUMMARY:**

1. Each environment of care and the physical condition of occupants poses unique fire safety risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Life Safety Management Program is designed to identify and manage the risks of the environments of care operated and owned by Tri-City Healthcare District (TCHD). The specific fire safety risks of each environment are identified by conducting and maintaining a proactive risk assessment. A fire safety program based on applicable laws, regulations, codes, standards, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by TCHD.
2. The Management Plan for Life Safety describes the risk and daily management activities that TCHD has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people, coming to the organization's facilities. The management plan and the Life Safety Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.
3. The program is applied to the Medical Center and all offsite clinics and care facilities of TCHD. The Life Safety Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care and business occupancies of TCHD.

B. **PRINCIPLES:**

1. All buildings of TCHD housing patient care services must be designed, operated, and maintained to comply with the 2012 edition of the National Fire Protection Association (NFPA) Life Safety Code, and the 2012 Edition of the NFPA Health Care Facilities Code.
2. All fire alarm, detection, and extinguishing systems and equipment must be maintained to comply with applicable codes and standards.
3. All staff must be educated and trained to respond effectively to fire, smoke, or other products of combustion to minimize the potential of loss of life or property in the event of a fire.
4. Appropriate temporary administrative and engineering controls must be designed, implemented, and maintained whenever existing deficiencies or conditions created by construction activities significantly reduce the level of life safety in any area where patients are cared for or treated.

C. **OBJECTIVES:**

1. Design and construct all spaces intended for housing patient care and treatment services to meet

national, state, and local building and fire codes.

2. Conduct required fire drills in all buildings of TCHD housing patient care services.
3. Calibrate, inspect, maintain, and test fire alarm, detection, and suppression systems in accordance with codes and regulations.
4. Inspect and maintain all buildings housing patient care services to assure compliance with the applicable requirements of the 2012 edition of the NFPA Life Safety Code and the 2012 Edition of NFPA Health Care Facilities Code.
5. Train all staff, volunteers, and members of the medical staff to respond effectively to fires.

D. **PROGRAM MANAGEMENT STRUCTURE:**

1. The Director of Engineering or Designee assures that an appropriate maintenance program is implemented. The Director of Engineering or Designee also collaborates with the Safety Officer to develop reports of Life Safety Management performance for presentation to the Environmental Health and Safety Committee on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other fire safety issues.
2. The facilities management technicians and selected outside service company staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe reliable performance of fire safety equipment in a timely manner. In addition, the technicians and service company staff perform necessary repairs.
3. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.
4. The Board of Directors of TCHD receives regular reports of the activities of the Life Safety Management program from the Environmental Health and Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Director of Engineering or Designee and appropriate clinical staff. The Board collaborates with the Chief Executive Officer (CEO) and other senior managers to assure budget and staffing resources are available to support the Life Safety Management program.
5. The CEO or designee of TCHD receives regular reports of the activities of the Life Safety Management program. The CEO or designee collaborates with the Director of Engineering or Designee and other appropriate staff to address fire safety issues and concerns.

E. **ELEMENTS OF THE LIFE SAFETY MANAGEMENT PLAN:**

1. Life Safety Management Plan (FS.EC.01.01.01 EP6)
   a. The Life Safety Management Program is described in this management plan. The Life Safety Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of TCHD experience an adverse outcome in the event of a fire.
2. Processes for Protecting Building Occupants and Property (FS.EC.02.02.01 EP1)
   a. The Director of Engineering or Designee and Safety Officer are responsible for coordinating the development of design, operations, maintenance, and training processes to minimize the potential for fires and of adverse consequences related to the presence of fire, smoke, or other products of combustion.
   b. Design
      i. The Director of Engineer or Designee and other project managers collaborate with qualified design professionals, code enforcement, and facility licensing agencies to assure that buildings and spaces are designed to comply with local, state, and national building and fire codes. American Institute of Architects (AIA) guidelines are also considered in the design process for compliance with the International Building Codes with California amendments. The Director of Engineer or Designee assures that all required permits and inspections are obtained or completed prior to occupancy. The Director of Engineer or Designee permanently

maintains all plans, inspection reports, and other documents related to the design and construction of any building or space housing patient care or treatment services of TCHD.

c. Management
   i. The Director of Engineer or Designee oversees the design, implementation, and documentation of processes designed to assure optimal performance and continual compliance with code requirements of fire alarm, detection, and suppression systems. Similar programs are in place for maintenance of building elements operating conditions that play a role in the fire safety level of the environment.
   ii. The Director of Engineer or Designee is responsible for assuring that all renovation and new construction within existing buildings is done in a manner that preserves compliance with codes and standards.

d. Fire Response Process
   i. The Safety Officer is responsible for the design and management of a fire response plan that meets the unique needs of the occupants of each department or service of TCHD. The current fire response plan is based on the remove from immediate danger, activate alarms, confine fire, extinguish or evacuate area "RACE" principle. Area specific response and evacuation plans that include training and equipment required to manage unique risks identified in areas are in place. The plans are evaluated annually as part of the overall program review.
   ii. The emergency number "66" is to be dialed to report a fire.
   iii. The unattached buildings located on the Medical Center campus will dial "66" to report a fire.
   iv. All buildings off the main Medical Center campus will dial "911" for assistance in case of a fire.

3. The hospital prohibits smoking on all facility grounds (FS.EC.02.03.01 EP2 & EC.02.01.03 EP1)
   a. TCHD has implemented a Smoke- Free Environment policy. The policy prohibits smoking of all kinds (ie: cigarettes, cigars, pipe, chewing tobacco, e-cigarettes, and all vapor producing devices) in any hospital building or campus grounds by all, including staff, visitors and patients.
   b. TCHD has identified alternatives to tobacco products that are offered to all. TCHD has developed tobacco replacement resources to assist staff and patients with smoking cessation as desired.
   c. The procedures for managing the use of tobacco replacement materials are followed and enforced by all managers and staff.
4. The hospital maintains free and unobstructed access to all exits (FS.EC.02.03.01 EP4)
   a. Leaders in all areas of the hospital are responsible for assuring that equipment, furniture, and supplies are not stored in corridors. The condition of corridors is evaluated during each environmental rounds activity. All violations are reported to the Director and/or Manager of the area where the deficiency was identified, the Safety Officer, and the Environmental Health and Safety Committee.
5. The hospital has a written fire response plan (FS.EC.02.03.01 EP9-10)
   a. The Safety Officer is responsible for coordinating the implementation of the fire response plan. All staff is oriented to the RACE response model and effective use of portable fire extinguishers. In addition, all staff are oriented to the department or service specific plans that account for the unique challenges posed by the condition of occupants and the design of space in which they work.
   b. The department and area specific fire response plans include information about:
      i. The roles of all employees, medical staff, volunteers, contract staff and students near the point of fire origin.
      ii. The roles of all employees, medical staff, volunteers, contract staff and students away from the point of fire origin.
         1) Note: TCHD believes strongly in the principle of life safety. The

organization recognizes as a practical matter that members of the medical staff and many volunteers and students are not present much of the time and are not likely to be a reliable resource during a fire response. Therefore, the medical staff, volunteers, and students do not have a specific defined role in the fire response plan. They are instructed to remain in the area they are located at the time an alarm sounds and to render assistance under the direction of the manager or employees of the area as needs arise.

iii. Operation of the fire alarm system.

iv. Exit routes and use of equipment used to relocate or evacuate patients, visitors, and staff.

6. Fire Drills (FS.EC.02.03.03 EP1 – 5)
   a. Regular fire drills are conducted to reinforce training and education. At least 50% of the drills are unannounced. The frequency of drills is based on regulations and accreditation requirements. All healthcare, ambulatory healthcare and overnight sleeping areas are drilled at least once per shift per quarter.
   b. If conditions evaluated as part of the Interim Life Safety Measures (ILSM) indicate a need for additional drills to enhance staff awareness of degraded life safety protection in various areas, there is documentation that the additional drills are performed. All freestanding business occupancies are drilled at least once per shift per year.
   c. All fire drills are evaluated to determine if individual areas respond appropriately. An aggregate evaluation of fire drills is done at least twice a year. The aggregate analysis looks for patterns or trends of deficiencies. When deficiencies are identified, there is documentation that the deficiencies are corrected.
7. Inspection, Testing, and Maintenance of Fire Safety Systems (FS.EC.02.03.05 EP1 – 20)
   a. The Director of Engineering or Designee works with qualified contractors and staff to design a program of calibration, inspection, maintenance, and testing to assure the reliability of all fire safety systems and equipment. The program includes systems and equipment such as fire sprinklers, smoke detection, fire pumps, fire dampers, doors, and shutters, and smoke control elements of the environment. Each system or piece of equipment is maintained to comply with requirements of the National Fire Protection Association or other applicable codes and standards. The hospital conducts annual tests of battery powered exit lights for 90 minutes. The hospital conducts monthly evaluations of nuclear powered exit signs and verified for expiration dates and replaced accordingly.
   b. When deficiencies are identified, they are corrected within 48 hours. If a deficiency cannot be corrected within 48 hours, the Facilities Manager evaluates the impact of the deficiency using the ILSM criteria to determine if an ILSM plan needs to be put in place until the deficiency can be corrected. All ILSM plans are monitored for effect and documentation demonstrating compliance with the plan is maintained by the Safety/Security Officer.
8. Life Safety Management (LS.EC.01.01.01 EP1 – 3)
   a. The Director of Engineering or Designee is responsible for maintaining the Statement of Conditions. The Director of Engineering or Designee prepares a quarterly report of the rate of completion of any Plan for Improvement for the Environmental Safety Committee. If any items will not be completed within the established timeframe plus The Joint Commission allowed six month grace period, the Director of Engineering or Designee is responsible for preparing a letter to the appropriate Joint Commission staff requesting an extension of the timeframe or a change of the method of correction.
9. Management of Fire Safety Risks (LS.01.02.01 EP1 – 14)
   a. A program of Interim Life Safety Management based on Interim Life Safety Measures (ILSM) is used to manage degradation of the level of life safety required by NFPA 101 – 2012 Life Safety Code. The ILSM program consists of a screening tool used to assess the severity of the potential impact of a degraded level of life safety. When risk factors indicate a need to implement one or more of the ILSM, a project specific Interim Life

Safety Management Plan (ILSMP) is designed.

b. The Director of Engineering or Designee and Safety Officer are responsible for implementation of the ILSMP. The implementation may include training, installation of engineering controls, posting of temporary advisory signs, and other actions deemed necessary. Affected staff are oriented and drilled, as appropriate, to familiarize them with the Interim Life Safety Management Plan.

c. The Director of Engineering or Designee and Safety Officer are responsible for monitoring the effectiveness of the implementation of the ILSMP. When deficiencies are identified, the Safety Officer and/or the Director of Engineering or Designee take appropriate action to resolve the deficiencies.

d. All monitoring and actions to resolve deficiencies related to an ILSMP are documented. The documentation is presented to the Environmental Health & Safety Committee as part of the quarterly Life Safety Management report to the Committee. All ILSM evaluations, plans, and monitoring documentation are maintained for at least three years.

10. The hospital monitors conditions in the environment (EC.04.01.01 EP1 – EC.04.01.01 EP11)

a. The Director of Risk Management coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Director of Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

b. Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to the Director of Risk Management who in turn works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

c. In addition, the Director of Risk Management and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated form environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Environmental Health and Safety Committee and the Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Officer provides summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.

d. The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of TCHD.

e. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven management of the environment of care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

f. The Environmental Health and Safety Committee and the Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

g. The Safety Officer prepares a quarterly report to the leadership of TCHD. The quarterly report summarizes key issues reported to the Committees and the recommendations of them.

h. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders of management responsibilities have been carried out. Semi-annual reports are provided to the Board of Directors related to the EC activities.

11. Every twelve months the hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan. (EC.04.01.01 EP15)
    a. The Safety Officer coordinates the annual evaluation of the management plan associated with the Life Safety Management Program functions.
    b. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care Program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Environmental Health and Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care Program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.
    c. In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety/Security Officer.
    d. The Environmental Health and Safety Committee reviews and approves the annual reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, organizational leaders, The Board of Directors, the Patient Safety Committee, and others as appropriate. The manager of each Environment of Care Program is responsible for implementing the recommendations in the report as part of the performance improvement process.
12. Analysis and actions regarding identified environmental issues (EC.04.01.03 EP1 – 3)
    a. The Environmental Health and Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.
13. Improving the Environment (EC.04.01.05 EP1 – 3)
    a. When the leadership of the hospital, quality improvement, or patient safety concurs with Environmental Health and Safety Committee recommendations for improvements to the Environment of Care Management Programs, a team of appropriate staff is appointed to manage the improvement project. The Environmental Health and Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.
    b. The Environmental Health and Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital leadership, performance improvement, and patient safety leadership.
14. Orientation and Ongoing Education and Training (LD.03.01.01 EP6 & EP8; HR.01.04.01 EP1 and EC.03.01.01 EP1 – 3)
    a. Orientation and training addressing subjects of the environment of care is provided to each employee, volunteer, and to each new medical staff member at the time of their employment or appointment.
    b. In addition, all current employees complete an annual review of life safety via a CBL module and documented in the Netlearning system.

c. The Human Resources Department assisted by the Education Department coordinates the general New Employee Orientation (NEO) program. New staff members are required to attend the general NEO program within 30 days of their date of employment. The Human Resources Department maintains attendance records for each new staff member completing the general orientation program.

d. New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.

e. The Safety Officer collaborates with the Environment of Care managers, department heads, the Director of Regulatory Compliance and Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed and updated to meet all applicable laws and regulations as necessary.

f. The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff is able to describe or demonstrate how job related risks are to be managed or eliminated as part of daily work. In addition the Safety Officer evaluates the degree to which staff members understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

g. Information about staff knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Environmental Health and Safety Committee. When deficiencies are identified action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

F. **GOALS/OBJECTIVES FOR 2018~~19~~**

1. Continue working with staff to assure they have a good working knowledge of the expectations of their roles during a Life Safety emergency situation.
2. Insure that RedHawk Life Safety continues to inspect fire systems in accordance with all Regulatory Agencies and corrects deficiencies within mandated time lines.
3. Continue working with department staff, ~~specifically OR~~ with **maintaining specific clearance spacing for fire extinguishers, pull-down stations and electrical panels, for compliance and safety purposes.**~~fire extinguisher trainings and hands on techniques when dealing with an emergency fire situation in their work area.~~
4. Continue to work with staff and contractors in regards to both pre and post activities during construction phases that are necessary to maintain the safety of staff, patients and visitors to the facility.

G. **REFERENCE(S):**

1. The Joint Commission/NFPA Life Safety Book for Health Care Organizations (2013)
2. The 2012 Edition NFPA 101 Life Safety Code
3. The 2012 Edition NFPA 99 Health Care Facilities Code

Tri-City Medical Center
Oceanside, California

Environment of Care Manual
Equipment Management

SUBJECT: **Medical Equipment Management Plan**

ISSUE DATE: 10/94
REVIEW DATE(S): 03/97, 7/00, 05/03, 05/08
REVISION DATE(S): 03/97, 7/00, 05/03, 05/08, 06/15, 11/18

Department Approval:	**06/16, 11/18**
Environmental Health and Safety Committee Approval:	**08/16, 11/18**
Administration Approval:	**03/19**
Professional Affairs Committee Approval:	**01/17, n/a**
Board of Directors Approval:	**01/17**

A. **SCOPE:**

1. The Medical Equipment Management Program is designed to assure proper selection, of the appropriate medical equipment to support a safe patient care and treatment environment. The Program will assure effective preparation of staff responsible for the use, maintenance, and repair of the equipment, and manage risks associated with the use of medical equipment technology Finally, the Program is designed to assure continual availability of safe, effective equipment through a program of planned maintenance, timely repair, ongoing education and training, and evaluation of all events that could have an adverse impact on the safety of patients or staff as applied to the building and services provided at Tri-City Healthcare District.
2. The program is applied to Tri-City Healthcare District medical center and offsite care locations. \
3. The Medical Equipment Management Plan describes the processes it implements to manage the effective, safe, and reliable operation of medical equipment as well as provide a safe environment for patients, staff members, visitors, and other individuals in the hospital. Directly or indirectly, the Medical Equipment Management Plan involves every person in the hospital who uses, maintains, or is associated with medical equipment.

B. **FUNDAMENTALS (RISKS):**

1. The sophistication and complexity of medical equipment continues to expand. Selecting new medical equipment technology requires research and a team approach.
2. Patient care providers need information to develop an understanding of medical equipment limitations, safe operating conditions, safe work practices, and emergency clinical interventions during failures.
3. Medical equipment may injure patients or adversely affect care decisions if not properly maintained.

C. **OBJECTIVES:**

1. The Objectives for the Medical Equipment Program are developed from information gathered during risk assessment activities, annual evaluation of the previous year's program, performance measures, and environmental tours. The Objectives for this Plan are:
   a. To increase training, both formal and informal for all resident technicians.
   b. Develop departmental rounds to ensure medical equipment safety within the facility.
   c. Keep the medical equipment inventory current and accurate.
   d. Minimize risks to patients, users, and the environment.
   e. Maintain the highest level of availability of medical equipment to clinical users.
   f. Reduce the need for premature replacement of equipment.

g. Comply with applicable laws, regulations, standards, and codes.
h. Continually seek opportunities for quality improvement and cost reduction.
i. Reduce unnecessary workload that does not produce positive impact of care delivery.

D. **ORGANIZATION & RESPONSIBILITY:**

1. The Hospital Governing Board receives regular reports of the activities of the Medical Equipment Management Program from the Environmental Health and Safety Committee. They review the reports and, as appropriate, communicate concerns about identified issues, and regulatory compliance. They provide support to facilitate the ongoing activities of the Medical Equipment Program.
2. The Chief Operating Officer (COO) receives regular reports of the current status of the Medical Equipment program through the Environmental Health & Safety Committee. The COO reviews the reports and, as necessary, communicates concerns about key issues and regulatory compliance to the medical staff, nursing, Clinical Engineering, and other appropriate staff.
3. The Manager of Clinical Engineering with COO support assures that the Medical Equipment Program is implemented in all key clinical areas. The program manages a variety of activities, including tracking of rental or leased equipment, warranty repairs, and contract services. The Program also assists in the management of the activities of specialty service contractors providing services to other departments, such as radiology, laboratory, respiratory care, and surgery and anesthesia.
4. The Manager of Clinical Engineering implements the in-house medical equipment maintenance program and tracks maintenance provided by original equipment manufacturers, and other contractors who provide maintenance and repair services for specific items of equipment.
5. Department heads orient new staff to their department and, as appropriate, specific uses of medical equipment. When requested, the Clinical Engineering Technicians provides assistance.
6. Individual staff members are responsible for learning and following job and task specific procedures for safe medical equipment operation.

E. **PERFORMANCE ACTIVITIES:**

1. The performance measurement process is one part of the evaluation of the effectiveness of the Medical Equipment Program. Performance measures have been established to measure important aspect of the Medical Equipment Program.
2. The following fundamental performance indicators will be monitored:
   a. SM completion rate benchmark is 95% or greater.
   b. Repair completion rate within 30-days benchmark is 85% or greater.
   c. Critical/High Risk Equip SM Mthly Completion rate is 100%.
   d. Use Error Percentages
   e. Could not Duplicate Percentages per year
   f. Equipment found without PM Safety Sticker <1%
3. As they occur:
   a. Safe Medical Device Act of 1990 (SMDA)
   b. Incident investigations
   c. Device recalls and alerts

F. **PROCESSES FOR MANAGING MEDICAL EQUIPMENT:**

1. The hospital plans activities to minimize risks in the environment of care – EC.01.01.01 EP7
   a. The hospital has a written plan for managing medical equipment. The organization develops and maintains the Medical Equipment Management Plan to effectively manage the medical equipment risks of the staff, visitors, and patients at Tri-City Healthcare District.
2. The hospital manages safety and security risks- EC.02.01.01 EP11
   a. The hospital responds to product notices and recalls. The Manager of Clinical Engineering responds and acts on medical equipment notices and recalls. Any notices or recalls (OEM voluntary or FDA) which are affected on any devices or equipment in the

facility will be acted on immediately and reported to the EHSC meeting. The Department Director (owner of the equipment) and Risk Manager will be notified of the notice or recall and action taken. The notice or recall will be annotated on the EHSC medical equipment report until the issue is resolved. This will also be discussed at the EHSC meeting to all members.

3. The hospital manages medical equipment risks - EC.02.04.01 EP1
   a. The hospital solicits input from individuals who operate and service equipment when it selects and acquires medical equipment. Tri-City Healthcare District utilizes a capital committee to select and assure the proper equipment is selected. The Capital Committee is made up of (at a minimum) Information Technology, Clinical Engineering, Nursing, Facility Management, Finance and Materials Management.
4. The hospital manages medical equipment risks - EC.02.04.01 EP2
   a. The hospital maintains a written inventory of all medical equipment. Tri-City Healthcare District maintains an electronic and written inventory of all medical equipment. This includes all Critical/High Risk equipment. The Manager of Clinical Engineering evaluates new types of equipment before initial use to determine whether to include this equipment in the inventory.
   b. Written criteria are used to identify risks associated with medical equipment. The risks include, equipment function, physical risks associated with use, and equipment incident history as it relates to patient safety. The risks identified are used to assist in determining the strategies for maintenance, testing, and inspection of medical equipment. In addition, the identified risks are used to guide the development of training and education programs for staff that use or maintain equipment.
   c. Equipment requiring a program of planned maintenance is listed as part of a maintenance inventory. The list includes equipment maintained by in-house staff as well as equipment maintained by vendors.
5. The hospital manages medical equipment risks - EC.02.04.01 EP3
   a. The hospital identifies high-risk medical equipment on the inventory for which there is a risk of serious injury or death to a patient or staff member should the equipment fail.
      i. Note: High-risk medical equipment includes life-support equipment. The Manager of Clinical Engineering identifies the activities used for maintaining, inspecting, and testing all of the medical equipment in the inventory used for the diagnosis, care, treatment, and monitoring of patients thus assuring safety and maximum useful life. The determination of the appropriate activity is made as part of the initial evaluation of equipment. Critical/High Risk equipment is identified and scheduled according to manufacturer recommendations. They are tracked using IDesk.
   b. Potential activities selected to ensure reliable performance include:
      i. Predictive maintenance based on manufacturer's recommendation.
      ii. Reliability-centered maintenance based on equipment history.
      iii. Interval-based inspections based on specified intervals between tests, inspections, or maintenance activity.
   c. Tri-City Healthcare District's Clinical Engineering Department follows manufacturer's recommendations for predictive (scheduled) maintenance including frequency and task (or the activity that requires MORE frequent inspections). Any changes of maintenance strategy and specific tasks shall be based on the experience accumulated locally or elsewhere, upon approval of the Environment of Care/Safety Committee or appropriate hospital authority.
6. The hospital manages medical equipment risks - EC.02.04.01 EP4
   a. The hospital identifies the activities and associated frequencies, in writing, for maintaining, inspecting, and testing all medical equipment on the inventory. These activities and associated frequencies are in accordance with manufacturers' recommendations or with strategies of an alternative equipment maintenance (AEM) program. The Manager of Clinical Engineering identifies the frequencies for inspecting,

testing, and maintaining medical equipment on the inventory in accordance with Manufacturers' recommendations. The frequency of scheduled (planned) maintenance is determined based on manufacturer recommendations, risk levels, and current hospital experience. The frequency of maintenance is determined at the time of initial evaluation of the medical equipment.

b. A work order is used to manage the work for each scheduled maintenance event. Work orders are issued for maintenance performed by in-house staff and by contractors. The Manager of Clinical Engineering manages the work order generation and completion process via IDesk. The Clinical Engineering Technicians perform assigned work orders and review prior to filing. Work done by outside contractors is tracked to assure the work is completed in accordance with the terms of a contract.

c. In addition, other departments manage performance testing and daily user maintenance of sterilizers.

7. The hospital manages medical equipment risks - EC.02.04.01 EP5
   a. The hospital's activities and frequencies for inspecting, testing, and maintaining the following items must be in accordance with manufacturers' recommendations:
      i. Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining must be in accordance with the manufacturer recommendations, or otherwise establishes more stringent maintenance requirements.
      ii. Medical laser devices.
      iii. Imaging and radiologic equipment (whether used for diagnostic or therapeutic purposes).
      iv. New medical equipment with insufficient maintenance history to support the use of alternative maintenance strategies Note: Maintenance history includes any of the following documented evidence:
         1) Records provided by the hospital's contractors.
         2) Information made public by nationally recognized sources.
         3) Records of the hospital's experience over time.
   b. The Manager of Clinical Engineering identifies the frequencies for inspecting, testing, and maintaining medical equipment on the inventory in accordance with Manufacturers' recommendations. The frequency of scheduled (planned) maintenance is determined based on manufacturer recommendations, and can be more often based on risk levels, and current hospital experience. The frequency of maintenance is determined at the time of initial evaluation of the medical equipment.
   c. A work order is used to manage the work for each scheduled maintenance event. Work orders are issued for maintenance performed by in-house staff and by contractors. The Manager of Clinical Engineering manages the work order generation and completion process via IDesk.
8. The hospital manages medical equipment risks - EC.02.04.01 EP6
   a. A qualified individual(s) uses written criteria to support the determination whether it is safe to permit medical equipment to be maintained in an alternate manner that includes the following:
      i. How the equipment is used, including the seriousness and prevalence of harm during normal use.
      ii. Likely consequences of equipment failure or malfunction, including seriousness of and prevalence of harm.
      iii. Availability of alternative or back-up equipment in the event the equipment fails or malfunctions.
      iv. Incident history of identical or similar equipment.
      v. Maintenance requirements of the equipment.
   b. The Manager of Clinical Engineering assists in the development of written procedures that are followed when medical equipment fails. These procedures include emergency clinical interventions and the location and use of backup medical

equipment. The leader of each department that uses Critical/High Risk medical equipment develops and trains staff about the specific emergency procedures to be used in the event of failure or malfunction of equipment whose failure could cause death or irreversible harm to the patient dependent on such equipment.

c. These emergency response procedures provide clear, specific instructions for staff responding to an emergency and provide information about notifying appropriate administrative staff of the emergency, actions required to protect patients from harm, contacts for spare equipment or repair services, and contacts to obtain additional staff to manage the emergency.

d. Each department leader maintains copies of applicable emergency procedures in accessible locations in their departments. Departmental staff receives orientation and ongoing education and training about the emergency procedures.

e. Each department Director/Manager reviews the department specific medical equipment emergency procedures annually.

9. The hospital manages medical equipment risks - EC.02.04.01 EP7

a. The hospital identifies medical equipment on its inventory that is included in an alternative equipment maintenance program. The Manager of Clinical Engineering will bring any alternative equipment maintenance programs to the Environmental Health & Safety Committee for approval before using the alternative measures. There are no alternative maintenance programs currently being used.

10. The hospital manages medical equipment risks - EC.02.04.01 EP8

a. The hospital monitors and reports all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990. The Risk Manager is responsible for monitoring and reporting all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990. The Risk Manager collects information about potentially reportable events through the incident reporting and investigation process. The Risk Manager and appropriate clinical staff conduct investigations of medical equipment incidents to determine if the incident is reportable under criteria established by the Food and Drug Administration. Clinical Engineering will help in the investigation only when instructed by Risk Management.

b. The Risk Manager uses the Sentinel Event Process to investigate and document reportable incidents. The Risk Manager reports for the Environmental Health & Safety Committee on those incidents determined to be reportable. The Risk Manager is also responsible for completing all reports and handling other communications with medical equipment manufacturers and the FDA required by the Safe Medical Devices Act.

c. Appropriate changes in processes and training are made through the performance improvement process. The changes are communicated to all appropriate staff.

11. The hospital manages medical equipment risks - EC.02.04.01 EP9

a. The hospital has written procedures to follow when medical equipment fails, including using emergency clinical interventions and backup equipment. The Manager of Clinical Engineering assists in the development of written procedures that are followed when medical equipment fails. These procedures include emergency clinical interventions and the location and use of backup medical equipment. The leader of each department that uses Critical/High Risk medical equipment develops and trains staff about the specific emergency procedures to be used in the event of failure or malfunction of equipment whose failure could cause death or irreversible harm to the patient dependent on such equipment.

b. These emergency response procedures provide clear, specific instructions for staff responding to an emergency and provide information about notifying appropriate administrative staff of the emergency, actions required to protect patients from harm, contacts for spare equipment or repair services, and contacts to obtain additional staff to manage the emergency.

c. Each department head maintains copies of applicable emergency procedures in accessible locations in their departments. Departmental staff receives orientation and ongoing education and training about the emergency procedures.
d. Each department Director/Manager reviews the department specific medical equipment emergency procedures annually.

12. The hospital inspects, tests, and maintains medical equipment - EC.02.04.03 EP1
    a. Before initial use and after major repairs or upgrades of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. (See also EC.02.04.01, EP 2). The Clinical Engineering staff will test all medical equipment on the inventory before initial usage and perform safety, operational, and functional checks. The inventory includes, equipment owned by Tri-City Healthcare District, leased, and rented from vendors. These inspection, testing and maintenance documents are maintained in the Clinical Engineering Department for review. The Manager of Clinical Engineering manages the program of scheduled inspection and maintenance.
13. The hospital inspects, tests, and maintains medical equipment - EC.02.04.03 EP2
    a. The hospital inspects, tests, and maintains all high-risk equipment. These activities are documented. (See also EC.02.04.01, EPs 3 and 4; PC.02.01.11, EP 2). The Manager of Clinical Engineering assures that scheduled testing (inspects, tests and maintains) of all Critical/High Risk equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Environmental Health & Safety Committee. If the monthly rate of completion falls below 100%, the Manager of Clinical Engineering will present an analysis to determine the cause of the problem and make recommendations for addressing it. These inspection, testing, and maintenance documents are maintained in the Clinical Engineering Department for review.
14. The hospital inspects, tests, and maintains medical equipment - EC.02.04.03 EP3
    a. The hospital inspects, tests, and maintains non–high-risk equipment identified on the medical equipment inventory. These activities are documented. The Manager of Clinical Engineering assures that scheduled testing (inspects, tests and maintains) of all Non Critical/Non High Risk equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Environmental Health & Safety Committee. If the monthly rate of completion falls below 95%, the Manager of Clinical Engineering will present an analysis to determine the cause of the problem and make recommendations for addressing it. These inspection, testing and maintenance documents are maintained in the Clinical Engineering Department for review.
15. The hospital inspects, tests, and maintains medical equipment - EC.02.04.03 EP4
    a. The hospital conducts performance testing of and maintains all sterilizers. These activities are documented. The Manager of Clinical Engineering is responsible for the maintenance and documentation of maintenance of all types of sterilizers used at Tri-City Healthcare District. Maintenance documentation to include SMs are maintained in IDesk (the Clinical Engineering Medical Equipment Database) and filed into the equipment file for review.
    b. Records of load testing (performance) and regular user maintenance are maintained by Sterile Processing Department (SPD) and Perioperative Services Department, respectively.
16. The hospital inspects, tests, and maintains medical equipment - EC.02.04.03 EP5
    a. The hospital performs equipment maintenance and chemical and biological testing of water used in hemodialysis. These activities are documented. The Manager of Clinical Engineering is responsible for managing the service and maintenance of the dialysis units performed by Fresenius. The service maintenance records are also entered into IDesk the Clinical Engineering shop medical equipment database and filed into the equipment file for review.

b. Engineering is responsible for managing the chemical and biological testing of water used in hemodialysis at Tri-City Healthcare District by Fresenius. The program of maintenance includes, regular cleaning and disinfection of all dialysis equipment, and testing for compliance with biological and chemical standards for the dialysis water supply. Documentation of the testing and maintenance activities is maintained in the Dialysis storage room for review.

17. The hospital inspects, tests, and maintains medical equipment - EC.02.04.03 EP14
    a. Qualified hospital staff inspect, test, and calibrate nuclear medicine equipment annually. The dates of these activities are documented. The Manager of Clinical Engineering assures that scheduled inspecting, testing, and calibrating (for the service and Scheduled Maintenance) of the Nuclear Medicine Camera and related equipment is performed in a timely manner at least annually. The service maintenance records are also entered into I-Desk the Clinical Engineering shop medical equipment database and filed into the equipment file for review.
18. The hospital collects information to monitor conditions in the environment. EC.04.01.01 EP1
    a. The hospital establishes a process(es) for continually monitoring, internally reporting, and investigating the following:
        i. Medical or laboratory equipment management problems, failures, and use errors
            1) Note 1: All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities.
            2) Note 2: Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, or services, or to prevent similar incidents, are not lost as a result of following the legal process. Medical/Laboratory equipment management problems, failures, and use errors will be reported to the EHSC by Clinical Engineering on the EHSC report. All use errors will have in-service education and follow-up.
19. The hospital collects information to monitor conditions in the environment. EC.04.01.01 EP10
    a. Based on its process (es), the hospital reports and investigates the following: Medical/laboratory equipment management problems, failures, and use errors. (See also EC.04.01.03, EP 1) Medical/Laboratory equipment management problems, failures, and use errors will be reported to the EHSC by Clinical Engineering on the EHSC report.
20. The hospital collects information to monitor conditions in the environment. EC.04.01.01 EP12
    a. The hospital conducts environmental tours every six months in patient care areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate environment of care risks. (See also EC.04.01.03, EP 1).Clinical Engineering participates on the multi-disciplinary team which conducts environmental safety tours every 6-months in patient care areas and annually in non-patient care areas at Tri-City Healthcare District .
21. The hospital collects information to monitor conditions in the environment - EC.04.01.01 EP15
    a. Every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness. On an annual basis, Manager of Clinical Engineering evaluates the objectives, scope, performance, and effectiveness of the Plan to manage the medical equipment risks to the staff, visitors, and patients at Tri-City Healthcare District. The basis for the evaluation will include but not be limited to the medical equipment performance standards and the EHSC Committee reports on medical equipment issues (supported from IDesk). The goal of the annual evaluation is to continually improve processes and outcomes to improve the patient experience.
22. The hospital addresses NPSG.06.01.01 - Improve the safety of clinical alarm systems. (EP 1-3 are completed) (EP 4-5 will be accomplished in 2015)
    a. EP 1 - Leaders establish alarm safety as a hospital priority.

b. EP 2 - Prepare an annual inventory of alarms used in the hospital and identify the default alarm settings. (For more information, refer to Standard EC.02.04.01)
c. EP 3 - Based on the annual inventory, identify the most important alarms to manage.
d. EP 4 - Establish policies and procedures for managing the alarms identified in EP 3 above that at a minimum address the following:
   i. Whether specific alarms are needed or unnecessarily contribute to safety concerns.
   ii. When alarms can be disabled.
   iii. When alarm parameters can be changed.
   iv. Who in the organization has the authority to make decisions about disabling alarms and changing alarm parameters.
   v. Monitoring and responding to alarms.
   vi. Checking individual alarms for accurate settings, proper operation, and detectability.
e. EP 5 - Educate staff about alarm policies and procedures.

G. **INFECTION CONTROL**

1. Clinical Engineering staff will observe the hospitals infection-control policies and procedures, including current CDC hand hygiene guidelines, in order to minimize the risk of cross-contamination to patients and clinicians. In addition, Clinical Engineering employees are required to follow the blood borne pathogens exposure control plan (including training, universal precautions, engineering and safe work practices, personal protective equipment usage, and post-exposure evaluation and follow-up) developed by Aramark Healthcare Technologies as required by OSHA per 29 CFR 1910.1030.

H. **PATIENT INFORMATION PRIVACY (HIPAA):**

1. As a service provider, Clinical Engineering staff do not use or disclose protected health information (PHI), as defined by the Health Insurance Portability and Accountability Act of 1996 – HIPAA, specifically the Standards for Privacy of Individually Identifiable Health Information. Any disclosure of protected health information to Clinical Engineering staff that occurs in the performance of their duties (such as what may occur while repairing a piece of medical equipment) is limited in nature, occurs as a by-product of the maintenance duties, and cannot be reasonably prevented. Such disclosures are incidental and permitted by the HIPAA Privacy Rule (45 CFR 164.502(a)(1)).
2. On the other hand, Clinical Engineering staff shall follow policies and procedures established by client to protect PHI, including attending required training and assisting clients in identifying privacy risks and practicing risk reduction measures. Specifically, the Technology Managers and CE staff is instructed to:
   a. Assist in identifying and recommending preventive measures for PHI theft risks for medical devices that are exposed to non-authorized employees, patients and visitors.
   b. Work with the Information Technology department to remove all PHI from equipment that is sent out for repair or disposal.
   c. Not use or disclose any information (oral, transmitted, or recorded in any form or medium) that relates to the health (past, present, or future) of or provision of healthcare to an individual.

I. **EMERGENCY PREPAREDNESS AND MANAGEMENT:**

1. Clinical Engineering staff will observe the client's emergency preparedness and management policies and procedures in order to provide care to the population served by the client in the case of local, regional, and national emergencies.

J. **GOALS AND OJECTIVES FOR FY ~~1917~~:**

1. Assess the entire inventory of medical scales throughout the organization for the ability to locked-down the scale to Kilograms only (not able to readout in pounds). Scales where the

ability to lockdown is not an option will have a visual reminder sticker added to the front of the device to alert care providers of the risk and to ensure that kilograms are always used for patient safety. Measurement will be the total number of hospital scales/number of scales locked-down to Kg. only and/or labeled with the warning to use Kg. only.

2. Increase use of DEFECTIVE stickers on medical devices in need of repairs, by creating a schedule of rounding of all departments and providing on-the-spot education to management and frontline staff. Measurement will be to have 90% or greater of medical devices in need of repair to have the proper use of a defective sticker when sent down to Bio-Med.

Tri-City Medical Center
Oceanside, California

Environment of Care Manual
Safety Management

SUBJECT: **Safety Plan**

ISSUE DATE: **11/87**
REVISION DATE(S): **05/96, 06/97, 07/00, 06/08, 03/11, 06/12, 06/15, ~~01/17~~ 11/18**

Department Approval:	**07/17, 11/18**
Environmental Health and Safety Committee Approval:	**08/17, 11/18**
Administration Approval:	**03/19**
Professional Affairs Committee Approval:	**11/17, n/a**
Board of Directors Approval:	**12/17**

A. **EXECUTIVE SUMMARY:**

1. Each environment of care poses unique risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Environment of Care Safety (EC) Program is designed to identify and manage the risks of the environments of care operated and owned by Tri-City Healthcare District (TCHD). The specific risks of each environment are identified by conducting and maintaining a proactive risk assessment. An environmental safety program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by TCHD.
2. The Management Plan for Environmental Safety describes the risk, safety, and daily management activities that TCHD has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other individuals, coming to the organization's facilities. The management plan and the environmental management program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.
3. The program is applied to the Medical Center and all offsite clinics and care sites owned and operated by TCHD. The Management Plan for Environmental Safety and associated polices extends to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care and business occupancies of TCHD. The plan also affects all staff, volunteers, medical staff and associates including contracted services of TCHD.

B. **PRINCIPLES:**

1. The identification of specific risks faced by patients and employees, and others is essential for designing safe work areas and work practices.
2. The identified risks and proven risk management practices are used to design procedures and controls to reduce the threats of adverse outcomes. In addition, the identified risks and the procedures and controls are used to educate staff to effectively use work environments and safe work practices to minimize the potential for adverse impact on them, patients, and other individuals coming into the environment.
3. Ongoing monitoring and evaluation of performance, assessment of accidents and incidents, and regular environmental rounds are essential management tools for improving the safety of the environment. The knowledge developed using these management tools is used to make changes in the physical environment, work practices, and increase staff knowledge.

C. **OBJECTIVES**

1. Perform an initial proactive risk assessment of the buildings, grounds, equipment, staff activities, and the care and work environment for patients and employees to evaluate the potential adverse impact on all persons coming to the facilities of TCHD.
2. Perform additional risk assessments when changes involving these issues occur.
3. Analyze accidents, incidents, and occurrences to identify root cause elements of those incidents.
4. Make changes in the procedures and controls to address identified root causes of incidents.
5. Conduct environmental (EOC) rounds in all areas of the hospital and affiliated medical practices. Staff making rounds evaluates the physical environment, equipment, and work practices. Rounds are conducted in all support areas at least annually and all patient care areas at least semi-annually.
6. Present quarterly reports of EC management activities to the environmental Health & Safety Committee. The reports from each EC area manager will identify key issues of performance and regulatory compliance, present recommendations for improvement, and provide information about ongoing activities to resolve previously identified EC issues. The Safety Officer coordinates the documentation and presentation of this information.
7. Assure that all departments have current organization-wide and department specific procedures and controls designed to manage identified risks.
8. Review the risks and related procedures and controls at least once every three years to assure that the EC programs are current.
9. Assign qualified individuals to manage the EC programs and to respond to immediate threats to life and health.
10. Perform an annual evaluation of the management plan and the scope, objectives performance and effectiveness of the environmental safety program.
11. Design and present environmental safety education and training to all new and current employees, volunteers, members of the medical staff and others as appropriate.

D. **PROGRAM MANAGEMENT STRUCTURE:**

1. The ~~Director~~ **Manager** of Safety (Safety Officer), ~~Director~~ **Manager** of Risk Management/Quality Improvement, ~~Director~~ **Manager** of Regulatory Compliance and Infection Control, and the Director of Engineering work as the Environmental Safety Leadership Team (ESLT) to develop the environmental safety program. They collaborate with leaders throughout the organization to conduct appropriate risk assessments, develop risk related procedures and controls, develop staff education and training materials, and manage day-to-day activities of the environmental safety program. They also collaborate with the Patient Safety Committee to integrate environment of care safety concerns into the Patient Safety program.
2. The Environmental Safety Leadership Team coordinates the development of reports to the Environmental Health and Safety Committee. The reports summarize organizational experience, performance management and improvement activities, and other environmental safety issues.
3. The Environmental Health and Safety Committee monitors and evaluates the processes used to manage the environment of care. Members of the Environmental Health and Safety Committee are appointed by the Committee Chair. The Environmental Health and Safety Committee meets a minimum of four (4) times per year. During each meeting one or more EC performance management and improvement reports is presented. In addition, reports of the findings of environmental rounds, incident analysis, regulatory changes and other issues are presented as appropriate. The Committee acts on recommendations for improvement, changes in procedures and controls, orientation and education, and program changes related to changes in regulations.
4. The Committee assigns individuals or groups responsibility for developing solutions to identified issues. Finally, the Committee maintains a tracking log to assure identified issues are acted on and that analysis of activities after implementation of changes demonstrates that the changes are effective.
5. Membership of the Committee includes representation from Nursing Administration, Facilities Management, Risk Management, Quality Improvement, Human Resources, Senior Administration, Bio-Medical Services, Education, Medical Staff, Physician representation,

Infection Control and others as deemed appropriate.

6. The Board of Directors of TCHD receives regular reports of the activities of the environmental safety program from the Environmental Health and Safety Committee. The Board reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer. The Board collaborates with the Chief Executive Officer (CEO) and other senior leadership to assure budget and staffing resources are available to support the environmental safety program.
7. The CEO or designee of TCHD receives regular reports of the activities of the Environmental Safety Program. The CEO or designee collaborates with the ESLT and other appropriate staff to address environmental safety issues and concerns.
8. The Emergency Management Program contains provisions for management staff on duty to take immediate, appropriate action in the event of a situation that poses an immediate threat to life, health, or property.
9. The Human Resources Department with the assistance from the Education Department and other leadership staff are responsible for the development and presentation of appropriate materials for orienting new staff members to the organization, the department to which they are assigned, and task specific safety and infection control procedures. The orientation and ongoing education and training emphasize patient safety.
10. Department leaders are responsible for assuring that all staff actively participates in the environmental safety program by observing established procedures and conducting work related activities in a manner consistent with their training. Department leaders also participate in the reporting and investigation of incidents occurring in their departments and in the monitoring, evaluation, and improvement of the effectiveness of the environmental safety program in their areas of responsibility.
11. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

E. ELEMENTS OF THE ENVIRONMENTAL SAFETY MANAGEMENT PROGRAM:

1. Appointment of Environmental Safety Leadership (EC.01.01.01 EP1)
   a. The CEO appoints a team of qualified individuals to assume responsibility for the development, implementation and monitoring of the environmental safety management program. The EESLT includes the Safety Officer, ~~Director~~ **Manager** of Risk Management/Quality Improvement, ~~Director~~ **Manager** of Regulatory Compliance and Infection Control, and the Director of Engineering.
   b. The ESLT coordinates the development and implementation of the environmental safety program and assures it is integrated with the patient safety, infection control, risk management, and other programs as appropriate.
   c. The ESLT maintains a current knowledge of environmental safety laws, regulations, and standards of safety, assesses the need to make changes to procedures, controls, training, and other activities to assure that the environmental safety management program reflects the current risks present in the environment of TCHD.
2. Designation of Persons to Intervene When Immediate Threats to Life, Health, or Property are identified (EC.01.01.01 EP2)
   a. The Emergency Management program includes specific response plans for TCHD that address implementation of an appropriate intervention whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings. The response plans follow the Hospital Incident Command System (HICS) all hazards response protocol. An appropriate event incident commander is appointed at the time any emergency response is implemented.
   b. The Immediate Threat Procedure is included in the Emergency Operations Plan. The procedure lists the communications and specific actions to be initiated when situations posing an immediate threat to patients, staff, physicians, or visitors or the threat of major

damage to buildings or property. The objective of the plan is to identify and respond to high risk situations before significant injuries, death or loss of property occurs.

c. The CEO has appointed the Safety Officer, the Nursing Administrative Supervisor on duty, and the Administrator on Call to exercise this responsibility. These individuals are to assume the role of incident command and to coordinate the mobilization of resources required to take appropriate action to quickly minimize the effects of such situations.

3. Environmental Safety Management Plan (EC.01.01.01 EP3)
   a. The Environmental Safety Management Program is described in this management plan. The Environmental Safety Management Plan describes the procedures and controls in place to minimize the potential adverse impact of the environment on patients, staff, and other people coming to the facilities of TCHD.
4. The hospital identifies safety risks associated with the environment of care (EC.01.02.01 EP1)
   a. The ESLT of TCHD performs proactive risk assessments to identify risks that create the potential for personal injury of staff or others or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting staff, patients, and others. The risk assessments use information from sources such as environmental "EOC" rounds, the results of root cause analysis (RCA), incident reports, and external reports such as The Joint Commission Sentinel Event Alerts, CDPH All Facilities Letters (AFLs), Cal/OSHA standards, and FDA product recall notices.
   b. The ESLT coordinates the risk assessment process with the Director of Engineering, department Directors and others as appropriate.
5. The hospital takes action to minimize or eliminate identified safety risks in the physical environment (EC.02.01.01 EP3)
   a. The results of the risk assessment process are used to create new or revise existing procedures and controls. They are also used to guide the modification of the environment or the procurement of equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of environmental safety in a planned and systematic manner.
6. Development and Management of Policies and Procedures (LD.04.01.07 EP1 & EP2)
   a. The Safety Officer follows the administrative policy for the development of organization-wide and department specific policies, procedures, and controls designed to eliminate or minimize the identified risks. The Safety Officer assists department leaders with the development of department or job specific environmental safety procedures and controls.
   b. The organization-wide policies and procedures and controls are available to all departments and services on the organizational intranet. Departmental procedures and controls are maintained by department directors. The department directors are accountable for ensuring that all staff are familiar with organizational, departmental, and appropriate job related procedures and controls. Department directors are also accountable for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each staff member is accountable for implementing the policies, procedures and controls related to her/his work processes.
   c. The policies, procedures and controls are reviewed when significant changes in services occur, when new technology or space is acquired, and at least every three years.
   d. The Safety Officer assists with the reviews of policies and procedures with department heads and other appropriate staff.
7. The hospital maintains all grounds and equipment (EC.02.01.01 EP5)
   a. The Director of Engineering (Facilities Management) is responsible for managing the appearance and safety of the hospital grounds. In addition, the Director of Engineering is responsible for assuring that the equipment used to maintain the grounds is in proper operating condition and that grounds staff is trained to operate and maintain the equipment.

b. The Director of Engineering (Facilities Management) is responsible for scheduling the work required to maintain the appearance and safety of hospital grounds. The Engineering staff and Security Officers make regular rounds of the grounds to identify unsafe conditions. The Security Manager and Engineering staff reports all deficiencies to the Director of Engineering (Facilities Management) for appropriate action.

8. The hospital responds to product notices and recalls (EC.02.01.01 EP11)
   a. The ~~Director~~ **Manager** of Safety and the Director of Materials Management coordinate a product safety recall system. TCHD utilizes the NRAC E-Class system that is designed to quickly assess safety recall notices; to respond to those that affect TCHD; and to assure all active safety recalls are completed in a timely manner.
   b. A quarterly report of safety recall notices that required action to eliminate defective equipment or supplies from TCHD is presented to the Environmental Health & Safety Committee by the ~~Director~~ **Manager** of Safety.
9. The hospital prohibits smoking (EC.02.01.03 EP1 & EP2)
   a. TCHD has developed a Smoke Free Environment policy. The policy prohibits smoking of any kind (ie: cigarettes, cigars, pipe, chewing tobacco, e-cigarettes and vapor producing devices) in any hospital building or grounds by all, including staff, visitors and patients.
   b. TCHD has identified alternatives to tobacco products that are offered to all. TCHD has developed tobacco replacement product resources to assist staff and patients with smoking cessation as desired. Staff may purchase tobacco replacement products via Employee Health at a discounted cost.
10. The hospital takes action to maintain compliance with its smoking policy (EC.02.01.03 EP6)
    a. The procedures for managing the use of smoking materials are followed and enforced by all leadership and staff.
11. The hospital monitors conditions in the environment (EC.04.01.01 EP1 - EP11)
    a. The ~~Director~~ **Manager** of Risk Management coordinates the design and implementation of the incident reporting and analysis process. The ~~Director~~ **Manager** of Safety (Safety Officer) works with Risk Management to design appropriate processes to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.
    b. Incident reports are completed by a staff member or witness to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management. Risk Management works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.
    c. In addition, the ~~Director~~ **Manager** of Risk Management and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment or staff behaviors that require action. The findings of such analysis are reported to the Environmental Health and Safety Committee and the Patient Safety Committee, as appropriate. The Safety Officer provides summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.
    d. The Safety Officer coordinates the collection of information about environmental safety, patient safety deficiencies including identification of opportunities for improvement from all areas of TCHD.
    e. The Environmental Health and Safety Committee and the Patient Safety Committee are responsible for identifying opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.
    f. The Chairperson of the Environmental Health & Safety Committee prepares quarterly reports to the leadership of TCHD. The quarterly reports summarize key issues reported to the EHSC and PSC committees with their recommendations. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure Hospital leaders that management responsibilities

have been carried out. Annual reports are provided to the Board of Directors related to EC, or more often if warranted.

12. Environmental tours are conducted annually in patient care areas (EC.04.01.01 EP12)
    a. Environmental "EOC" rounds at TCHD are conducted throughout the year on a schedule prepared by the ESLT. Each patient care area is scheduled for an environmental tour every twelve months. The Safety Officer with the ESLT coordinates correction of identified deficiencies with the appropriate department director(s).
    b. Additional environmental "EOC" tours are performed when construction or other activities create unusual risks that may require design and implementation of a plan to manage Interim Life Safety Measures, Infection Control Risk Measures, Proactive Construction Risk Management Measures, or other temporary issues.
    c. The ESLT analyzes the results of the environmental tours to determine if deficiencies are corrected in a timely manner and to determine if there are patterns or trends that require action to improve practices or environmental conditions.
13. Environmental tours are conducted annually in non-patient care areas (EC.04.01.01 EP13)
    a. Environmental "EOC "rounds at TCHD are conducted throughout the year on a schedule prepared by the ESLT. Each non-patient care area is scheduled for an environmental tour annually. The Safety Officer with the ESLT coordinates correction of identified deficiencies with the appropriate department director(s).
    b. Additional environmental "EOC" tours are performed when construction or other activities create unusual risks that may require design and implementation of a plan to manage Interim Life Safety Measures, Infection Control Risk Measures, Proactive Construction Risk Management Measures, or other temporary issues.
14. The hospital uses its tours to identify deficiencies, hazards, and unsafe practices (EC.04.01.01 EP14)
    a. The ESLT manages a process of environmental "EOC" rounds designed to evaluate staff knowledge and skills, observe current environmental and patient safety practices, and to evaluate environmental conditions. Findings of the environmental rounds are used as a resource for improving environmental and patient safety procedures and controls, updating orientation education and education programs, and improving staff performance.
    b. The ESLT analyzes the results of the environmental tours to determine if deficiencies are corrected in a timely manner and to determine if there are patterns or trends that require action to improve practices or environmental conditions.
15. Every twelve months the hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan. (EC.04.01.01 EP15)
    a. The ~~Director~~ **Manager** of Safety (Safety Officer) coordinates the annual evaluation of the management plans associated with the Environment of Care functions.
    b. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Environmental Health and Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.
    c. In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review (PPR). Any deficiencies identified

on an annual basis will be immediately addressed by a plan for improvement.

d. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.

e. The results of the annual evaluation are presented to the Environmental Health and Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes.

f. The annual evaluation is distributed to the CEO, Board of Directors, organizational leaders, the Patient Safety Committee, the Quality Assurance Performance Improvement Committee and others as appropriate. The manager of each Environment of Care program is responsible for implementing the recommendations in the report as part of the performance improvement process.

16. Analysis and actions regarding identified environmental issues (EC.04.01.03 EP1 – EP3)

a. The Environmental Health and Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement.

b. Each time a need for improvement is identified the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the quality improvement program, and the patient safety program.

17. Improving the Environment (EC.04.01.05 EP1 – EP 3)

a. When the leadership of the hospital, regulatory compliance, quality improvement, or patient safety concurs with the Environmental Health and Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Environmental Health and Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

b. The Environmental Health and Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, performance improvement, and patient safety leadership.

18. Orientation and Ongoing Education and Training (LD.03.01.01 EP6 & EP8; HR.01.04.01 EP1 & EC.03.01.01 EP1 – EP3)

a. Orientation and training addressing the environment of care is provided to each employee, contract staff and volunteer. All Licensed Independent Practitioners (LIP) receive orientation to the Environment of Care in accordance with the Medical Staff policies and bylaws.

b. In addition, annual EOC training is provided and documented via NetLearning.

c. The Human Resources Department with participation from the Education Department coordinates the general New Employee Orientation (NEO) program. New staff members are required to attend the NEO program within 30 days of their date of employment. The Human Resources Department with participation from the Education Department maintains attendance records for each new staff member completing the general orientation program.

d. New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the policies, procedures and controls in place to minimize or eliminate them during routine daily operations.

e. The Safety Officer collaborates with the EC managers, department leaders, the ~~Director~~ **Manager** of Risk Management/Quality, ~~Director~~ **Manager** of Regulatory Compliance and Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job related physical risks are to be managed or eliminated

as part of daily work. In addition, the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

f. Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Environmental Health and Safety Committee. When deficiencies are identified action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

F. **GOALS/OBJECTIVES FOR FY~~18~~19:**

1. ~~Meet all of the new Cal/OSHA Workplace Violence Prevention in Healthcare, Title 8, Chapter 4, § 3342 regulation requirements by April 1, 2018.~~
2. Complete ~~WPV~~ **Safety** risk assessments for all departments, services throughout the medical center and off-site locations.
3. **Continue to provide education to staff in identifying and reporting Work Place Violence.**

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

1. Administrative Policy: Smoke Free Environment #205

H. **REFERENCE(S):**

1. The Joint Commission/NFPA Life Safety Book for Health Care Organizations (2013)
2. Cal/OSHA Workplace Violence Prevention in Healthcare, Title 8, Chapter 4, § 3342

Tri-City Medical Center
Oceanside, California

Environment of Care Manual
Security Management

SUBJECT: **Security Management Plan**

ISSUE DATE: **01/97**
REVISION DATE(S): **01/99, 07/00, 04/03, 12/05, 12/11, 06/15, 01/17, 11/18**

Department Approval:	**07/17, 11/18**
Environmental Health and Safety Committee Approval:	**08/17, 11/18**
Administration Approval:	**03/19**
Professional Affairs Committee Approval:	**11/17, n/a**
Board of Directors Approval:	**12/17**

A. **EXECUTIVE SUMMARY:**

1. Each environment of care poses unique security risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The security management program is designed to identify and manage the security risks of the environments of care operated and owned by Tri-City Healthcare District (TCHD). The specific risks of each environment are identified by conducting and maintaining a proactive risk assessment. A security management program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified.
2. The Management Plan for a Secure Environment describes the security risk and daily management activities that TCHD has put in place to achieve the lowest potential for adverse impact on the security of patients, staff, and other individuals, coming to the organization's facilities. The management plan and the Security Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.
3. The scope of the program is applied to the medical center and all offsite care centers owned and operated by TCHD. The Security Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care and business occupancies of TCHD. The plan also affects all employees, volunteers, medical staff and associates including contracted services of TCHD.

B. **PRINCIPLES:**

1. Security is a system made up of human assets and technology.
2. Visible and clandestine components of the system are used to reduce the potential for criminal activity, the threat of workplace violence, and to increase feelings of security among patients, staff, and others coming to TCHD.
3. Initial and ongoing assessment of security threats is essential for timely identification of changes in the types of security threats facing TCHD.
4. Collection and analysis of information about adverse security events provides information to help predict and prevent personal violence, crime, and other incidents.
5. Staff awareness of security is an essential part of an effective program. TCHD orients and trains all staff to basic components of the security program, including workplace violence prevention and active threat, along with techniques for managing security risks related to work areas or daily activities.

C. **OBJECTIVES:**

1. Perform an initial proactive risk assessment of the buildings, grounds, equipment, staff activities, and the care and work environment for patients and employees to evaluate the potential adverse impact on all persons coming to the facilities of TCHD.
2. Perform additional risk assessments when changes in the campus design or patterns of security events indicate a change in the security threat level.
3. Analyze security incidents and occurrences to identify root cause elements.
4. Conduct ongoing random security patrols in all areas of the medical center, affiliated business offices and outpatient facilities. Staff making rounds evaluates the physical environment, equipment, and work practices. Rounds are conducted in all support areas and all patient care areas at least once per day.
5. Present reports of Environment of Care management activities to the Environmental Health and Safety Committee quarterly. The reports identify key issues of performance and regulatory compliance, present recommendations for improvement, and provide information about ongoing activities to resolve previously identified security issues. The ~~Director~~ **Manager** of Security coordinates the documentation and presentation of this information.
6. Assure that departments have current organization-wide and as needed department specific procedures and controls designed to manage identified security risks.
7. Review the risks and related procedures and controls at least once every three years to assure that the security program is current.
8. Assign qualified individuals to manage the program and to respond to immediate security threats.
9. Perform an annual evaluation of the management plan and of the scope, objectives performance and effectiveness of the security program.
10. Design and present security education and training to all new and current employees, volunteers, members of the medical staff, contract staff and others as appropriate.
11. Provide timely response to emergencies and requests for assistance.
12. Communicate with law enforcement and other civil authorities as needed.
13. Manage access to the grounds, buildings, and sensitive areas of TCHD.

D. **PROGRAM MANAGEMENT STRUCTURE:**

1. The Board of Directors of TCHD receives regular reports of the activities of the Security program from the Environmental Health and Safety Committee. The Board reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer.
2. The Board collaborates with the Chief Executive Officer (CEO) and other senior leaders to assure budget and staffing resources are available to support the Security Program.
3. The CEO or designee of TCHD receives regular reports of the activities of the Security program. The CEO or designee collaborates with the ~~Director~~ **Manager** of Security and other appropriate staff to address security issues and concerns.
4. The ~~Director~~ **Manager** of Security works under the general direction of the CEO or designee. The ~~Director~~ **Manager** of ~~Security is~~**Security is** responsible for managing the Security Program. The ~~Director~~ **Manager** of Security reports program findings to the Environmental Health and Safety Committee. The reports summarize organizational experience, performance management and improvement activities, and other security issues.
5. Department leaders are responsible for orienting new staff members to the department and to job and task specific security procedures. The orientation and ongoing education and training emphasize patient safety. Department heads are also responsible for participating in the reporting and investigation of incidents occurring in their departments.
6. Individual staff members are responsible for learning and following job and task specific procedures for secure operations.

E. **ELEMENTS OF THE SECURITY PLAN:**

1. Appointment of Security Leadership (SEC.EC.01.01.01 EP1)

a. The CEO of TCHD appoints the Safety Officer, and selects a qualified individual capable of overseeing the development, implementation and monitoring of the security program. The Safety Officer's job is defined by a job description. The CEO or a designee evaluates the competence of the Safety Officer annually.

b. The ~~Director~~ **Manager** of Security coordinates the development and implementation of the security program and assures it is integrated with the patient safety, information management, and other programs as appropriate. The ~~Director~~ **Manager** of Security's job is defined by a job description. The CEO or a designee evaluates the competence of the ~~Director~~ **Manager** of Security annually.

c. The ~~Director~~ **Manager** of Security maintains a current knowledge of laws, regulations, and standards of security. The ~~Director~~ **Manager** of Security also continually assesses the need to make changes to procedures, controls, training, and other activities to assure that the security management program reflects the current risks present in the environment of TCHD.

2. Designation of Persons to Intervene When Immediate Threats to Life, Health, or Property are identified (EC.01.01.01 EP2)

a. The Emergency Management program includes specific response plans for TCHD that address implementation of an appropriate intervention whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings. The response plans follow the HICS (Hospital Incident Command System) all hazards response protocol. An appropriate Incident Commander is appointed at the time any emergency response is implemented.

b. The Immediate Threat Procedure is included in the Emergency Operations Procedure manual. The procedure lists the communications and specific actions to be initiated when situations posing an immediate threat to patients, staff, physicians, or visitors or the threat of major damage to buildings or property. The objective of the procedure is to identify and respond to high risk situations before significant injuries, death or loss of property occurs.

c. The CEO has appointed the Safety Officer, the Nursing Administrative Supervisor on duty, and the Administrator on Call to exercise this responsibility. These individuals are to assume the role of incident command and to coordinate the mobilization of resources required to take appropriate action to quickly minimize the effects of such situations.

3. Management Plan for a Secure Environment (SEC.EC.01.01.01 EP4)

a. The Security Management Program is described in this management plan. The security management plan describes the policies, procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of TCHD experience an adverse security event.

4. Proactive Risk Assessment (SEC. EC.02.01.01 EP1)

a. The ~~Director~~ **Manager** of Security of TCHD coordinates proactive risk assessments to identify risks that create the potential for personal injury of staff or others or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting staff, patients, and others.

b. The ~~Director~~ **Manager** of Security works with department directors, managers, the Patient Safety Officer, Risk Management and others as appropriate.

c. The Security Department will be responsible for enacting proactive security measures as follows:

i. Scheduling patrolling of the Medical Center and parking lots to help prevent work place violence/accidents.

ii. Locking/unlocking of exterior doors, departments, and associated rooms; on-going inspections of all sensitive areas throughout the Medical Center.

iii. Ensuing that all employees and physicians properly display their photographic identification badges at all times.

iv. Submitting reports to the Director of Engineering pertaining to security and safety violations, including but not limited to: defective lighting, damaged equipment, unsafe situations or conditions that may present a danger to others.
v. Maintaining unrestricted locations for the timely loading and unloading of persons seeking medical treatment in the Emergency Department and Women's Center. Security will also ensure a location for long-term vehicle parking.
vi. Monitoring the Security Department CCTV.
vii. Providing campus escort services 24 hours per day as needed for employees and visitors.

5. The hospital takes action to minimize or eliminate identified security risks in the physical environment (EC.02.01.01 EP3)
   a. The results of the risk assessment process are used to create new or revise existing procedures and controls. They are also used to guide the modification of the environment or the procurement of equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of security in a planned and systematic manner.
   b. In response to the 2016 Cal/OSHA, Workplace Violence Prevention in Healthcare, Title 8, Chapter 4, § 3342 regulations, TCHD has created new environmental risk assessment tools and general employee education programs.
   c. TCHD has elected to implement the Non-Violent Crisis Intervention Program (NVCI) for the mandated training of staff working in high-risk areas in compliance with the California Health and Safety Code Section 1247.7 and 1257.8. This training includes:
      i. General safety measures.
      ii. Personal safety measures.
      iii. The assault cycle.
      iv. Aggression and violence predicting factors.
      v. Characteristics of aggressive and violent patients and victims.
      vi. Verbal and physical maneuvers to diffuse and avoid violent behavior.
      vii. Strategies to avoid physical harm.
      viii. Restraining techniques.
      ix. Resources available to employees coping with violence (stress debriefing, employee assistance programs, etc.).
   d. ~~A condensed version of the~~ **The** NVCI program will be offered to ancillary staff routinely assigned to the Emergency Department. Ancillary department managers will be responsible for determining staff appropriate for this training.
6. Development and Management of Policies and Procedures (LD.04.01.07 EP1 and EP2)
   a. The ~~Director~~ **Manager** of Security follows the administrative policy for the development of organization-wide and department specific policies, procedures, and controls designed to eliminate or minimize the identified risks. The ~~Director~~ **Manager** of Security assists department leaders with the development of department or job specific environmental safety procedures and controls.
   b. The organization-wide policies, procedures and controls are available to all departments and services on the organizational intranet. Departmental policies, procedures and controls are maintained by department directors. The directors are responsible for ensuring that all staff is familiar with organizational, departmental, and appropriate job related policies, procedures and controls. Department directors are also responsible for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each staff member is responsible for implementing the policies, procedures and controls related to her/his work processes.
   c. The policies, procedures and controls are reviewed when significant changes in services occur, when new technology or space is acquired, and at least every three years. The ~~Director~~ **Manager** of Security coordinates the reviews of procedures with department

leaders and other appropriate staff.

7. Identification of Patients, Staff, and Others Entering the Facility (SEC.EC.02.01.01 EP7)
   a. The identification of staff is an interdisciplinary function. Several Directors share responsibility for designing identification systems and establishing procedures and controls to maintain the effectiveness of the systems.
   b. The current systems in place at TCHD include photographic ID badges for all staff, volunteers, students, contracted staff and members of the medical staff, password systems to limit access to authorized users of information system applications, physical security systems to limit access to departments and areas of the hospital, and distinctive clothing/badges to facilitate rapid visual recognition of critical groups of staff.
   c. The identification of patients is also an interdisciplinary function. The current system includes personal identification of patients in medical records and by use of various arm band systems.
   d. The identification of others entering TCHD is managed by the Security and Materials Management Departments. The ~~Director~~ **Manager** of Security in collaboration with the CEO or designee and other appropriate staff provides a secure environment that requires identification of all contractors/vendors and the badging of visitors to the various areas of the facility. The Director of Materials Management manages the procedures for identification of vendors. The ~~Director~~ **Manager** of Security takes appropriate action to remove unauthorized persons form areas and to prevent unwanted individuals from gaining access to TCHD.
8. Identification and Management of Security Sensitive Areas (SEC.EC.02.01.01 EP8)
   a. The following areas have been designated as sensitive areas:
      i. Emergency Department.
      ii. ~~Behavioral Health and Crisis Stabilization Units.~~
      iii. Maternal Child Health.
      iv. Neonatal Intensive Care Unit.
      v. Pharmacy Department.
      vi. Human Resources Department.
      vii. Adult Critical Care Unit.
      viii. Information Technology.
      ix. Administration.
      x. 3rd Floor Center Tower Progressive Care Unit.
      xi. Medical Records Office and Storage areas.
      xii. Nuclear Medicine Hot Lab.
   b. Staff in each sensitive area participates in training addressing the unique risks of the area and the procedures and controls in place to manage them. Key personnel and security staff receive specialized training related to processes in high risk security areas.
   c. The Security Plan has a program for the inspection, preventative maintenance and testing of the following security equipment:
      i. Emergency Department:
         1) Electronic access control.
         2) Panic buttons.
         3) Closed Circuit Television (CCTV) cameras.
         4) Security Officer Station – Posted 24 hours per day.
      ii. ~~Behavioral Health Units:~~
         ~~1)~~ ~~Electronic access control.~~
         ~~2)~~**1)** ~~Panic buttons.~~
         ~~3)~~**2)** ~~CCTV~~.
      iii. Maternal Child Health Units:
         1) Electronic access control.
         2) Access Control System CCTV.
         3) Department policy in place for identifying visitors.

4) Department procedure for uniquely identifying mother-infants.
5) Teaching program to educate parents or guardians to explain the security processes.
6) Unique identification for staff members.
7) Unique Visitor Badge identification for visitors.

iv. Neonatal Intensive Care Unit:
1) Electronic access control.
2) Panic buttons.
3) The Maternal Child Health units are protected with both 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.

v. Pharmacy Department:
1) Electronic access control.
2) Infrared Security System.
3) Panic buttons.

vi. Business Office:
1) Electronic access control.
2) Panic buttons.
3) Local area surveillance system.

vii. Human Resources department:
1) Panic buttons.
2) Access Control System CCTV.

viii. Adult Critical Care Unit:
1) Electronic access control.

ix. Case Management:
1) Panic buttons.

9. Management of Security Incidents Including an Infant or Pediatric Abduction (SEC.EC.02.01.01 EP9)
   a. The ~~Director~~ **Manager** of Security has developed procedures for rapid response to breaches of security. The on-duty Security Officers and local police have the manpower and technological resources to respond to a wide variety of incidents. The ~~Director~~ **Manager** of Security or a designee is responsible for assessing breaches of security and determining what resources are required to respond effectively.
   b. The ~~Director~~ **Manager** of Security, Safety Officer and the Director of Women's and Children's Services are responsible for the design and management of systems to reduce the threat of abduction of infants or children and to respond to any threats of or actual abductions.
   c. A Code Adam is announced over the paging system, as well as selected radios when a potential or actual abduction has occurred.
      i. All available staff responds per the Patient Care Services Code Adam.
      ii. The Code Adam plan is tested at least annually and the responses are documented, evaluated, critiqued and as appropriate corrective activity, additional training, or program improvements are made.
   d. The ~~Director~~ **Manager** of Security and the Director of Women and Newborn Services are required to conduct at least one abduction drill annually. In addition, activations of the abduction alert system and all attempted or actual abductions of infants or children are treated as security incidents and reported and analyzed appropriately.
10. The hospital monitors conditions in the environment (EC.04.01.01 EP1 – EP11)
   a. The Director of Risk Management coordinates the design and implementation of the incident reporting and analysis process. The ~~Director~~ **Manager** of Security works with the Director of Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and

property damage related to environmental conditions.

b. Incident reports are completed by the staff member or witness to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management. Risk Management works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

c. In addition, the Director of Risk Management and the ~~Director~~ **Manager** of Security collaborate to conduct an aggregate analysis of incident reports generated to determine if there are patterns of deficiencies in the environment or staff behaviors that require action. The findings of such analysis are reported to the Environmental Health and Safety Committee and the Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Committee Chairpersons provide summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.

d. The ~~Director~~ **Manager** of Security works with the Environmental Health and Safety Committee to collect information about security deficiencies and opportunities for improvement from all areas of TCHD. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the six environments of care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

e. The Environmental Health and Safety Committee and the Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the Environment of Care Management Programs.

f. The Safety Officer and the Patient Safety Committee prepare a quarterly report to the leadership of TCHD. The quarterly report summarizes key issues reported to the Committees and the recommendations of them. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders of management responsibilities have been carried out.

11. Every twelve months the hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan. (EC.04.01.01 EP15)

a. The Safety Officer coordinates the annual evaluation of the management plans associated with each of the Environment of Care functions.

b. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each EC program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources.

c. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Environmental Health and Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of the Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

d. In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.

e. The results of the annual evaluation are presented to the Environmental Health and Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, the Board of Directors, organizational leaders, the Patient Safety Committee, and others as appropriate. The manager of each Environment of Care Program is responsible for implementing the recommendations in the report as part of the performance improvement process.

12. Analysis and actions regarding identified environmental issues (EC.04.01.03 EP1 – EP3)
    a. The Environmental Health and Safety Committee receives reports of activities related to the environmental "EOC Rounding" program at least quarterly.
    b. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital and the Patient Safety Committee as indicated.
13. Improving the Environment (EC.04.01.05 EP1 – EP3)
    a. When the leadership of the hospital, quality improvement, or patient safety concurs with the Environmental Health and Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Environmental Health and Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.
    b. The Environmental Health and Safety Committee will also establish a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, quality improvement, and patient safety leadership.
14. Orientation and Ongoing Education and Training (LD.03.01.01 EP6 and EP8; HR.01.04.01 EP1 and EC.03.01.01 EP1 – EP3)
    a. Orientation and training addressing the environment of care and workplace safety is provided to each employee, contract staff and volunteer. All Licensed Independent Practitioners (LIP) receive orientation to the Environment of Care and workplace safety in accordance with the Medical Staff policies and bylaws.
    b. In addition, annual Environment of Care and workplace safety training is provided and documented via NetLearning.
    c. The Human Resources Department with assistance from the Education Department coordinates the general New Employee Orientation (NEO) program. New employees are required to attend the general NEO orientation program within 30 days of their date of employment. The Human Resources Department and the Education Department maintains attendance records for each new staff member completing the general orientation program.
    d. New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the policies, procedures and controls in place to minimize or eliminate them during routine daily operations.
    e. The Safety Officer collaborates with the Environment of Care leaders, the ~~Director~~ **Manager** of Quality Improvement, Infection Control, Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care program and revised as necessary.
    f. The Safety Officer gathers data during environment of care rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job related physical risks are to be managed or eliminated

as part of daily work. The environment of care rounds evaluate the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

g. Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Environmental Health and Safety Committee. When deficiencies are identified action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

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

1. Patient Care Services: Code Adam Policy

G. **REFERENCE(S):**

1. The Joint Commission Environmental of Care Standards
2. Cal/OSHA Workplace Violence Prevention in Healthcare, Title 8, Chapter 4, § 3342 regulations

Tri-City Medical Center
Oceanside, California

Food and Nutrition Services

DELETE - See Nutrition Assessment and Care for Adult Geriatric Patients Policy

SUBJECT: Scope of Nutrition Services for Oncology Patients

ISSUE DATE: 10/11
REVISION DATE(S): 11/11

Food and Nutrition Services Department Approval Date(s):	~~02/17~~01/19
Medical Staff Department/Division Approval Date(s):	n/a
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	02/19
Administration Approval:	03/19
Professional Affairs Committee Approval Date(s):	n/a
Board of Directors Approval Date(s):	

~~A. **POLICY**~~

~~1. Function: A systematic method for the Registered Dietitian to collaborate with the physician in the assessment of nutrition status of patients, the education of patients regarding nutritional therapies, and the provision of appropriate medical nutrition therapy given the patient's medical diagnosis and assessed nutritional requirements.~~

~~2. Circumstances:~~

~~a. Setting: All adult patients (age 14 years and older) admitted to or being treated at Tri-City Medical Center~~

~~b. Supervision: None required~~

~~3. Referrals for a nutrition assessment are generated if certain criteria are met via the adult admission assessment in Compass Power Chart.~~

~~4. Registered dietitians (RD) will assess nutritional status of triggered patients within 48 hours of referral, considering age of patient, disease states, nutrition history, medical history, medical therapies/treatments and laboratory values.~~

~~5. Registered dietitians (RD) may assess nutrition status of any patient and implement an appropriate nutrition care plan, to include evaluation and recommendations for enteral and parenteral nutrition support, addition of supplements, modification of food texture, and education of patients/families regarding appropriate nutrition intervention for a particular disease state.~~

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

~~1. Referrals for nutrition assessment are generated if any of the following criteria are met upon completion of the admission data base by nursing:~~

- ~~>75 years of age with abdominal or thoracic surgery~~
- ~~currently receiving TPN or enteral feedings~~
- ~~unplanned weight loss of >10# in last month~~
- ~~hyperemesis with >10# weight loss~~
- ~~presence of pressure ulcer or skin breakdown~~
- ~~Braden score of <15~~
- ~~eating disorder~~
- ~~impaired nutrient intake~~
- ~~nausea/vomiting/diarrhea~~
- ~~intake of less than 50% normal in 3 days~~
- ~~aspiration risk~~
- ~~GI problem other than constipation~~

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

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

Body Mass Index (weight (kg)/height (m2) is determined to assess health and body fat.

Body Mass Index Body Size Classification Table

Underweight	**<18.5**
Normal Weight	18.5-24.9
Overweight	25-29.9
Obesity	>30
Extreme Obesity	>40

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

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

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

Table 1

Assessment of Energy Requirements	
(a) Harris Benedict	
Men:	66.5 + 13.75 (w) = 5.0 (h) - 6.76 (a)
Women:	655 + 9.56 (w) = 1.85 (a) - 4.68 (a)

Apply appropriate activity & stress factors

(b) 20 Kcal/Kg to 25-30 Kcal/kg/d (disease specific guidelines follow)

(c) Ireton-Jones Energy Equations:

EEE(V) = 1784 -11 (A) + 5 (W) + 244 (S) + 239 (T)

EEE(S) = 629 - 11 (A) + 25 (W) - 609 (O)

EEE = kcal/day

S = spontaneously breathing

V = ventilator dependent

A = age (years)

W = body weight (kg)

S = sex (male = 1, female = 0)

T = trauma

B = burn

O = obesity (if present = 1, absent = 0)

Table 2

Assessment of Protein Requirements

RDA = 0.8gm/kg IBW or actual weight

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

Table 3

Assessment of Fluid Requirements

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

10. Registered Dietitian will develop a nutrition care plan indicating type of nutritional support (i.e. oral, oral with supplements, appropriate enteral feeding, or suggestion of parenteral feeding) to be given and its implementation. Determination of care plan will be based on assessment. Care plan will be individualized to meet specific needs of each patient. Goals will be individually determined with delineation of methods of achievement of goals and time frames. Dietitian will confer with MD for appropriate ordering and intervention, with RN for delivery of nourishment, with pharmacy and nursing for TPN and Drug Nutrient Interaction.
11. Registered Dietitian will monitor intake, input and output, weight, changes in medical condition and/or treatment and laboratory data and make recommendations as necessary. Intake may be monitored via calorie count. (Refer to Policy and Procedure for Calorie Count.)
12. Registered Dietitian will document patient's reaction and tolerance to dietary regimen.
13. Registered Dietitian will assess adequacy of enteral and parenteral feedings in relation to patient's nutritional requirements (see Policy and Procedures for Enteral Feedings and TPN Patients).
14. Registered Dietitian may offer appropriate nutritional supplements to patients at any time when a patient is not consuming 100% of assessed calories/protein requirements. (see Table 1 and Table 2) Selection of appropriate supplement will be based upon assessment of patient's diagnosis, laboratory values, tolerance, and personal preference.
15. Registered Dietitian may implement texture changes in foods when indicated based upon patient tolerance and or personal preference (i.e. regular to mechanical soft or pureed).
16. Registered Dietitian will periodically reassess patient's nutritional status throughout hospital stay and document on Nutrition Reassessment form in Compass Power Chart every 1-7 days depending upon patient's status and individualized needs.
16. Obstetric patients will not be assessed unless Registered Dietitian is requested to do so by Physician/Nurse or if patient has nutritional risk factors, i.e. "lying in" or gestational diabetes. (See policy for high risk OB patients.)

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

C. **REFERENCE LIST**

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

Nutrient Requirements for Specific Disease States

Disease State	Calories	Protein	Other considerations
Obesity Critically Ill Obesity	18-22-25 kcal/kg IBWactual wt or 20-25 kcal/kg adjusted body weight {(actual wt – IBW) x 0.25) + IBW BMI>30-50:11-14kcals/kg actual wt BMI>50: 22-25 kcals/kg IBW	1.2 to 1.5 2.0gm/kg ideal wt BMI 30-40: 2.0gm/kg IBW BMI ≥40: up to 2.5gm/kg IBW	Consider lower protein requirements in presence of hepatic disease or renal insufficiency
Pulmonary/Respiratory	25 to 30 kcal/kg ARDS: 20 – 30 kcal/kg	1.0 to 1.5 gm/kg	Do not overfeed. If mechanically ventilated, limit CHO to 4-5 mg/kg/min. Consider small frequent feedings.
Renal	ARF: 30-45 kcal/kg CRF: 35-38 kcal/kg *may reduce requirements if wt loss desired or to avoid overfeeding in ventilated pts	Prerenal:0.6 – 0.8 gm/kg ARF: 1.0 – 1.5 gm/kg CRF: 1.0 – 1.2 gm/kg (with hemodialysis) 1.0 – 1.5 gm/kg (with peritoneal dialysis) Nephrotic syndrome: 0.8 – 1.0 gm/kg	Fluid & electrolytes as tolerated
Hepatic	Cirrhosis: 25-35 kcal/kg Hepatitis: 35 kcal/kg	Cirrhosis/hepatitis without encephalopathy: 1.0-1.2 gm/kg Cirrhosis/hepatitis with acute encephalopathy: 0.6 – 0.8 gm/kg; resume 1.0 – 1.2 gm/kg asap Cirrhosis with chronic encephalopathy: 0.6 – 0.8 gm/kg	If persistent encephalopathy, consider BCAA (hepatic formula; i.e. Nutra Hep for enteral, Hepatamine for parenteral.)
Diabetes	Needs as per normal assessment	10-20% total calories	
Cancer	25 – 35 kcal/kg, dependent upon individual patient	1.0 – 1.5 gm/kg Cancer Cachexia: 1.5-2.5gm/kg	Consider consequences of surgery, chemo, errx, radiation therapy.
Cardiac	25 – 30 kcal/kg	1.0 – 1.5 gm/kg	
Sepsis/critical care	25 – 30 kcal/kg Use obesity factors as applicable	1.2 – 1.5 gm/kg	Monitor glu levels; lipid levels if ventilated on propofol
Wound care	25 – 30 kcal/kg	1.2 – 1.5 gm/kg	30 – 35 ml/kg

	~~(adjusted levels as appropriate for obesity)~~		~~Consider supplement with Vitamin C, zinc, Vitamin A if clinically deficient in these nutrients; evidence of clinical deficiency may be difficult to assess; thus,consider supplemental MVI with minerals.~~

Tri-City Health Care District
Oceanside, California

Infection Control

DELETE: Policy being deleted due to BHU Closure.

ISSUE DATE: 09/01

SUBJECT: Department Specific: Behavioral Health Services (BHS)

REVISION DATE: 07/03, 07/07, 07/10, 06/14

Infection Control Department Approval:	~~09/17~~12/18
Infection Control Committee Approval:	~~10/17~~01/19
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~01/18~~02/19
Administration Approval:	03/19
Professional Affairs Committee Approval:	~~04/18~~ n/a
Board of Directors Approval:	04/18

~~A. POLICY:~~

~~1. Patients with mental illness may be at increased risk for infection because of impaired judgement, poor impulse control, reduced self-care, irregular or poor medication compliance, lack of personal hygiene or dental care. The unique practices of the various treatment settings in the Behavioral Health Services (BHS), as well as the behaviors of the clients themselves, can lead to a heightened risk for transmission to other clients and staff. Infection Prevention in BHS requires application of recommended prevention strategies to the extent possible. The unique behavioral traits of some clients may pose an obstacle to traditional methods. The goal is to identify infections and utilize strategies to prevent transmission in this at risk population.~~

~~B. PREVENTION STRATEGIES:~~

~~1. Standard Precautions are implemented for every patient in BHS regardless of their diagnosis. Hand hygiene and cough etiquette is encouraged among staff and patients. Hand hygiene and personal hygiene reinforced daily during community meetings. Staff and patients perform hand hygiene prior to eating meals.~~

~~2. The BHS does not have negative pressure rooms. Patients requiring Airborne Precautions for infectious tuberculosis, measles, or varicella (chickenpox or disseminated herpes zoster) shall be transferred to an appropriate medical bed within the hospital.~~

~~3. A patient requiring Contact Precautions for conditions other than multi-drug resistant organisms (e.g. MRSA and VRE) or Droplet Precautions may remain on the unit if the psychiatrist deems this necessary. Patients requiring Droplet precautions will be asked to wear a surgical mask as tolerated (if patient presents as a danger to self, consideration of one-on-one observation will be considered).~~

~~4. If a patient is diagnosed with a multi-drug resistant organism (e.g. MRSA and VRE) the patient's clinical situation, hygiene practices and facility resources will be considered in deciding whether to implement Contact Precautions with that patient.~~

~~5. Clean linen is kept covered and stored inside a clean supply room. Dirty utility rooms are locked~~

~~6. The cleanliness of the kitchen is the responsibility of the staff.~~

~~7. Each patient will be assigned a closet for personal clothes and belongings.~~

~~8. Patients will be instructed on the use of laundry facilities. Patients are to wash only their own clothes with direct staff supervision. Staff is responsible for the cleanliness of the laundry area. Family members can be asked to take heavily soiled clothing home for washing.~~

~~9. Housekeeping performs sanitizing, disinfecting, and general cleaning tasks such as but not limited to trash/recycling removal, dusting, vacuuming, polishing, and mopping.~~

~~10. Shower area is to be cleaned by the environmental services staff assigned to the BHS after each patient use.~~

11. Sharps boxes will not be kept in patient rooms for safety reasons. Staff to wipe off reusable equipment with hospital approved disinfectant wipes in between patient use.

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

1. Employee Health & Wellness - Policy: Injury Illness Prevention Program
2. Infection Control: Aerosol Transmissible Diseases and Tuberculosis Control Plan IC.11
3. Infection Control: Cleaning and Disinfection IC.9
4. Infection Control: Hand Hygiene IC.8
5. Infection Control: Philosophy - IC 1
6. Infection Control: Standard and Transmission Based Precautions IC.5

D. **REFERENCE(S):**

1. APIC Text of Infection Control and Epidemiology 4th edition 2014 Chapter 49 Behavioral Health; Larysa M. Fedoriw, MPH.
2. 1. Management of Multidrug-Resistant Organisms In Healthcare Settings, Healthcare Infection Control Practices Advisory Committee (HICPAC) 2006 Jane D. Siegel, MD; Emily Rhinehart, RN MPH CIC; Marguerite Jackson, PhD; Linda Chiarello, RN MS; the Healthcare Infection Control Practices Advisory Committee

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL

ISSUE DATE: 03/02

SUBJECT: Risk Assessment and Surveillance Plan

REVISION DATE(S): 07/13, 08/14, 05/16, 03/17

Infection Control Department Approval:	~~12/18~~01/19
Infection Control Committee Approval:	~~01/18~~01/19
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~01/18~~02/19
Administration Approval:	03/19
Professional Affairs Committee Approval:	~~02/18~~ n/a
Board of Directors Approval:	02/18

A. **PURPOSE OF RISK ASSESSMENT:**

1. Sound epidemiological principles must be considered in the formation of the surveillance program designed to provide maximum information and identify opportunities to reduce disease. Measures directed toward cost effective care must include best practice and technology to prevent infection. The economic impact of an efficient and flexible infection control plan is especially relevant in times of changing reimbursement and payment patterns. Tri-City Healthcare District's (TCHD) plan outlines how this may be accomplished within the confines of resources, external regulatory guidelines, and medical staff requirements.

B. **PURPOSE OF SURVEILLANCE:**

1. The foundation of and most important purpose of this program is to decrease the risk of infectious complications for all patients, healthcare workers, visitors and staff. Ongoing epidemiological information assists with identifying at risk populations and opportunities to interrupt prevent or reduce the occurrence of healthcare associated infections. Surveillance will be compared to nationally recognized benchmarks such as the National Healthcare Safety Network (NHSN) rates whenever possible.

C. **RESPONSIBILITY:**

1. Successful creation of an organization-wide infection control program requires collaboration with all relevant components/functions. Individuals within the hospital who have the power to implement plans and make decisions related to prevention and control of risks related to infections are included in the design and coordination of processes. In consultation with the Medical Staff, Directors, Medical Director of Infection Control, Environmental Health and Safety Committee, Patient Safety Officer and the Infection Control Committee, the Infection Preventionist (IP) shall implement a systematic process for monitoring and evaluating the quality and effectiveness of the infection control program. Significant deviations are discussed in Infection Control Committee, Quality Improvement Medical Staff Committees as needed, Environmental Health and Safety Committee and the Patient Safety Committee and referred to appropriate councils and committees for action.
2. Infection Prevention and Control Services are staffed with Infection Preventionists. There are computer resources with Internet connection, Microsoft Office software, NHSN National internet based database, a real-time electronic data mining surveillance tool and access to the hospital's electronic medical records (Cerner and Affinity). Telephone with voice mail, and fax access is provided. The office is located within the Surgical Scheduling office.
3. Infection Control Services works in conjunction with others, as a consultant and resource for best practices. We support system changes and an interdisciplinary focus to improving care. We

believe that all our employees, medical staff, and volunteers play an important role in preventing and controlling infections. Ultimately, the leadership team within the district is responsible for adopting and ensuring compliance with appropriate policies and practices.

D. **LINKS WITH INTERNAL SOURCES:**

1. On at least an annual basis, the IP department will meet with the affected departments (i.e. Medical Staff and Employee Health) to assess whether the goals and priorities have been achieved and what steps are required to implement any indicated changes. The goals are shared with and reviewed by the Infection Control Committee. Education on infection control goals and priorities will be included with quarterly reports and during individual meetings with the hospital leadership. The IP staff reports to Infection Control Committee quarterly and attends other medical staff and hospital committees as requested, regulatory requirements and department specific Quality Reports are reviewed.

E. **LINKS WITH EXTERNAL SOURCES:**

1. The San Diego County Public Health Department, state health authorities, the Division of Occupational Safety and Health, and other recognized infection control specialists, for example, the Centers for Disease Control and Prevention (CDC), Association for Professionals in Infection Control and Epidemiology (APIC), Society for Healthcare Epidemiology of America (SHEA), and the California Healthcare Association (CHA) are important links between the district and outside resources. Infection Control department subscribes to automatic notifications available via email from the CDC, San Diego County Public Health (CAHAN) and California Department of Health and Human Services. Infection surveillance covers a broad range of processes and activities with potential for intervention and these organizations assist with the where, when, and how of targeting.
2. Healthcare associated infections (HAI) are reported by the IP staff to the external healthcare organizations when the infection was not known at the time of transfer. TCHD receives reports from outside organizations when a patient develops an infection that might meet criteria for a healthcare associated infection. Home Health/Hospice quality review staff report directly to Infection Control Committee.
3. The following conditions will be reported to external healthcare organizations with the intent to satisfy The Joint Commission IC 02.01.01(and recorded in the patient's chart using PowerForm). The Infection Surveillance Report will document notification to the referring healthcare organization within 7 days of discovery by the TCHD Infection Prevention and Control Staff:
    a. Positive culture from a surgical site and surgery performed at another facility.
    b. Influenza rapid test is positive and patient was discharged to another healthcare facility prior to results being known.
    c. Positive C difficile toxin test known after the patient was discharged to another healthcare facility.
    d. Positive MDRO culture known after the patient was discharged to another healthcare facility and the patient had no history of the same MDRO.
    e. Unusual occurrences based on the opinion of the Infection Prevention staff in consultation with the Infection Control Medical Director and Director of Regulatory Compliance.

F. **PERTINENT RISK FACTORS:**

1. Each facility is unique and we considered the following factors in our planning.
    a. National and international published scientific studies, community standard of care, professional recommendations and regulatory requirements.
    b. A review of hospital specific surveillance data from years past.
    c. Medically fragile and at-risk populations such as newborns and those with invasive devices.

d. The increasing antibiotic resistance in our facility and across the United States (as reported by the CDC in by NHSN).
e. The vaccination/immunity rates of the community and employees.

G. **EPIDEMIOLOGICAL FACTORS: INTERNAL AND EXTERNAL:**

1. TCHD is impacted by factors such as location, population served, community health, financial status, population age, clinical focus, and healthcare worker demographics and these were included in our planning.
2. The hospital's geographic location is in northern San Diego County. San Diego County is the second most populous of California's 58 counties, and the fifth largest county in the United States. San Diego is currently home to 3.~~31~~ million residents.~~, and is anticipated to grow to four million by 2020.~~
3. Located within the North County geographic region are 3 college campuses along with a Marine Corp Base (Camp Pendleton).
4. San Diego County is becoming increasingly bicultural due to its close proximity to Mexico. In addition, the county is already ethnically diverse, and will be increasingly so. **The largest San Diego County racial/ethnic groups are White (45.9%) followed by Hispanics (33.5%) & Asian (11.5%).** ~~Of residents under 18, 37% are Hispanic, and the Hispanic population is expected to continue to grow at a rapid rate.~~ Approximately 21.5% of the county's populations are immigrants, including refugees, who come from other countries, speak **many**~~68~~ different languages, and have a variety of needs as they assimilate into their new environment. **38.8% of people in San Diego County speak a non-English language.** The senior and disabled populations are growing disproportionately compared to the rest of the population. **Since 2015, San Diego County has become the 4th largest population of homeless individuals in the US.**
5. Demographic information **(as of 2016)** on the three cities most often served by TCHD is listed below.

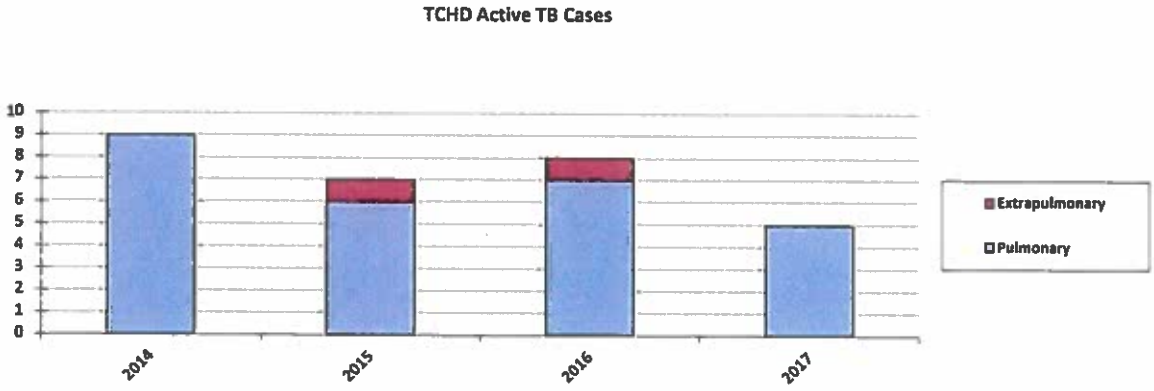
City	Median income	Total # residents	White	Hispanic	Asian & Pacific Islander
Oceanside	$ 60,487~~720~~	~~161,029 (2000)~~ 175,441~~4,558~~ (2014)	476.0 %	36.8~~35.3~~ %	7.8~~8.2~~%
Vista	$ 61,433~~7,421~~	~~89,857 (2000)~~ 101,665 ~~98,079~~ (2014)	36.5~~40~~ .8%	54.7~~48.4~~ %	4.07~~1~~%
Carlsbad	$ 113,217~~96,346~~	~~78,247 (2000)~~ 113,957~~2,299~~ (2014)	72.6~~1.~~ 9%	14.3~~15.1~~ %	7.7%

a. http://www.city-data.com/city/Oceanside-California.html
b. http://www.city-data.com/city/Vista-California.html
c. http://www.city-data.com/city/Carlsbad-California.html

6. Enteric illness represents a significant burden of disease in the US and because of this the San Diego County Health and Human Services Agency conducts outbreak investigation and education to reduce the medical and cost-related impact of these diseases in the community. Food borne illnesses largely result from the ingestion of food or water contaminated by fecal matter or ingestion of infected animal products. Hospitals play an important role in early intervention by the identification and reporting of significant bacteria. The most common mandated reported enteric illnesses in SD County are Campylobacter, ~~Giardia,~~ Hepatitis A, Salmonella and Shigella.
7. In San Diego, overall rates for the three major reportable sexually transmitted diseases (Chlamydia, Gonorrhea & Syphilis) have increased from 2016~~5~~ to 2017~~6~~. National trends were reflective at the local level, including high rates of STD's among young women and MSM (men

who have sex with men). San Diego County has the third largest number of HIV & AIDS cases in California.

8. In 2017~~5~~, San Diego County reported 2374 cases of active tuberculosis while in 2016, 258 cases were reported. TB drug susceptibility information was available for 99% of the culture proven cases for 2017~~6~~ in San Diego. Multidrug-resistant (MDR-TB) strains were found in 3 (1.4%) of the cases. In 2015, Tri City Medical Center reported 1 case of MDR-TB. No cases were found in 2017~~6~~. In SD County for 2017~~6~~, Hispanics had the highest rates of TB at 5244%, Asian/Pacific Islanders at 3644%, non-Hispanic Whites at ~~6~~7% and non-Hispanic Blacks at ~~6~~8%.TB cases born outside of the US compromised 74% of San Diego County's cases.(Source: County of San Diego Tuberculosis Control Program 2016 Fact Sheet Date March 14~~2~~4, 2018~~7~~).
9. At TCHD, most AFB positive smears and cultures grow organisms that are not communicable person to person. In 2017~~6~~, there were ~~5~~7 patients with pulmonary TB and zero~~1~~ with extrapulmonary TB. An additional 21 cases were reported as rule out TB in 2017~~6~~. The number of active TB patients seen annually at TCHD varies from 5 –12.



10. Tri City Medical Center Financial Characteristics for Fiscal Year 201~~8~~7

a. The top six insurance coverage are as follows:

MEDICARE	23~~26.08~~%
MEDICARE SR HMO	12~~12.59~~%
MEDI-CAL HMO	19~~16.17~~%
HMO	6~~4.83~~%
Other Goverrnmental	~~67.29~~%
Medi-Cal	22~~17.52~~%

b. Patient census:

	Average. Daily Census	Average. Length of Stay*	Total Pt. Days
Acute Care (excludes all below)	124.2~~128.3~~	4023~~3.78~~	45,329~~46,828~~
ICU*	16.3~~14.6~~	2.89~~3.03~~	5,947~~5,318~~
BHU	14.1~~16.0~~	7.65~~9.25~~	5,131~~5,854~~
NICU	12.7~~13.9~~	8.89~~9.35~~	4,647~~5,084~~
Rehab Serv.	7.4~~6.7~~	14.70~~12.85~~	2,704~~2,429~~

i. *ICU ALOS includes discharges, transfers out, and expirations. All other areas are based only on discharges.

c. In acute care FY 1~~8~~7, the three largest age groups are 56-65 year olds (14~~8~~.4%), 66-75 year olds (14~~8~~.2%), and 26-35~~76-85~~ year olds (13.9~~18.7~~%).

d. Twelve~~Thirteen~~ percent (7,394/60,935~~8,290/62,555~~) of Emergency Department patients are admitted to the hospital.

11. The total number of employees working at TCHD FY 2018~~7~~ is approximately 2,68~~527~~ with about 1,74~~5615~~ (65~~61.5~~%) staff providing direct patient care. This number includes 50~~479~~ employees which were terminated at some point during FY2018~~7~~.
12. TCHD's primary focus is on basic community services. The top ten major diagnostic categories (DRGs) are the following:
    a. Obstetrics
    b. Newborns & Neonates
    c. Musculoskeletal & Connective Tissue
    d. Circulatory System
    e. Infectious & Parasitic Diseases
    f. **Nervous**~~Digestive~~ System
    g. Respiratory
    h. **Digestive**~~Nervous~~ System
    i. Mental Diseases
    j. Kidney & Urinary Tract
13. Top five Inpatient Surgical Procedures (Fiscal Year 2018~~7~~): Cesarean section (CSEC), spinal fusion (FUSN), ~~laminectomy (LAM), cholecystectomy (CHOL) and~~ knee prosthesis (KPRO), **cholecystectomy (CHOL), hip prosthesis (HPRO).**~~.~~
14. Home Care Services provides skilled, intermittent care to individuals in a home setting. The restorative, rehabilitative services are provided by Registered Nurses, Licensed Vocational Nurses, Masters of Social Work, Licensed Clinical Social Workers, Certified Home Health Aides, Physical Therapists, Occupational Therapists, Speech Therapists and/or Dietitians. For FY 2018~~6~~ in Home Care:

Average LOS	Top Payers	Top Primary DX Categories
32.1~~38.6~~ days	Medicare- 55.11~~52~~% HMO/PPO 26.83~~28~~%	-Factors influencing Status/Sup Class -Injury/Poisoning -Circulatory (not HTN, HF or CVD) -Respiratory (~~not~~ COPD)

15. General Process
    a. Infection Prevention staff will regularly review, information from internal sources (case manager, RLs) or external sources (other IC practitioners, home health/hospice, or nursing homes) and the positive microbiology reports (furnished by the clinical laboratory). The following are some of the patterns or issues that are evaluated:
        i. Clusters of infections by the same organism, in the same ward or service or infections after undergoing the same procedure.
        ii. Infections due to unusual or highly resistant/significant organisms such as MRSA, VRE, ESBL, CRE, and/or C.difficile Infection.
        iii. All cases of reportable communicable diseases as mandated by Title 17. These shall be reported in accordance with the ordinances of the County of San Diego Department of Health.
    b. Unusual or problem situations shall be brought to the Infection Control Committee for review and discussion. See Epidemiologic Investigation of a Suspected Outbreak policy.
    c. In the absence of the Infection Prevention staff, hospital staff can direct questions to Employee Health Services, ~~Director of Regulatory Compliance,~~ **or the** Medical Director of Infection Control and/or Chair of the Infection Control Committee.

H. TARGETED AND FOCUSED SURVEILLANCE FOR FY 2018~~7~~:

1. Infection control surveillance activities are systematic, active, concurrent, and require ongoing observation while meeting mandated reporting requirements. Our efforts are directed towards high risk, high volume and device/procedure associated infections. (such as urinary tract infections, selected surgical site infections, ventilator-associated events , and central line bacteremia) Goals will include limiting unprotected exposure to pathogens throughout the organization, Enhancing hand hygiene and limiting the risk of transmission of infections associated with procedures, medical equipment and supplies and medical devices.
2. Surgical Site Infections:
   a. Due to ever-decreasing lengths of stay, the majority of postoperative infections are not seen while the patient is in the hospital. Further, the increasing trend toward more outpatient surgery and shorter postoperative hospital stays limits the ability of infection control practitioners to detect infections.
   b. Surgical Site Infections that occur within 30 to 90 days (based upon the individual NHSN definitions). Surgical patients are risk stratified using the methods described in the CDC's NHSN surgical site component.
   c. Case finding methods include a review of all microbiology cultures, and ICD coding for post-operative infection. Potential cases have a chart review performed by Infection Prevention staff using the most recent NHSN definitions (Centers for Disease Control and Prevention).
   d. Infection rates are identified using the NHSN definitions and are reported to the California Department of Public Health through NHSN. In accordance with California senate bill requirements: facilities are required to report surgical site infections on 29 surgical procedures. Tri City Medical Center performs and reports on 25 of the procedures, they are listed below:

AAA	Abdominal aortic aneurysm repair	Resection of abdominal aorta with anastomosis or replacement
APPY	Appendix surgery	Operation of appendix (not incidental to another procedure)
BILI	Bile duct, liver or pancreatic surgery	Excision of bile ducts or operative procedures on the biliary tract, liver or pancreas (does not include operations only on gallbladder)
CARD	Cardiac surgery	Open chest procedures on the valves or septum of heart; does not include coronary artery bypass graft, surgery on vessels, heart transplantation, or pacemaker implantation
CBGB	Coronary artery bypass graft with both chest and donor site incisions	Chest procedure to perform direct revascularization of the heart; includes obtaining suitable vein from donor site for grafting.
CBGC	Coronary artery bypass graft with chest incision only	Chest procedure to perform direct vascularization of the heart using, for example, the internal mammary (thoracic) artery
CHOL	Gallbladder surgery	Cholecystectomy and cholecystectomy
COLO	Colon surgery	Incision, resection, or anastomosis of the large intestine; includes large-to-small and small-to-large bowel anastomosis; does not include rectal operations
CSEC	Cesarean section	Obstetrical delivery by Cesarean section
FUSN	Spinal fusion	Immobilization of spinal column
FX	Open reduction of fracture	Open reduction of fracture or dislocation of long bones that requires internal or external fixation; does not include placement of joint prosthesis
GAST	Gastric surgery	Incision or excision of stomach; includes

		subtotal or total gastrectomy; does not include vagotomy and fundoplication
HPRO	Hip prosthesis	Arthroplasty of hip
HYST	Abdominal hysterectomy	Removal of uterus through an abdominal incision
KPRO	Knee prosthesis	Arthroplasty of knee
LAM	Laminectomy	Exploration or decompression of spinal cord through excision or incision into vertebral structures
NEPH	Kidney surgery	Resection or manipulation of the kidney with or without removal of related structures
OVRY	Ovarian surgery	Operations on ovary and related structures
PACE	Pacemaker surgery	Insertion, manipulation or replacement of pacemaker
REC	Rectal surgery	Operations on rectum
SB	Small bowel surgery	Incision or resection of the small intestine; does not include small-to-large bowel anastomosis
SPLE	Spleen surgery	Resection or manipulation of spleen
THOR	Thoracic surgery	Non cardiac, nonvascular thoracic surgery; includes pneumonectomy and hiatal hernia repair or diaphragmatic hernia repair (except through abdominal approach.)
VHYS	Vaginal hysterectomy	Removal of the uterus through vaginal or perineal incision
XLAP	Abdominal surgery	Abdominal operations not involving the gastrointestinal tract or biliary system. Includes diaphragmatic hernia repair through abdominal approach.

e. GOAL#1: The combined surgical site infection rate will not be statistically significantly higher than the most recent published NHSN rates, using the standardized infection ratio (SIR).

f. GOAL#2: Each individual surgical site infection rate (that is able to be calculated) will not be statistically significantly higher than the most recent published NHSN rates, using the standardized infection ratio (SIR).

3. Antibiotic Resistant Bacteria

a. Antibiotic resistance is an ongoing concern. Multiple studies have documented increased costs and mortality due to infections caused by multidrug resistant organisms. Data will be collected using positive cultures on patients with community acquired and hospital acquired methicillin resistant Staphylococcus aureus (MRSA), Vancomycin resistant enterococci (VRE), Extended spectrum-beta-lactamase (ESBL), *and Carbapenem-resistant Enterobacteriaceae (CRE)*. MDRO and C.difficile infection risk assessment is performed annually to determine need for additional interventions, resources, and surveillance. In addition, positive blood cultures with MRSA or VRE and positive C.difficile infections are reported to CDPH through NHSN Multi-Resistant Organism & Clostridium difficile Infection Module (LabID Event Reporting).

b. GOAL#1[SP1]: The number of healthcare associated MRSA infections will remain below the Institute for Healthcare Improvement's (IHI) published rate of 3.95 hospital acquired infections per 1000 patient days for the calendar year.

$$\frac{\text{\# Patients with + MRSA and/or VRE cultures}}{\textbf{1000 patient days}\sout{\text{\# Hospital Discharges}}}$$

c. GOAL#2: The MRSA and VRE Lab ID events (Blood culture specimen) rate will not be statistically higher than the most recent NHSN published rates (using the SIR).

4. Clostridium difficile (C. difficile) surveillance is performed utilizing the Multi-Resistant Organism and Clostridium difficile Infection Module (LabID Event Reporting).
   a. All positive C. difficile results are entered into NHSN. Increases in hospital onset (HO) cases will be reviewed and action taken if they are epidemiologically associated.
   b. GOAL #1: The C. difficile hospital onset (HO) rate will not be more than expected based upon NHSN SIR Rates.
5. Ventilator Associated Event – Adult Critical Care Unit
   a. VAE is conducted on persons in the ICU who had a device to assist or control respiration continuously through a tracheostomy or by endotracheal tube within the 48 hour period before the onset of infection (inclusive of the weaning period). Current CDC/NHSN VAE definitions are followed.. The definition has three tiers: ventilator associated condition (VAC), infection related ventilator associated condition (IVAC), and possible ventilator associated pneumonia (PVAP). ~~All three tiers will be reported and each PVAP case will be reviewed.~~ **All PVAP cases will be reviewed & reported to Critical Care Committee and the Infection Control Committee.**
      i. GOAL **#1:** ~~:~~ **There will be less PVAP cases than the prior year. The number of PVAP cases will trend lower than the prior year.**
      ~~i.~~**ii. GOAL #2: The NHSN standardized utilization ratio (SUR) will be less than 1.0**~~There will be seven consecutive months without a possible ventilator associated pneumonia~~ (PVAP- Tier 3).

~~VAE cases in ICU x 1000~~
~~Total # ventilator days for the month[SP2]~~

6. Central Line Associated Bloodstream Infection (CLABSI) –
   a. Patients with a central line (defined by NHSN as a vascular access device that terminates at or close to the heart or one of the great vessels) and a primary bloodstream shall be counted. If a bloodstream infection occurs while a central line is in place or if a central line was inserted > than two calendar days before the onset of infection a chart review will be performed. Current CDC/NHSN definitions are used to determine CLABSI events.
   b. GOAL #1: Using NHSN definitions for CLABSI, the CLABSI rate for ICU patients will not be statistically higher than the NHSN standardized infection ratio (SIR).
   c. GOAL #2: Using NHSN definitions for CLABSI, the CLABSI rate for non-ICU patients will not be statistically higher than the NHSN standardized infection ratio (SIR).
7. Catheter Associated Urinary Tract Infection (CAUTI)
   a. Symptomatic urinary tract infection – Patients with positive urine cultures and indwelling foley catheters are reviewed. Current CDC/NHSN definitions are used to determine CAUTI events.

~~# of CAUTI cases x 1000~~
~~Estimation of urinary catheter days~~

   b. GOAL #1: Using NHSN definitions for catheter associated urinary tract infection (CAUTI), the CAUTI **SIR**~~rate~~ for ICU patients will not be statistically higher than the NHSN standardized infection ratio (SIR).
   c. GOAL #2: Using the NHSN definitions for CAUTI, the CAUTI **SIR**~~rate~~ for non ICU patients will not be more than expected based upon the NHSN standardized infection ratio (SIR).
8. Hand Hygiene
   a. Hand hygiene compliance rates are collected by manual observation performed by unit staff on a monthly basis. The Hand Hygiene compliance rates are reported to the

Managers, Directors, Regulatory Compliance Committee, and the Infection Control Committee. Tri City Medical Center follows the World Health Organization's 5 Moments model for hand hygiene.

~~b. GOAL #1: Hand hygiene observations are performed in every patient care area at least once a month.~~

~~c.~~**b.** GOAL #~~1~~2: Overall hand hygiene compliance rate will be at least 90% per quarter.

9. Environmental and Patient Care Rounds
   a. Environment of Care rounds are performed monthly and overseen by the Environmental Health & Safety (EHSC) Committee. These rounds will identify risks associated with, but not limited to, medical equipment and supplies. In addition, tracers are performed monthly on a schedule throughout the patient care areas.
   b. GOAL #1: Infection Control assessments will be represented **100**~~90~~% of the time during scheduled environmental rounds.
   c. GOAL #2 Infection Control assessments will be represented **100**~~90~~% of the time during scheduled tracers.
   d. GOAL #3: Engineering staff in collaboration with Infection Control will complete an Infection Control Construction Permit 100% of the time for projects that require a Class III or higher containment.
10. Reportable Diseases
   a. Assisted by the Microbiology Laboratory and Emergency Department, required reporting to Public Health is performed by phone, fax or mail using the California Confidential Morbidity Report or other special form as directed by the County of San Diego Department of Health. Case finding is done through review of microbiology reports and calls from hospital staff (including physicians).
   b. GOAL: Required reportable disease will be sent to the local health department within the required time frame 100% of the time.
11. Employee Health collects and reports the following:
   a. GOAL#1: There will be 10% less needle stick injuries from the previous calendar year
      i. Number of needle sticks injuries and details of department involved, device, and cause.
   b. GOAL#2: 100% of employees will complete the annual tuberculosis screen
      i. # Staff completing annual TB screening (PPD, blood test or survey)/ # **e**~~E~~mployees in whom compliance is required.
   c. GOAL #3: Greater than 90% of Tri City Medical Center staff (per NHSN definition) will receive influenza vaccine.
      i. # Employees and who received influenza vaccine/# employees who worked at least one day during the flu season.
   d. GOAL #4: Greater than 90% of Tri City Medical Center inpatient Acute Rehab unit ~~and Behavioral Health Services~~ staff (per NHSN definition) will receive influenza vaccine.
12. Home Care, collects and reports the following:
   a. GOAL #1: CAUTI and CLABSI rates will be monitored and reported to the Infection Control Committee quarterly.
   b. GOAL #2: There will be less than two CAUTI infections in the calendar year.
      i. **# UTI cases**~~Cases UTIs~~ with foley catheter/Total # device days.
   c. GOAL #3: There will be no infections related to central lines in the calendar year.~~).~~
      i. **# BSI cases**~~Cases BSI~~ with Central Line/Total # device days.

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

1. Infection Control Policy: Philosophy
2. Infection Control Policy: Epidemiologic Investigation of a Suspected Outbreak
~~2.~~3. **Infection Control Risk Assessment 2019**

J. **REFERENCE(S):**

1. County of San Diego Public Health & Human Services Agency, ~~(June 2015)~~ Public Health Services. Retrieved from http://www.sandiegocounty.gov/hhsa/programs/phs/
2. Centers for Disease Control and Preventions, National Healthcare Safety Network (NHSN) Tracking Infection in Acute Care Hospitals/Facilities. (2017) http://www.cdc.gov/nhsn/acute-care-hospital/index.html
3. County of San Diego Tuberculosis Control and Refugee Health Program.) TB Statistics-Fact Sheet 2016 (March 2017). Retrieved from http://www.sandiegocounty.gov/hhsa/programs/phs/tuberculosis_control_program/
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
5. The City of San Diego (2017~~5~~), Economic development: Population **https://www.sandiego.gov/economic-development/sandiego/facts**
6. **https://datausa.io/profile/geo/san-diego-county-ca/**
~~5.~~

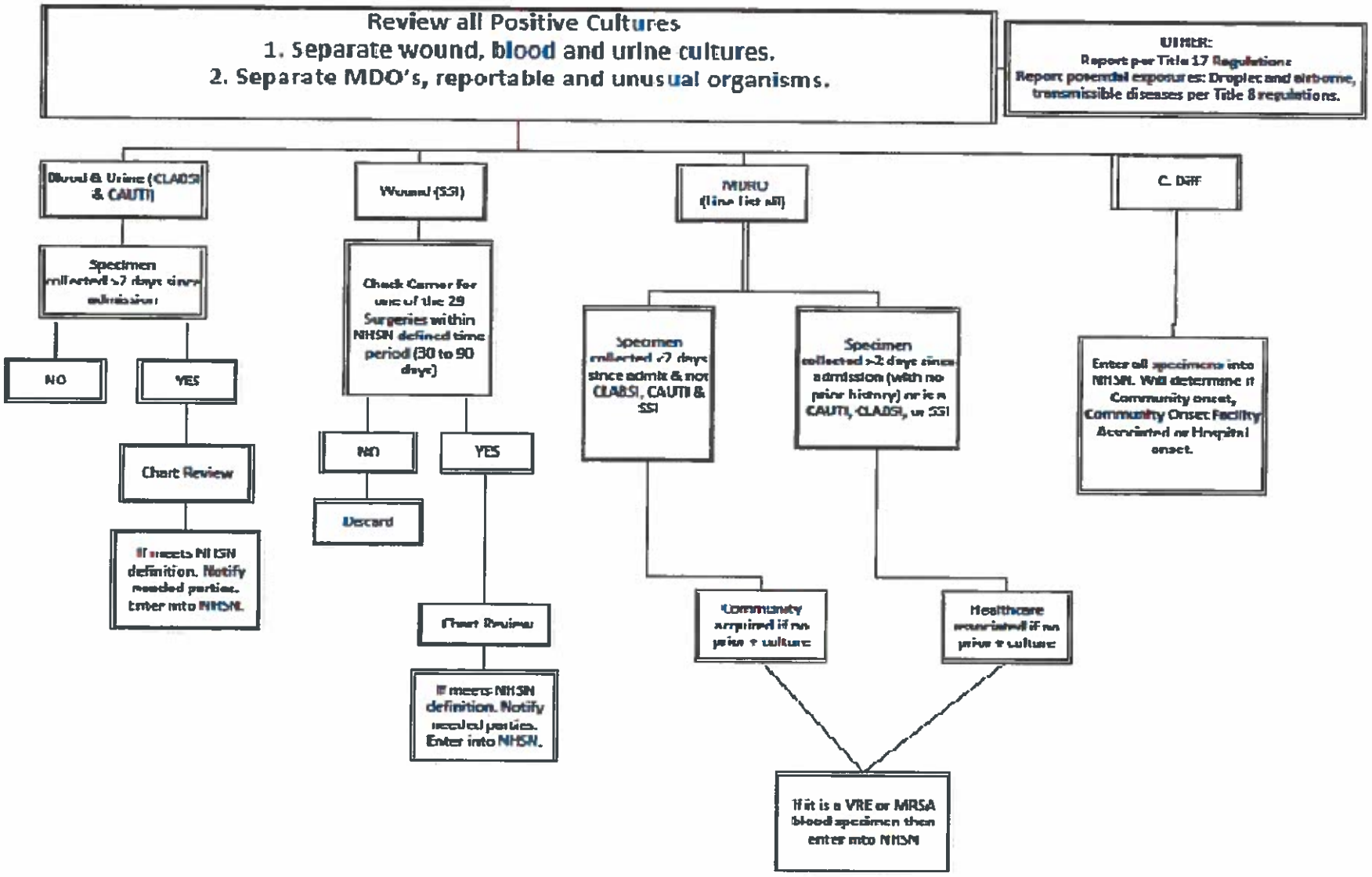
INFECTION CONTROL PROGRAM TIMELINE FY 20187

Infection Control Committee	Meet			Meet			Meet			Meet		
Targeted Surveillance	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
SSI	*			*			*			*		
Multi-antibiotic Resistant Organisms • VRE • MRSA • ESBL • CRE	*			*			*			*		
CLABSI	*			*			*			*		
CAUTI	*			*			*			*		
VAE in ICU	*			*			*			*		
Home Health report of CAUTI, and CLABSI ,ST Infections &SSI rates	*			*			*			*		
Outbreak Investigation and Disease Reporting	*	*	*	*	*	*	*	*	*	*	*	*
OSHA Compliance												
• Tuberculosis Exposure Control Plan Review				*								
• Bloodborne Pathogen Exposure Control Plan Review	*											
Employee Health												
• TB Screening (PPD or questions)	*											
• N95 Fit-testing	*											
• Sharps & BBP Exposures	*			*			*			*		
• Infectious Diseases Exposures	*			*			*			*		
• Influenza Campaign				Begin			*			*		
Environment of Care												
• Infection control staff review of current construction projects	*	*	*	*	*	*	*	*	*	*	*	*
• Sterile Processing Department Report	*			*			*			*		
• Pharmacy Report on Biologicals and findings	*						*					
• Environment of Care Officer, Patient Safety Officer and/or Engineering report	*			*			*			*		
Surveillance Plan												
• Managers or Directors Meetings (Education & Planning)	*	*	*	*	*	*	*	*	*	*	*	
• Input (Education & Planning)												

• Present Risk Assessment and Surveillance Plan to ICC							*					
• ICC Approval of Plan							*					
Performance Improvement Projects												
• Reducing Surgical Site Infections: COLO	*	*	*	*	*	*	*	*	*	**	*	*
• Hand Hygiene Compliance	*	*	*	*	*	*	*	*	*	*	*	*
• Reducing CLABSIsCLABSI's & CAUTI's	*	*	*	*	*	*	*	*	*	*	*	*
• Reducing CDiff	*	*	*	*	*	*	*	*	*	*	*	*
Education												
• New Employees	*	*	*	*	*	*	*	*	*	*	*	*
• Unit Based or Topic Specific (As requested) Performed through Quest, during rounds, presentations, power minute.	*		Not Learning	*	*	*	*	*	*		*	*

*Presented to IC

DELETE


Review all Positive Cultures
1. Separate wound, blood and urine cultures.
2. Separate MDO's, reportable and unusual organisms.
OTHER:
Report per Title 17 Regulations
Report potential exposures: Droplet and airborne, transmissible diseases per Title 8 regulations.
Blood & Urine (CLABSI & CAUTI)
Wound (SSI)
MDRO (line list all)
C. Diff
Specimen collected >7 days since admission
NO
YES
Chart Review
If meets NHSN definition. Notify needed parties. Enter into NHSN.
Check Cerner for use of the 29 Surgeries within NHSN defined time period (30 to 90 days)
NO
YES
Discard
Chart Review
If meets NHSN definition. Notify needed parties. Enter into NHSN.
Specimen collected >7 days since admit & not CLABSI, CAUTI & SSI
Specimen collected >2 days since admission (with no prior history) or is a CAUTI, CLABSI, or SSI
Enter all specimens into NHSN. Will determine if Community onset, Community Onset Facility Associated or Hospital onset.
Community acquired if no prior + culture
Healthcare associated if no prior + culture
If it is a VRE or MRSA blood specimen then enter into NHSN

Infection Control Risk Assessment: 2019

Potential Risks/Problems	Probability					Risk/Impact (Health, Financial, Legal, Regulatory)					Current Systems/Preparedness					Score
	Expected	Likely	Maybe	Rare	Never	Catastrophic Loss (life/limb/ function/ financial)	Serious Loss (Function/ Financial/	Prolonged Length of Stay	Moderate Clinical/ Financial	Minimal Clinical/ Financial	None	Poor	Fair	Good	Solid	≥ 10 Hi 7-9 Med ≤ 6 Lo
	4	3	2	1	0	5	4	3	2	1	5	4	3	2	1	
Multi-Drug Resistant Organisms (MDRO)																
MRSA		X							X					X		7
C Diff			X						X					X		6
CRE				X					X					X		5
VRE				X					X					X		5
ESBL/other Gram Negative bacteria				X					X					X		5
Prevention Activities																
Lack of Hand Hygiene Compliance			X						X					X		6
Lack of Respiratory Hygiene/ Cough Etiquette				X					X					X		5
Lack of Patient Influenza Immunization			X					X							X	6
Lack of LIPs Influenza Immunization			X					X						X		7
Isolation Activities																
Lack of Adherence to Standard Precautions			X						X					X		6
Delayed Identification of airborne transmissible diseases			X						X					X		6
Policy and Procedure																
Failure to follow established policy or procedure- TB discharge approval				X					X					X		5
Emergency preparedness																
Ebola Preparedness				X			X							X		7
Influx of Infectious Patients				X					X					X		5
Pandemic Influenza				X					X					X		5

Potential Risks/Problems	Probability					Risk/Impact (Health, Financial, Legal, Regulatory)					Current Systems/Preparedness					Score
	Expected	Likely	Maybe	Rare	Never	Catastrophic Loss (life/limb/ function/ financial)	Serious Loss (Function/ Financial/ Legal)	Prolonged Length of Stay	Moderate Clinical/ Financial	Minimal Clinical/ Financial	None	Poor	Fair	Good	Solid	≥ 10 Hi 7-9 Med ≤ 6 Lo
	4	3	2	1	0	5	4	3	2	1	5	4	3	2	1	
Healthcare Associated Infections (HAI)																
Central Line Associated Blood Stream Infections				X			X							X		7
Catheter Associated Urinary Tract Infections				X					X					X		5
Surgical Site Infections				X			X							X		7
Ventilator Associated Event (PVAP) in ICU				X			X							X		7
Lice and Scabies				X						X					X	3
Norovirus				X					X					X		5
Influenza				X					X					X		5
Bloodborne Pathogens				X					X					X		5
Environment																
Legionella Disease				X			X							X		7
Air Handling				X					X				X			6
Cleaning/ Disinfection			X						X					X		6
Monitoring Negative Air Pressure Rooms				X					X					X		5
Lack of Negative Pressure Rooms				X					X					X		5
Infection Related to Construction/ Renovation				X			X							X		7
Employee Health																
Lack of Staff Influenza Immunization			X						X					X		6
Lack of Staff Immunization, other			X						X					X		6
New hire health screen				X						X					X	3
Exposure to Bloodborne Pathogens			X				X							X		8
Exposure to infectious disease			X						X					X		6
Annual TB screening of staff			X						X						X	5
Pertussis				X					X					X		5
Lack of LIP Screening			X							X				X		5
Other																
Risk of Community Outbreak				X					X					X		5

The Infection Control (IC) Risk assessment grid is a visual tool to develop IC program priorities and stratify infection risks based on our geography, location in the community, our patient population and the review of our previous IC data analysis. The annual IC Plan is developed based on these risks.

The IC Risk assessment is an ongoing, continual process. A more focused review is done on an annual basis after reviewing the quarterly and annual reports with the Infection Control committee.

Risk Assessment Completed on: Jan. 2018

ID MD, ICC Chair	IP	EH	RN	MD	Quality	Lab	Administration
Pharmacy	EOC	OR	Housekeeping	Engineering		PSO	

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER
~~**PATIENT CARE SERVICES POLICY MANUAL**~~
~~**Women's Diagnostic Center**~~

ISSUE DATE: **SUBJECT:** **Diagnostic Mammography**

REVISION DATE(S):

Mammography Department Approval:	**10/17**
Department of Radiology Approval:	**~~06/18~~0/~~18~~02/19**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/18~~02/19**
Administration Approval:	**03/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/11**

A. **AUTHORIZED TO PERFORM:**
1. Licensed Radiologic Technologist possessing certification from the **American Registry of Radiology Technologists** (~~A.R.R.T.~~) and California **Certified Radiologic Technologist** (~~C.R.T.~~) in Mammography. Must have performed 200 mammograms in a 24-month period as per **Mammography Quality Standard Act** (~~M.Q.S.A~~) regulations.

B. **PURPOSE :**
1. To provide consistent guidelines for diagnostic mammograms on patients who have signs and/or symptoms of breast disease, or radiographic finding of cancer.

C. **POLICY:**
1. To be done on persons with a palpable lump previous breast bx (within 5 years if benign) or any abnormality in the breasts or per physicians request.
   a. Specific focus of clinical concerns including, but not limited to, mass, induration, axillary lymphadenopathy, some types of nipple discharge, skin changes, or persistent or focal areas of pain or tenderness.
   b. Possible radiographic abnormalities detected on Screening Mammography.
   c. Short, interval follow-up (e.g., less than one year) for clinical or radiographic concerns.
   d. Patients whose examination requires direct involvement of the Radiologist for special views, breast physical examination, or consultation.
   e. Women who have implants as dictated to **the facilty~~us~~** by the American College of Radiology (~~A.C.R.~~).
   f. Women who have been treated for breast cancer (either with breast conservation or mastectomy), one year post-surgery.

D. **PROCEDURE:**
1. Views to be done are:
   a. Craniocaudal views (cc)
   b. Mediolateral Oblique views (mlo)
   c. Mediolateral views (ml)
2. Identify on patient history sheet, any information regarding the problem patient is having and draw any surgical scars seen on the breast.
3. Show films to Radiologist prior to patient departure when at all possible.

E. **EXTERNAL LINK(S):**

1. Mammography Quality Standards Act (MQSA) of 1998 https://www.fda.gov/downloads/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/UCM110849.pdf

F. REFERENCE(S):

1. Mammography Quality Standards Reauthorization Act, Pub. L., Title XLII § 263b. (1998).
~~3.~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE: 03/06	**SUBJECT:** Appropriate Use of Commercial Support and Exhibits
REVISION DATE(S): 05/08, 11/12, 12/15	**POLICY NUMBER:** 8710-603

Medical Staff Department Approval:	03/17, 01/19
CME Committee Approval:	04/08, 10/12, 10/15, 01/18, 01/19
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	05/08, 11/12, 11/15, 05/18, 02/19
Administration Approval:	03/19
Professional Affairs Committee Approval:	06/18, n/a
Board of Directors Approval:	05/08, 11/12, 12/15, 06/18

A. PURPOSE:

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

B. DEFINITION(S):

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

C. POLICY:

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

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

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

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

i. Written Agreement documenting terms of support

1) TCHD and the commercial supporter will have a written agreement indicating the terms, conditions, and purposes of the commercial support for all directly and jointly sponsored activities.

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

3) The Letter of Agreement must be signed by TCHD (accredited provider) and commercial supporter.

ii. Expenditures for an individual providing CME

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

2) TCHD CME Committee/designee is responsible for payment of honoraria and expense reimbursement in compliance with policy governing such.

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

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

iii. Expenditures for learners

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

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

iv. Accountability

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

5. Standard 4: Appropriate Management of Associated Commercial Promotion

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

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

c. Educational materials such as slides, abstracts and handouts cannot contain any advertising, trade name or product message.

d. The program book which contains non-CME elements that are not directly related to the transfer of education may include product promotion material or product specific advertisement.

e. Commercial interests cannot provide a CME activity to learners either by distribution of self-study activities or arranging for electronic access to CME activities. The commercial supporter may distribute promotional materials developed by the provider.
f. CME Exhibits are not considered "Commercial Support;" however, the ACCME Standards of Commercial Support apply with regard to the location of the exhibits.
   i. Exhibitors may not display exhibits in the same room as the CME activity or in the direct path of the activity.
   ii. Exhibitors may not promote products or services directly prior to, during, or immediately following the CME activity in the same lecture hall.
   iii. Exhibitors/vendors are required to complete a "CME Exhibit Request Form." Prior approval from the CME Committee/designee is required for vendors to exhibit during a TCHD sponsored CME activity.
   iv. Reasonable exhibit fees shall be assessed to exhibitors in an amount to be determined by the CME Committee, but shall not be less than $500, and are due and payable to "TCHD Medical Staff Treasury" prior to the activity.

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

D. RELATED DOCUMENT(S):

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

E. REFERENCE(S):

1. Accreditation Council for Continuing Medical Education (ACCME) Standards for Commercial Support
2. *Institute for Medical Quality (IMQ)/California Medical Association (CMA) 2017 CME Accreditation Standards Manual/ Essential areas and their Elements/ Accreditation Criteria*
   a. Element 3.3: The provider must present CME activities in compliance with the ACCME's policies for disclosure and commercial support

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE: 10/05	**SUBJECT:** CME Speaker & Honoraria Reimbursement
REVISION DATE(S): 05/09, 11/12, 12/15	**POLICY NUMBER:** 8710-604
Medical Staff Department Approval:	03/17, 01/19
CME Committee Approval:	04/09, 10/12, 10/15, 01/18, 01/19
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	05/09, 11/12, 11/15, 05/18, 02/19
Administration Approval:	03/19
Professional Affairs Committee Approval:	06/18, n/a
Board of Directors Approval:	05/09, 11/12, 12/15, 06/18

A. **PURPOSE:**

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

B. **POLICY:**

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

C. **PROCEDURE:**

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

D. **REFERENCE:**

1. ACCME Standards of Commercial Support – Standard 3.7

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE: 05/08	**SUBJECT: Conflict of Interest Resolution**
REVISION/~~REVIEW~~ DATE(S): 05/08, 11/12, 08/14	**POLICY NUMBER: 8710-605**
Medical Staff Department Approval:	**03/17, 01/19**
CME Committee Approval:	**04/08, 10/12, 08/14, 01/18, 01/19**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**05/08, 11/12, 08/14, 05/18, 02/19**
Administration Approval:	**03/19**
Professional Affairs Committee Approval:	**06/18, n/a**
Board of Directors Approval:	**05/08, 11/12, 08/14, 06/18**

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

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

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

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

ii. Content Validation Form

2. Ask participants if commercial bias was observed in the speaker/author's presentation.
3. If commercial bias is determined, appropriate action shall be taken by the CME Committee/designee to rectify future CME activities and reduce the potential for commercial bias in these activities.

E. **FORM(S)**:
1. Faculty Disclosure **Form** & Resolution Declaration ~~Form;~~
~~1.~~**2.** Content Validation Form

F. **REFERENCE(S):**
1. ACCME Standards of Commercial Support

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 12/~~20~~12

SUBJECT: CPOE Power Plan Revisions/Additions

REVISION DATE(S):

POLICY NUMBER: 8710-568

~~**Approvals:**~~

Medical Staff Department Approval:	02/19
Physician Information Technology Committee Approval:	~~04/15~~02/19
Pharmacy & Therapeutics Committee:	n/a
Medical Executive Committee Approval:	~~04/15,~~ 02/19
Administration Approval:	03/19
Professional Affairs Committee Approval~~Governance and Legislative Committee~~:	~~05/15~~ n/a
Board of Directors Approval:	05/15

A. **PURPOSE:**
1. To provide a process for revising existing CPOE Power Plans or implementing new ones.

B. **DEFINITIONS:**
1. CPOE – Computerized Physician (or Provider) Order Entry
2. Power Plan – A grouping of orders that can be implemented together to facilitate the ordering process

C. **POLICY:**
1. All Power Plans must be created in the approved format and must be approved as prescribed in the procedure below.

D. **PROCEDURE:**
1. Physicians may customize existing Power Plans that have been moved to their personal folder.
2. Requests for revisions (by physician, pharmacy, or nursing) to an existing Power Plan or a new Power Plan shall be submitted ~~to IT~~ **Division/Department meeting for approval**. Requests must be in writing and must provide the exact language to be included in the Power Plan. **Once approved by department/division a Request for Assistance (RFA) will be placed by Physician Engagement Specialist. A Physician Champion will be assigned.**
3. Revisions will be built in the Cert domain for ~~testing~~ **validation** by all disciplines that are affected and will be signed off by ~~Medical Staff Department/Division~~ **Physician Champion** representative(s) prior to building the changes in the production domain.
4. **Final** Revisions will be reviewed and approved by **Physician Information Technology Committee (PITC)** ~~by the appropriate physician~~
5. The new/revised Power Plan/orders will be implemented and appropriate staff educated as needed.
6. PITC will ~~forward the~~ list ~~of~~ all new or revised Power Plans/orders in **minutes and sent** to Medical Executive Committee as an informational item on their agenda.
7. All medical power plans must be reviewed and approved every three years.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE: 10/05	**SUBJECT:** Educational Planning, Needs Assessment, Objectives and Evaluation of a Continuing Medical Education (CME) Activity
REVISION DATE(S): 05/09, 08/12, 12/15	**POLICY NUMBER:** 8710-600

Medical Staff Department Approval:	03/17, 01/19
CME Committee Approval:	04/09, 07/12, 10/15, 01/18, 01/19
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	05/09, 08/12, 11/15, 05/18, 02/19
Administration Approval:	03/19
Professional Affairs Committee Approval:	06/18, n/a
Board of Directors Approval:	05/09, 08/12, 12/15, 06/18

A. PURPOSE:

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

B. DEFINITION(S):

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

C. EDUCATIONAL PLANNING – NEEDS ASSESSMENT

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

D. EDUCATIONAL PLANNING - OBJECTIVES

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

E. EVALUATION & IMPROVEMENT

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

F. PROCEDURE

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

d. Acknowledgement of educational grants or other financial contributions (if known at the time of the publication)

7. Relevant Financial Relationships (Conflicts of Interest) – Disclosure of relevant financial relationships will be provided at every CME activity. See Commercial Support and Disclosure of Interest policy.
8. Evaluations/Sign-In Sheets – An activity evaluation form and a sign-in sheet shall be provided at every CME activity where AMA PRA Category I Credit™ is awarded.
9. Faculty - The CME Coordinator shall summarize the evaluations and provide a copy of the evaluation summary, a letter of appreciation and honorarium (if applicable) to the speaker within four weeks of activity closure.
10. Learners – The CME Coordinator may send a follow-up e-mail to the learners six (6) weeks following the activity.
11. CME Committee – The CME Coordinator shall provide the CME Committee with a summary of evaluations.
12. CME Credit - The CME Coordinator shall provide TCHD Medical Staff members a copy of their CME records upon request.
13. Record Maintenance - CME records shall be maintained for a minimum of six (6) years.

G. REFERENCE(S):

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

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE: 10/05

SUBJECT: Joint Providership/Co-Providership

REVISION DATE(S): 05/09, 08/12, 09/14

POLICY NUMBER: 8710-602

Medical Staff Department Approval:	07/18, 01/19
CME Committee Approval:	04/09, 07/12, 08/14, 07/18, 01/19
Pharmacy & Therapeutics Committee:	n/a
Medical Executive Committee Approval:	05/09, 08/12, 09/14, 08/18, 02/19
Administration Approval:	08/18, 03/19
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/09, 08/12, 09/14, 08/18

A. **PURPOSE:**
1. To outline criteria utilized for Joint Providership or Co-Providership of a CME activity.

B. **DEFINITION(S):**
1. Joint Providership– A relationship between an accredited CME provider and a non-accredited provider in which the accredited provider works in partnership with the non-accredited provider to plan and present CME activities in accordance with the mission of the accredited provider.
2. Co-Providership– A relationship between two accredited CME providers to plan and present CME activities.

C. **POLICY:**
1. The non-accredited organization should have as its primary interest the dissemination of health care information or the findings of medical research.
2. The non-accredited organization agrees to follow all procedures outlined by Tri-City Medical Staff and contained in the CME Policy Manual.
3. The Course Director should be a physician with an affiliation in the non-accredited organization.
4. The program planning request should be received at least six (6) months before the scheduled date of the activity. Timing for the activity should not conflict with other CME activities sponsored by Tri-City Medical Center.
5. Tri-City Medical Center CME planning forms are to be completed and submitted as part of the course file.
6. All promotional material shall follow Tri-City Medical Center's CME policies and be submitted for approval to the CME Coordinator before being distributed. Appropriate accreditation statements will be used and all materials must indicate joint sponsorship with Tri-City Medical Center CME as the accredited sponsor.
7. A course coordinator should be designated by the non-accredited organization to manage the administrative details.
8. All potential joint/co-providership relationships will be examined on their individual merits. Although all CME activities joint/co-providership with Tri-City Medical Center CME must comply with this policy, Tri-City Medical Center CME reserves the right to refuse to enter into a joint/co-providership agreement for any reason whatsoever, regardless of that organization's willingness to comply with this policy.
9. The responsibilities and role of the joint/co-provider will be clearly delineated in a letter of agreement between the joint/co-provider and Tri-city Medical Center CME. Tri-City Medical Center CME has the right to withdraw from any activity if the joint/co-provider fails to meet its

obligations as described in the letter of agreement or fails to comply with Tri-City Medical Center CME policies and procedures.

10. Tri-City Medical Center CME will charge fees for its services. These fees and the terms for its payment will be mutually agreed upon and delineated in the aforementioned letter of agreement between Tri-City Medical Center CME and the joint/co-provider.
11. All commercial support for Joint/co-provider activities shall be obtained as unrestricted grants, and all aspects of commercial support should be disclosed prior to approval of the activity. The CME Coordinator acting in behalf of the CME Committee will administer commercial support.
12. Joint provider activities shall be consistent with Tri-City Medical Center's CME Mission Statement.
13. Tri-City Medical Center, through its CME Committee, shall participate in the planning and implementation of these activities. A representative from the non-accredited entity should attend the CME Committee meeting to discuss progress.
14. All activity expenses are the responsibility of the organization seeking joint providership. Evidence of a proposed neutral budget is to be completed before expenses are incurred. Tri-City Medical Center will withdraw from an activity if resources are inadequate for the development of a high quality educational product or activity.
15. Attendance information should be submitted to the CME Coordinator within two (2) weeks of the activity in order to provide timely distribution of CME certificates.
16. The proposed CME activity Cannot be advertised prior to CME Committee approval and the designation of CME credit.

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

1. Written Agreement for Joint Providership—~~Sample~~

~~**Written Agreement for Joint Providership - Sample**~~

Tri-City Medical Center
Written Agreement for Joint Providership

Remove form sample from policy

Program Title: _____
Program Date: _____
Program Representative(s): _____

Tri-City Medical Center and **[INSERT NAME]** agree to enter into a joint providership arrangement, the terms and conditions of which are to plan and implement the above referenced CME activity. This agreement is effective until such time as all responsibilities outlined herein are fulfilled.

As part of the Joint Providership Agreement, Tri-City Medical Center and **[INSERT NAME]** agree to the terms and conditions described below.

Role of the Accredited Provider
As the accredited provider of the CME activity, Tri-City Medical Center will take all actions necessary to ensure compliance with the Essentials for Accreditation and Standards for Commercial Support of Continuing Medical Education. Any action not explicitly stated here, but deemed necessary by Tri-City Medical Center to comply with these requirements, will be implemented.

Role of the Non-Accredited Provider
As the non-accredited joint provider of the CME Activity, [INSERT NAME] will abide by all policies and procedures set forth by the Accredited Provider including the ACCME Standards of Commercial Support with regard to product promotion and location of exhibits.

Educational Program Development
a) Tri-City Medical Center is responsible for ensuring that the content, quality, and scientific integrity of the CME activity are compliant with currently adopted standards for continuing medical education.
b) All planning sessions must be documented by the organization and all such information forwarded to Tri-City Medical Center upon completion of the program.
c) Learning objectives must be developed for each presentation and must be printed on all promotional brochures.

Tri-City Medical Center assumes responsibility for:
a) Verifying the needs assessment approving the program content, objectives, and proposed faculty in consultation with the organization (or joint provider)
b) Reviewing site selection
c) Overseeing development of brochures and promotional materials
d) Awarding appropriate CME credits
e) Maintaining records

Program budget and funds administration must be approved by Tri-City Medical Center.

Tri-City Medical Center will provide the necessary materials for obtaining:
a) Speaker disclosure
b) Learning objectives
c) Speaker A/V requirements
d) Program evaluation

Promotional Materials
a) The content of all brochures and promotional materials must be reviewed and approved by Tri-City Medical Center. Tri-City Medical Center must be listed on all materials as the joint provider. No materials pertaining to the CME activity will be distributed without the review of all parties and the consent of Tri-City Medical Center.
b) All continuing medical education program announcements must include the following language:
*This activity has been planned and implemented in accordance with the Institute for Medical Quality and the California Medical Association's CME Accreditation Standards (IMQ/CMA) through the Joint Providership of Tri-City Medical Center and [INSERT NAME]. Tri-City Medical Center is accredited by IMQ/CMA to provide continuing medical education for physicians. Tri-City Medical Center designates this educational activity for a maximum of **[NUMBER]** hour in AMA PRA Category 1 Credit™ toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.*

Tri-City Medical Center
Written Agreement for Joint Providership

Remove form sample from policy

c) No statement of credit can be printed in the materials or promotional mailings without notification from Tri-City Medical Center that credit has been awarded. Do not state "CME credit applied for" or similar wording.

Educational Program Evaluation
All educational activities must be formally evaluated. Tri-City Medical Center will provide a sample evaluation instrument. An evaluation summary, prepared by the joint provider, will be forwarded to Tri-City Medical Center CME committee for its review within two weeks of the activity.

Disclosure of Financial Interests and Off Label Uses
Tri-City Medical Center requires the financial disclosure of any significant financial interest or other relationship that a faculty member has with the manufacturers of any commercial product(s) discussed in the educational presentation. All faculty members are required to comply and will not be able to participate in the educational activity unless they do so. Faculty members are also required to disclose if the product being addressed is not labeled for the use under discussion. Compliance that this disclosure has taken place must be documented. ***This information must be disseminated to all program participants.***

Financial Management
Non-accredited organization **[INSERT NAME]** will be responsible for all costs associated with the planning, development and presentation of the program, including but not limited to advertising, speaker fees, speaker handouts and catering costs.

Agreed by Authorized Representatives

Signature / Date	Signature / Date
Print Name	Print Name
Title	Title

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 10/08 **SUBJECT:** Medical Staff Standards of Conduct

REVISION DATE(S): 02/09, 02/19 **POLICY NUMBER:** 8710 – 552

Medical Staff Department Approval:	03/17
~~Medical Division~~Professional Behavior Committee Approval:	~~10/08~~02/19
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~10/08,~~ 02/19
Administration Approval:	03/19
Professional Affairs Committee:	n/a
Board of Directors Approval:	10/08

A. **PURPOSE** Members of the Medical Staff are expected to adhere to the Medical Staff Standards of Conduct including, but not limited to, the following:

B. **GENERAL CONSIDERATIONS:**

1. It is the policy of the Medical Staff to require members **to** fulfill their Medical Staff obligations in a manner within generally accepted bounds of professional interaction and behavior. The Medical Staff is committed to supporting a culture and environment that values integrity, honesty, and fair dealing with each other, and to promoting a caring environment for patients, practitioners, employees, and visitors.
2. Rude, combative, obstreperous, **or dangerous** behavior, as well as willful refusal to communicate or comply with reasonable rules of the Medical Staff and Tri-City Medical Center may be found to be disruptive behavior. It is specifically recognized that patient care and hospital operations can be adversely affected whenever any of the ~~forgoing~~**foregoing** occurs with respect to interactions at any level at Tri-City Medical Center, in that all personnel play an important part in the ultimate mission of delivering quality patient care **in a safe manner**.
3. In assessing whether particular circumstances in fact are affecting quality patient care or hospital operations, the assessment need not be limited to **the** care of specific patients, or to direct impact on patient health. Rather, it is understood that quality patient care embraces, in addition to medical outcome, matters such as timeliness of services, appropriateness of services, timely and thorough communications with patients, their families, and general patient satisfaction with the services rendered and the individuals involved in rendering those services.

C. **CONDUCT GUIDELINES:**

1. Upon receiving Medical Staff membership and privileges at Tri-City Medical Center, the member enters a common goal with all members of the organized Medical Staff to endeavor to maintain the quality of patient care and appropriate professional conduct.
2. Members of the Medical Staff are expected to behave in a **civil and** professional manner at all times and with all people, patients, ~~professional~~ peers, Tri-City Medical Center staff, visitors, and others in affiliation with Tri-City Medical Center.
3. Interactions with all persons shall be conducted with courtesy, respect, civility, and dignity. Members of the Medical Staff shall be cooperative and respectful in their dealings with other persons in ~~and~~ **or** affiliated with Tri-City Medical Center.
4. Complaints and disagreements shall be aired constructively, in a non-demeaning manner, and through official Medical Staff channels.
5. Cooperation and adherence to the reasonable policies of Tri-City Medical Center and the Medical Staff **are**~~is~~ required.

6. Members of the Medical Staff shall not engage in conduct that is offensive or disruptive, whether it is written, oral or behavioral.

D. **DISCIPLINARY PROCEEDINGS FOR FAILURE TO COMPLY:**

1. Any ~~Quality Review Report (QRR)~~**report** received due to failures to comply as outlined in Sections C will be referred to the respective Department Chair/Division Chief **and/or the Chair of the Professional Behavior Committee** for review and consideration. If required the Medical Executive Committee (MEC) may promulgate to the Professional Behavior Committee for the purpose of investigating and addressing the perceived misconduct, and providing progressive remedial measures, including, when necessary referring the matter to MEC pursuant to Article IV, §6.~~1-4~~ to initiate an investigation.

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

1. **Behavior Code of Conduct Report - Sample**

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

1. Medical Staff Bylaws ~~September 2008~~
2. Sentinel Event Alert # 40 Joint Commission
3. California Hospital Association (CHA) ~~2008~~ Rules

Sample

BEHAVIOR CODE OF CONDUCT REPORT

Name of Facility:_____

Date:_____ Time of Event:_____

Name of person completing the form:_____

1. What led to the conduct you are reporting?_____

2. Check the type of conduct:
   - ☐ Physical, sexual, or verbal harassment
   - ☐ Shouting or yelling
   - ☐ Hostile, sarcastic, or demeaning
   - ☐ Non-constructive expression of personal opinions
   - ☐ Non-constructive criticism
   - ☐ Failing to communicate necessary information
   - ☐ Excessive expression of personal opinions
   - ☐ Inappropriate comments or illustrations in the patient's medical record
   - ☐ Swearing or cursing
   - ☐ Slamming or throwing objects
   - ☐ Racial or sexist remarks or gestures
   - ☐ Public criticism of performance
   - ☐ Lack of intelligible communication
   - ☐ Abruptly hanging up the phone
   - ☐ Retaliation
   - ☐ Other:_____

3. Please describe what happened?_____

4. List names of patients, employees, medical staff members, visitors, or others involved:_____

5. List everyone who saw the event:_____

6. How do you think this conduct affected patient care, hospital operations, your work, or your team members' work?_____

7. What did you or others first do to address this conduct?_____

8. Did you or others take any other follow-up action?_____

Information documented will kept as confidential as possible. Forward completed forms to _____
He or she may contact you for more information.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE: 04/09	**SUBJECT: Regularly Scheduled Series (RSS)**
REVISION DATE(S): 12/09, 11/12, 09/14	**POLICY NUMBER: 8710-606**
Medical Staff Department Approval:	**07/18, 01/19**
CME Committee Approval:	**10/09, 10/12, 08/14, 07/18, 01/19**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**11/09, 11/12, 09/14, 08/18, 02/19**
Administration Approval:	**08/18, 03/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/09, 11/12, 09/14, 08/18**

A. **PURPOSE:**
1. To outline criteria and process for approving and evaluating outcomes for Regularly Scheduled Series (RSS).

B. **DEFINITION(S)**: A regularly scheduled Series (RSS) is planned to have:
1. A series with multiple sessions
2. The series occurs on an ongoing basis (offered weekly, monthly, or quarterly)
3. The series is planned by and presented to the accredited organization's professional staff
4. The series are only offered as directly-sponsored activities to the accredited organization's professional staff

C. **POLICY:**
1. RSS conferences such as cancer conferences and cardiovascular conferences are approved on the basis of common needs and goals for each session for a one-year period.
2. Initial RSS Request: Required documentation to be provided to the CME Committee at least 60 days before the first session is scheduled:
   a. Request for AMA PRA Category 1 Credit(s)™
   b. Planner and Faculty disclosure forms
3. Continuing RSS: For regularly scheduled series conferences currently taking place with Category 1 credit, the planner shall submit on an annual basis to the CME Coordinator the Annual Evaluation and Outcomes form and a new Request for AMA PRA Category 1 Credit(s)™ and Faculty Disclosure form(s). A 60-day time frame for CME Committee review is encouraged.
4. Conference Planner: The conference planner is responsible for providing the following documentation to the CME Coordinator within 30 days of the session date:
   a. Session Case Selection & Outcomes form
   b. Completed evaluation forms
   c. Evaluation summary
   ~~c.~~**d. CME Reporting Form**
   ~~d.~~**e.** Attendance roster
   ~~e.~~**f.** Case summaries (if applicable)
   ~~f.~~**g.** Copy of promotion materials (flyer)
5. Regularly scheduled series conferences must be at least 50 minutes in length for one (1) category 1 credit.

D. **EVALUATION – IMPROVEMENT:**
1. Learners will complete an annual RSS *Learner Evaluation* form. Results will be summarized

and provided to the CME Committee.

E. REFERENCE(S):

1. Institute for Medical Quality (IMQ)/California Medical Association (CMA) 2014 CME Accreditation Criteria and Policies for Continuing Medical Education (CME) * with annual report.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 03/07

SUBJECT: Surgical Assistance

REVISION DATE(S): 11/11, 07/12

POLICY NUMBER: 8710 – 545

Medical Staff Department Approval ~~Date~~:	~~03/17~~07/18
Operating Room Committee Approval:	07/18
Division of GVS Approval ~~Date~~:	~~03/17~~08/~~18~~09/18
Pharmacy ~~and~~ & Therapeutics Committee Approval ~~Date~~:	n/a
Medical Executive Committee Approval ~~Date~~:	~~03/17~~10/~~18~~11/18
Administration Approval:	03/19
Professional Affairs Committee Approval ~~Date~~:	~~04/17~~ n/a
Board of Directors Approval ~~Date~~:	04/17

1. **PURPOSE:**
   1. To identify Amount and Level of Assistance required in Surgical Cases.

SURGICAL CASES	AMOUNT OF ASSISTANCE		LEVEL OF ASSISTANCE		
	1ST	2ND	MD	MD/PA/RNFA	OTHER
GENERAL					
Abdominal Perineal/ Low Anterior Resection	X			X	
~~Bowel Resections (Major, as determined by surgeon)~~	~~X~~			~~X~~	
~~Gastric Procedures (Major, as determined by surgeon)~~	~~X~~			~~X~~	
~~Bariatric Procedures (Major, as determined by the surgeon)~~	~~X~~			~~X~~	
~~Biliary Procedures (Major, as determined by surgeon)~~	~~X~~			~~X~~	
Robotic Procedures (Major, as determined by the surgeon)	X			X	
Hepatic Procedures/Whipple/Major Liver Resection~~Hepatic/Pancreatic Procedures~~	X			X	
~~Mastectomy Radical~~	~~X~~			~~X~~	
~~Pelvic Exenteration~~	~~X~~			~~X~~	

SURGICAL CASES	AMOUNT OF ASSISTANCE		LEVEL OF ASSISTANCE		
	1ST	2ND	MD	MD/PA/RNFA	OTHER
~~Thyroid Procedures~~	~~X~~			~~X~~	
VASCULAR					
~~Aortic Procedures~~	~~X~~			~~X~~	
~~Carotid Procedures~~	~~X~~			~~X~~	
~~Peripheral Vascular Bypass~~	~~X~~			~~X~~	
THORACIC					
~~Open Esophageal Procedures~~	~~X~~			~~X~~	
~~Thoracoscopy Procedures~~	~~X~~			~~X~~	
~~Thoracotomy~~ **Robotic Thoracic** Procedures **(Major, as determined by the surgeon)**	X			X	
UROLOGIC					
Open Prostatectomy Procedures	X			X	
Open Renal Procedures	X			X	
~~Open Ureteral Procedures~~	~~X~~			~~X~~	
Cystectomies	X			X	
ORTHOPEDIC					
~~Total Large Joint Procedures~~	~~X~~			~~X~~	
~~Spinal fusion/rodding procedures~~	~~X~~			~~X~~	
OB/GYN					
Hysterectomy Procedures	X			X	
Cesarean Sections	X			X CNM	X Emergency
~~**NEUROSURGERY**~~					
~~Craniotomies (except burr holes)~~	~~X~~			~~X~~	
~~Spinal fusion/rodding procedures~~	~~X~~			~~X~~	
ENT					

SURGICAL CASES	AMOUNT OF ASSISTANCE		LEVEL OF ASSISTANCE		
	1ST	2ND	MD	MD/PA/RNFA	OTHER
~~Radical Neck Procedures~~	~~X~~			~~X~~	
~~Thyroid Procedures~~	~~X~~			~~X~~	
~~Parotidectomy~~	~~X~~			~~X~~	
~~ORAL/MAXILLOFACIAL~~					
~~Cranial/Facial Procedures~~	~~X~~			~~X~~	~~X DDS~~
CV					
Open Heart Procedures	X	X	X	X*	
~~Carotid Procedures~~	~~X~~			~~X~~	

2. Amount and level of assistance for all other procedures are at the discretion of the operating surgeon.
3. For emergent surgical cases, the amount and level of assistance for procedure may be waived at the discretion of the surgeon.

2. **Open Heart Procedures:**
   1. 1st Assistant must be another cardiac/thoracic surgeon or surgeon
   2. 2nd Assistant may be MD or PA/RNFA

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 06/05 **SUBJECT: Medication Management Program**

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

Pharmacy Department Approval:	~~06/15~~09/18
Pharmacy & Therapeutics Committee Approval:	~~06/05, 07/06, 07/09, 1/12, 07/15~~09/18
Medical Executive Committee Approval:	~~06/05, 07/06, 07/09, 1/12, 08/15~~10/18
Administration Approval:	03/19
Professional Affairs Committee Approval:	~~09/15~~ n/a
Board of Directors Approval:	~~06/05, 07/06, 07/09, 1/12,~~ 09/15

A. **POLICY**:

1. The Pharmacy and Therapeutics Committee, acting on behalf of the medical staff, shall implement a Medication Management Assessment and Evaluation Program to provide a system to ensure medication use within the organization is conducted in a safe and optimal manner. The Medication Management Assessment and Evaluation program requires the routine evaluation of literature for new technologies and best practices that have been demonstrated to enhance safety in other organizations to determine if these practices are conducted successfully within the organization or if they should be implemented to improve the medication management system. The Medication Management Assessment and Evaluation Program identifies risk points (including medication errors and adverse drug reactions) and identifies areas to improve patient safety as well as the overall use of medications throughout the organization.
2. For the purposes of this program the definition of medication includes:
   a. Prescription medications
   b. Sample medications
   c. Herbal remedies
   d. Vitamins
   e. Nutraceuticals (substances not controlled by the FDA, not proven beneficial by authoritative sources, however the public commonly utilizes – example: Ingestible Shark Cartilage)
   f. Over-the-counter drugs
   g. Vaccines
   h. Diagnostic and contrast agents
   i. Radioactive medications
   j. Respiratory therapy treatments
   k. Parenteral nutrition
   l. Blood derivatives
   m. Intravenous solutions (plain, with electrolytes and/or other drugs)
   n. Any product designated by the FDA as a drug
3. The Pharmacy and Therapeutics Committee will maintain oversight for the Medication Management Assessment and Evaluation Program. The program is based on the principles of performance improvement, with a focus on identification and measurement of processes and activities that are high-volume, high-risk, problem-prone and patient safety related. The program includes data collection and measurement of medication management processes, identification of opportunities or areas of improvements, the testing of incremental improvements and the recommendation of improvements to the organization's leaders. The main goal of improving the performance of medication management processes is to continuously improve patient health outcomes and reduce the occurrence of medication related

errors and medication related adverse patient outcomes, including adverse drug reactions. The following essential processes will be conducted to adequately assess and evaluate how medication is managed throughout the institution.

a. Process Design
b. Performance Measurement
c. Performance Assessment
d. Performance Improvement

4. The Pharmacy Director **or designee** is responsible for reporting medication management processes to the Pharmacy and Therapeutics Committee, whose members in turn are responsible for assessing, monitoring and evaluating the processes and outcomes of the medication management throughout the institution.

B. **PROCEDURE**:

1. The Pharmacy and Therapeutics Committee will collaborate and work together as a team with the Pharmacy Director **or designee**, and other designated members of the institution, to develop, implement and evaluate the organization wide Medication Management Assessment and Evaluation Program. As appropriate to the setting, individuals involved in the system of medication management include licensed independent practitioners, healthcare professionals and staff involved in medication management processes.
   a. Assessment and Evaluation Process: The following core medication management processes carried out by the organization are measured, assessed and evaluated:
      i. Selection and procurement
      ii. Storage
      iii. Ordering and transcribing
      iv. Preparing and dispensing
      v. Administration
      vi. Monitoring the effects and side effects on patients
   b. Over time, data is collected on all of the above processes.
2. The Pharmacy Department provides fundamental functions as well as key oversight responsibilities and activities in the system of medication management. The Pharmacy Department performs the following functions and activities:
   a. Selection and procurement of medications
   b. Storage of medications
   c. Maintenance of adequate medication inventory
   d. Oversight of ordering and transcribing processes
   e. Preparation of medications
   f. Medication dispensing
   g. Direct and indirect scheduled medication security and control
   h. Drug floor stock distribution
   i. Drug utilization monitoring and evaluation
   j. Provision of drug information to the organization's staff
   k. Patient/family/staff counseling and education
   l. Provision of formal and informal in-service to the nursing and other staff licensed to administer medications
   m. Provision of ~~IV additive service~~**sterile compounding services**
   n. Clinical dosing of specific medications (i.e., aminoglycosides)
3. The Pharmacy Department will be responsible to monitor the outcomes of its important functions and activities through internal performance improvement activities through investigation, data collection and monitoring of the internal processes conducted within, or by, the Pharmacy and its personnel. External performance improvement activities related to medication management will be monitored by the Pharmacy Department through data collection from a wide variety of sources including, but not limited to, medication error reports (which include real and potential errors), and adverse drug reaction reports.

4. The Pharmacy Department will collect data systematically for improvement priorities and continuing measurement. The process of data collection activities will be (when appropriate and as often as possible) collaborative and interdisciplinary in nature.
5. To adequately monitor and evaluate the medication management system in place within the institution the Pharmacy Department collects data on the following:
    a. Processes and outcomes
    b. Medication errors (real and potential)
    c. Adverse drug reactions
    d. High-risk, high-volume and problem-prone processes
    e. Patients needs, expectations and department specific patient satisfaction questionnaires and/or surveys
    f. Infection control activities
    g. Patient safety reports
    h. Current literature for new technologies and best practices
    i. Risk management issues and findings
6. Performance Measures:
    a. Administration of medication is of high-risk and therapeutic benefit to the patient. Medication management processes are measured on an ongoing basis. The following are performance measures or categories of measures for which data is collected, aggregated, reviewed and analyzed in an effort to identify risk points and areas to improve patient safety. The list is not exhaustive and may be revised in accordance with data collected, which may indicate the benefit of inclusion or exclusion of a performance measure from the monitoring and evaluation cycle. Measures include, but may not be limited to:
        i. Medication errors - wrong drug, dosage, time, route or rate of administration, wrong patient, omission, duplication or administration without an order, adverse reaction to medication (includes potential errors or "near misses")
        ii. Medication order filled incorrectly
        iii. Medication order prepared incorrectly
        iv. STAT medication not sent within established time frames
        v. Controlled substance missing and/or incorrect count
        vi. Occurrences that have an adverse result on a patient
        vii. Equipment breakage/failure that has an adverse result on a patient
        viii. Equipment not available
        ix. Security incident
        x. Expired, recalled or otherwise unusable drug dispensed
        xi. Formulary management
        xii. Labeling of drugs
        xiii. Education of patients and family
        xiv. Drug recall measures
        xv. Surveillance, prevention and control of infection
        xvi. Research investigational drugs
        xvii. Management of Human Resources (i.e., licensure requirements and entry level qualifications)
        xviii. Patient outcomes; long and short range continuing education
        xix. Technical quality control activities
        xx. Adverse drug reactions
7. Drug Usage Evaluation is an important component of the Medication Management Assessment and Evaluation Program. The Pharmacy and Therapeutics Committee, acting on behalf of the medical staff shall implement as a component of the overall Medication Management Assessment and Monitoring Program a Drug Usage Evaluation Program to ensure the safe, appropriate and efficacious use of medications throughout the institution. Drug usage will be monitored in a systematic and continuous manner. The Pharmacy and Therapeutics Committee

will determine the specific medications to be evaluated as well as the criteria to be applied. Based on the findings of the Drug Usage Evaluation Program, the Pharmacy and Therapeutics Committee will forward recommendations to the medical staff to correct or improve medication use.

8. Priorities for the selection of medications for evaluation shall be based on one (1) or more of the following factors:
   a. The number of patients affected by the medication use (i.e., frequency of medication use)
   b. The significance, including degree of risk, to individual patients
   c. The degree to which use of the medication is known or suspected to be problem-prone
   d. Ability to improve the outcome of a specific disease for which medication is an integral part of the treatment
9. Criteria for evaluation will be developed by the Pharmacy Department, in conjunction with the medical staff, based on objective measures that reflect the appropriate use of the medication as determined by community medical standards, current literature and best practices. The evaluation shall focus on processes that measure:
   a. Prescribing or ordering of medications
   b. Transcribing of medications
   c. Preparing and dispensing
   d. Administration
   e. Monitoring the medications' effects on patients
10. The Pharmacy Department, in conjunction with the medical staff, will conduct the evaluations, obtaining quantitative data and present a written report of findings to the Pharmacy and Therapeutics Committee on a quarterly basis. Reports shall include criteria, findings, causes/conclusions and recommendations.
11. The Pharmacy and Therapeutics Committee will determine actions to be recommended to the medical staff based on an analysis of:
   a. Thresholds or control limits exceeded
   b. Undesired patterns or trends
   c. Opportunities to improve performance or minimize adverse reactions
12. To adequately address the amount of medications that may prove beneficial for drug usage evaluation priorities for ongoing assessment have been developed. These priorities are based upon the following:
   a. The number of patients taking a medication
   b. The balancing of risk with therapeutic potential
   c. Medications known or suspected to be problem-prone
   d. Therapeutic effectiveness, (i.e., use of antibiotics to treat pneumonia)
13. The Pharmacy and Therapeutics Committee shall determine if, and when, a medication evaluation requires discontinuation or needs to be continued as a:
   a. Full evaluation
   b. Limited evaluation
14. Based on the findings of the Drug Usage Evaluation Program, the Pharmacy and Therapeutics Committee will forward recommendations to the medical staff to correct or improve medication use.
   a. The performance assessment process conducted for evaluation of the medication management program, as a whole is systematic, interdisciplinary and interdepartmental. The Pharmacy Department uses a systematic process to assess collected data. Other disciplines will collect data related to medication management processes conducted within their department. The assessment process will include statistical quality control techniques as needed. Data assessment begins with a clear understanding of the medication management processes under review. The framework for systematic assessment includes the multidisciplinary analysis of data to answer questions about the

processes and outcomes that are being monitored throughout the organization. The following issues shall be assessed and evaluated:

i. Current level of performance
ii. Stability of current processes
iii. Identification of areas that could be improved
iv. Identification of improvement priorities
v. Effectiveness of strategies implemented to improve performance
vi. Specifications for new or redesigned processes determined and met

15. An interdisciplinary approach will be made to make comparisons of processes and outcomes over time. The data will be compared and reference databases utilized as needed. Priorities for improvement will be assessed. Improvement activities will be implemented based upon assessment conclusions. The Pharmacy Department as well as the Pharmacy and Therapeutics Committee (as appropriate) will collaborate as necessary with other disciplines throughout the organization.
16. The organization will systematically improve the performance of its medication management system. The Pharmacy and Therapeutic Committee will assess and evaluate data provided and will determine and implement strategies to improve performance. The Pharmacy and Therapeutics Committee will implement actions that result in desired, measurable changes in processes. To achieve improvements and improve patient safety, the Pharmacy and Therapeutics Committee will participate in the following performance improvement activities:
    a. Planning
    b. Testing
    c. Assessing results and redesigning if necessary
    d. Implementing
    e. Assessing the effectiveness of implemented actions
    f. Reevaluation as deemed necessary to assure gains made are sustained

C. **ANNUAL REVIEW:**

1. The Medication Management Assessment and Evaluation Program will be assessed and measured annually for its effectiveness and consistency within the improving organization performance framework in place within the facility. If the identified improvements are not realized within a defined time period, the organization will reexamine the process within the function that is being monitored. The findings, conclusions, recommendations and actions will be communicated by the Pharmacy and Therapeutics Committee to the following:
    a. Medical Executive Committee
    b. Governing Body

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE: 07/97	**SUBJECT: NICU Scope and Qualifications**
REVISION DATE(S): 07/98, 01/06, 01/09, 03/12	**POLICY NUMBER: 505**

Rehabilitation Department Approval:	**~~12/15~~11/18**
Perinatal Collaborative Practice Committee Approval:	**01/19**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**02/19**
Administration Approval:	**03/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **POLICY:**

1. Provides developmental and feeding evaluation and treatment in the NICU and newborn nursery per physician orders within the scope of California Physical Therapy, Occupational Therapy and Speech Therapy practice acts, and as limited by Tri-City Medical Center's Policies and Procedures and Standards of Practice **and as an area identified as advanced practice.** ~~.~~

B. **PROCEDURE:**

1. Assessment/Therapy
   a. Neurobehavioral Assessment including a neuromuscular exam, analysis of movement patterns, joint range of motion, behavioral organization, sensory response testing and oral mechanisms/feeding evaluation.
   b. Initial and ongoing positioning assessments and recommendations for use of specific positioning aids to promote musculoskeletal development, prevent contractures and **promote cranial molding/brain development**~~plagiocephaly~~, and facilitate optimal quiet alert and sleep states.
   c. Ongoing assessment of non-nutritive oral motor development and effectiveness in relation to adjusted age. Recommend appropriate pacifier and positioning to promote oral motor performance and endurance consistent with gestational age.
   d. Ongoing assessment of nutritive oral motor development and effectiveness by bottle and/or breast in relation to adjusted age. Recommend nipple/bottle style, positioning, external oral support and pacing, assisting with respiratory coordination, necessary for safe feeding. Recommend oral feeding frequency to promote efficient feeding skills, prevent fatigue and weight loss, and improve quality and consistency of feeding experience for nursing staff, caregiver and infant.
   e. Ongoing assessment of sensory responses to stimuli including auditory, visual, tactile, vestibular and proprioceptive in relation to adjusted age/medical status to promote progressively more mature sensory integration and responses.
   f. Continuing assessment of state regulation as related to infant's ability to achieve and maintain a variety of alert states and promote increased endurance for handling/social interaction typical of their developmental age.
   g. Performance of the following standardized tests when appropriate for infants:
      i. Neurological assessment of pre-term and full-term infants: consists of 6 behavioral states, 9 neurobehavioral states, 6 reflexes, 16 muscle tone and movement items.

ii. Test of Infant Motor Performance (TIMP) **or Gross Motor Assessment (GMA)**: 34 weeks-4 months corrected. Posture and movement assessment, spontaneous and elicited.
iii. N-PASS: Pain assessment scale.
iv. Early Feeding Skills Assessment (EFS): assesses readiness, physiological and behavioral states, oral-motor coordination, swallowing coordination, and state following feedings.
v. Breast-feeding and Bottle-feeding assessment.

h. Participate with Nursing and Lactation consultants in Kangaroo Care and breastfeeding process to promote development of baby's oral motor skills, state regulation and parent/infant interaction through positioning and assessment of sensory responses.
i. Participate in weekly multidisciplinary discharge meeting to provide update on developmental status and needs, progress with parent/caregiver teaching, and discuss follow-up needs. Will help coordinate discharge **follow up recommendations.**~~care with the local CCS Medical Therapy Program and Units for CCS-eligible infants with OT/TR needs.~~
j. Participate in multidisciplinary family conferences as needed to discuss feeding, development and neuromuscular issues and follow-up needs in NICU and post-discharge.
k. ~~Splinting~~**Orthotic Fabrication**/casting/**taping** for neuromuscular problems and contracture management per physician order.
l. Participate in Modified Barium Swallow Studies, as appropriate:

2. **Occupational Therapy** (OT)**/Physical Therapy** (PT) **Roles and Responsibilities:**
~~1.~~**a.** **Infant** ~~for~~ positioning
~~m.~~**b.** **Infant** ~~and/or~~ feeding~~.~~

3. **Speech Therapy** (ST)**/OT Roles and Responsibilities**
~~n.~~**a.** **Assess swallowing function in conjunction with Radiology (Video** ~~F~~**Fluoroscopy Swallow Studies**~~S~~**/Modified Barium Swallow Studies**~~MBSS~~**/Fiber Optic Endoscopic Evaluation of Swallow**~~FEES~~ **to include dual discipline attendance)** to ~~assess swallowing function in conjunction with Radiology~~.
~~o.~~**b.** Ongoing parent and staff teaching regarding developmental level, feeding deficits and skills (breast, bottle and non-nutritive suck), neuromuscular and orthopedic status, positioning needs and sensory issues.
~~p.~~**c.** As needed, parent teaching in car seat safety and adaptive positioning, per American Academy of Pediatrics and per Standardized National Highway Traffic Safety Administration curriculum.
~~q.~~**d.** Provide treatment plans to appropriate staff to communicate oral motor, feeding, positioning, and sensory recommendations with other team members. ~~A CCS-paneled therapist will have oversight of all OT/PT staff who are not CCS-paneled and working in the NICU with infants with CCS-eligible conditions.~~
~~r.~~**e.** Maintain a NICU role delineation document which specifies provision of care by discipline.

~~2.~~**4.** Infection Control
a. Follows Unit-specific infection control procedures (Department/Patient Care Manual) to include initial hand washing prior to treatment, post-treatment, and between patients, and adheres to Tri-City Medical Center's general policies regarding blood-borne pathogens and infection control.

~~3.~~**5.** All personnel assigned to the NICU must follow these requirements:
a. Any article of therapist's clothing should be changed prior to treating a patient if it becomes:
i. Noticeably soiled
ii. Substantially wet
iii. Contaminated by bodily fluids or secretions

b. Specific to NICU: any employee demonstrating the following symptoms will not provide direct patient contact and must check with Employee Health:
   i. Sore throat
   ii. Eye drainage
   iii. Herpes virus infection
   iv. Vomiting
   v. Runny nose
   vi. Fever

c. Safety & Quality
   i. Follows NICU and Rehabilitation Services unit-specific Department Safety Policies and Procedures.
   ii. Performs all procedures per Policies and Procedures and specific protocols responding to patient needs in a timely manner.
   iii. Provides education for family and other caregivers and staff regarding developmental level, neuromuscular/orthopedic status, oral motor/feeding skills, sensory integration, positioning, Kangaroo Care/breast feeding, home program activities and referrals for community and outpatient services, as indicated.
   iv. Participates in NICU task force and/or PI activities as needed, per Tri-City Medical Center Performance Improvement Plan care in NICU setting.
   v. Engages in professional communication, with customer service emphasis in all interactions with parents and staff.

d. Qualifications
   i. Must be licensed as a PT, OT **or SLP by Sstate of CaliforniaA** ~~or SLP by ASHAthe State of California~~.
   ii. Must maintain an active CPR card.
   iii. Complete the required unit-specific training by NICU Coordinator or appointed preceptor.
   iv. Completion of 2 years therapy experience with ~~pediatric or infan~~ **NICU/PICU specifict** population.
   v. Completion of continuing education specific to developmental care of the high-risk NICU infant, including mentoring and academic study.
   vi. Demonstration of unit competency based on completion of orientation and continued proficiency as determined by annual peer review.
   ~~vii. Annual completion of one (1) continuing education course specific to NICU diagnosis to keep skills current with standards of practice.~~
   ~~i.~~**vii.** Completion of application with California Children's Services to be a CCS-paneled provider working with infants and children aged 0-21 years that have CCS-eligible conditions.

Tri-City Medical Center
Oceanside, California

DELETE – incorporated into the Patient Care Services Policy: Medications; High Risk-Alert

PERI-ANESTHESIA NURSING SERVICES POLIC

SUBJECT: SECOND WITNESS PROCEDURE FOR HIGH RISK MEDICATION ADMINISTRATION AND DOCUMENTATION IN PACU, SPRA AND PRE-OP HOLD

ISSUE DATE: 11/11
REVISION DATE(S):

Surgical Services Department Approval Date(s):	~~10/17~~05/18
Department of Anesthesiology Approval Date(s):	n/a
Operating Room Committee Approval Date(s):	n/a
Pharmacy and Therapeutics Approval Date(s):	01/19
Medical Executive Committee Approval Date(s):	02/19
Administration Approval:	03/19
Professional Affairs Committee Approval Date(s):	n/a
Board of Directors Approval Date(s):	

~~A. PURPOSE~~

~~1. To outline the procedure of the second nurse witness for checking and documenting Insulin and Heparin doses to reduce medication errors.~~

~~B. INSULIN / HEPARIN ADMINISTRATION:~~

~~1. Review physician's written order and gather supplies for medication administration.~~
~~2. Pull medication from Pyxis and draw up dose.~~
~~a. Keep syringe with correct dose within the bottle to show second RN witness.~~
~~b. Primary nurse and second RN witness will check blood sugar documented in Cerner and validate dose to be given per physician's written orders.~~
~~c. Validation will take place at the patient's bedside - right patient, right dose, right route, right drug, right reason, right documentation (the Seven Rights).~~
~~d. Witness does not have to stay at bedside during medication administration.~~

~~C. DOCUMENTATION:~~

~~1. Document the medication administration and second nurse witness in the patient's medical record.~~
~~a. Documentation shall include: medication, dose, route, time and the first name, last name and title of the primary RN and the witness RN.~~
~~b. Outpatients: Document on the Outpatient Nursing Notes.~~
~~c. Inpatients: Document on the Electronic Medication Administration Record (EMAR).~~

Tri-City Medical Center	~~Women and Children's Services~~**Women and Newborn Services**
PROCEDURE:	**UTERINE TAMPONADE DEVICES**
Purpose:	To provide guidelines for the use of uterine tamponade balloons for postpartum hemorrhage management.
Supportive Data:	Estimates of the incidences of Postpartum Hemorrhage range from 1:100 to as frequent as 1:20. The indication for use of the ~~EBB or~~ Bakri **uterine** tamponade balloon **catheter** is for the temporary management of lower uterine segment bleeding. The placement is intended to reduce uterine bleeding when conservative management is warranted. Close monitoring for signs or arterial bleedings, continued uterine bleeding associated with atony and/or disseminated intravascular coagulation (DIC) is required.
Equipment:	~~1.~~ OB Hemorrhage Cart ~~2.~~ One sterile ~~EBB or~~ BAKRI Tamponade Balloon Device ~~3. One (1000 ml) 0.9% Normal Saline bag for the EBB~~ ~~4.~~ One (500 ml) 0.9 % Normal Saline **IV** bag ~~for the EBB and BAKRI~~ ~~5.~~ Foley Catheter bag to be attached to tamponade device, post placement for drainage collection for both devices ~~6.~~ Foley Catheter for urine collection ~~One 60 ml leur lock syringe to remove residual air in the EBB uterine and vaginal balloons prior to insertion~~ **Sterile gloves** ~~7.~~ **X-ray detectable sponges Ultrasound, if requested.**

A. **POLICY:**

1. The ~~EBB/~~Bakri **uterine** tamponade balloon is not a substitute for surgical management and fluid resuscitation for life threatening postpartum hemorrhage.
2. Maximum ~~recommended~~ **indwelling** time for the balloon ~~placement~~ is **24 hours**.
3. Contraindications or exclusion criteria include but are not limited to:
   a. Arterial bleeding requiring surgical intervention or angiographic embolization
   b. Complete uterine atony, although it may be effective in partial uterine atony
   c. Post-partum bleeding cases indicating hysterectomy
   d. Untreated uterine anomaly
   e. Cervical cancer
   f. Purulent infections of the vagina, cervix or uterus
   g. Surgical site that would prohibit the device from effectively controlling bleeding
   h. DIC

B. **PROCEDURE:**

1. The Registered Nurse (RN) assisting the physician with placement shall:
   a. Perform hand hygiene and don sterile gloves.
   b. Ensure the physician has determined uterus is clear of any retained placental fragments, arterial bleeding or lacerations.
   c. Insert a Foley catheter prior to the procedure, if not already in place.
   d. Get equipment ready to assist physician with placement of the balloon. The deflated balloon should be placed in the uterus, inserted past the cervical canal and internal ostium.
   ~~e. FOR EBB:~~
      ~~i. Remove residual air from both balloons with sterile 60 ml syringe.~~

~~Women and Newborn Services Department Review~~	Department of OB/GYN	Perinatal Collaborative Practice	Department of Pediatrics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
5/14, 11/18	4/14, 02/19	n/a	n/a	n/a	7/14, 02/19	03/19	8/14, n/a	8/14

~~ii. Under the direction of the provider, use the uterine and vaginal spikes to fill both balloons.~~
~~iii. Filling process is to be incremental (50-100ml) with provider assessment.~~
~~iv. Use a 1000 ml bag of fluid to fill the UTERINE balloon, the 500 ml bag of fluid to fill the VAGINAL balloon~~
~~v. Maximum fill amount for EBB uterine balloon is: 750 mL/ Vaginal balloon: 300 mL~~

~~f.~~e. ~~FOR~~ BAKRI:
   i. Attach 500 ml bag of normal saline to the Bakri administration set **(rapid instillation component)**, using the three way stop cock and syringe to draw up no more than 500 ml to inflate the balloon. DO NOT overinflate the balloon.
   ii. Apply gentle traction to the balloon shaft to ensure proper contact between the balloon and tissue surface by securing it to the patient's leg. (If provider desires to maximize the tamponade effect and maintain the balloon's position s/he may pack the vagina with iodine or antibiotic soaked gauze pads).
   iii. Maximum fill amount for BAKRI: 500 mL.

~~g.~~f. Once balloon is inflated, document the amount of fluid used to create the tamponade and if any vaginal packing is used, this must be counted and documented. (See Vaginal Sponge Count Procedure)

~~h.~~g. Connect the ~~EBB/~~ BAKRI drainage port to a Foley collection bag and monitor the drainage amount hourly.
   i. Notify the physician if blood volume output is greater than or equal to 200mL in one hour or collection exceeds 100 mL/ hr. consistently.
   ii. The balloon drainage port and tubing may need to be flushed clear of clots with 20 mL sterile isotonic saline, as needed.

~~i.~~h. Assess the patient's pain level/ uterine cramping, intake and output, hourly at a minimum.

~~j.~~i. Vital signs shall be monitored every 5-1-5 minutes throughout the insertion process per physician direction and then monitored:
   1) Every 15 minutes x 1 hour post procedure, then every hour x 3, then every 4 hours x 24 hours post procedure.
   2) Temperature shall be taken every hour x 4, then every 4 hours.

~~k.~~j. There is no need to complete fundal massage when the balloon is in place, but the position/location of the fundus/ fundal height should be documented at least once a shift. (Note any changes in position or height)

~~l.~~k. The patient shall remain on strict bed rest until the balloon is removed. Consider application of sequential devices.

~~m.~~l. Administer prophylactic antibiotics as ordered.

~~n.~~m. Notify the physician for any signs of worsening patient condition.

~~o.~~n. BALLOON REMOVAL:
   i. The balloon **must be removed by the physician within 24 hours of placement** or sooner as indicated
   ii. Verify that the fluid amount instilled into the balloon, matches the amount the physician removes from the balloon.
   iii. Verify that initial vaginal packing count, matches removal count, if used. (An x-ray should be considered when a count is unknown or incorrect)
   iv. After the balloon is removed, monitor the patient's vital signs and vaginal/ uterine bleeding initially, every 30 minutes x 4, and then hourly or per physician order.

~~p.~~o. Document all assessments, interventions and communications in the electronic medical record.

C. **REFERENCE(S):**

1. **ACOG practice bulletin: clinical management guidelines for obstetrician-gynecologists number 76, October 2006: postpartum hemorrhage. Obstet Gynecol. 2006:108(4):1039-1047.**

2. **Bakri, Y. N., Amri, A., Abdul Jabbar, F. (2001). Tamponade-balloon for obstetrical bleeding. International Jounral of Gynecology and Obstetrics, 74, 139-142.**

~~1.~~3. Dabelea, V., Schultze, P.M>, & McDuffie, R.S. (2007). Intrauterine Balloon Tamponade in the Management of Postpartum Hemorrhage, American Journal of Perinatology, Vol 24, No 6, 359-364.

~~2.~~4. Tindell, K., Garfinkel, R., Abu-Haydar, E.,, Ahn, R., Burke, TF, Conn, K., Eckardt, M. (2012) Uterine balloon tamponade for the treatment of postpartum haemorrhage in resource-poor settings: a systematic review

~~3.~~5. Simpson, K.R., & Creehan, P.A. (2008). Association of Women's Health, Obstetric and Neonatal Nurses: Perinatal Nursing (3rd ed.). Philadelphia, PA.

ADMINISTRATION REVIEW CONSENT AGENDA
BEHAVIORAL HEALTH SERVICES POLICIES AND PROCEDURES
RECOMMENDED FOR DELETION DUE TO UNIT CLOSURE
March 18th, 2018

CONTACT: Scott Livingstone, COO

Policies and Procedures	Reason	Recommendations
Behavioral Health Services		
1 Table of Contents	SUSPEND	Forward to BOD for Approval
14-Day Certification Review Hearings	SUSPEND	Forward to BOD for Approval
5250: 14-Day Involuntary Holds	SUSPEND	Forward to BOD for Approval
5270 30 Days of Additional Intensive Treatment	SUSPEND	Forward to BOD for Approval
72-Hour Hold Evaluation and Treatment of the Involuntary Patient	SUSPEND	Forward to BOD for Approval
Abuse Reporting Forms	SUSPEND	Forward to BOD for Approval
Administration of Antipsychotic Medication	MOVE TO PATIENT CARE SERVICES (PCS)	Forward to BOD for Approval
Administration of Zyprexa Relprevv	SUSPEND	Forward to BOD for Approval
Approved Abbreviations, Behavioral Health Unit (BHU) and Crisis Stabilization Unit (CSU) Specific	SUSPEND	Forward to BOD for Approval
Assisting Medi-Cal Recipients with Grievance and Appeals Processes	SUSPEND	Forward to BOD for Approval
Behavioral Health Unit / Crisis Stabilization Unit Departmental Disaster Implementation Plan	SUSPEND	Forward to BOD for Approval
Conducting Searches Patient Room Patient Belongings	SUSPEND	Forward to BOD for Approval
Confidentiality	SUSPEND	Forward to BOD for Approval
Consent for Psychotropic Medications	MOVE TO PCS	Forward to BOD for Approval
Consent related to Mental Health Treatment	SUSPEND	Forward to BOD for Approval
Elopement Precautions	MOVE TO PCS	Forward to BOD for Approval
Emergency Medication	MOVE TO PCS	Forward to BOD for Approval
Cleaning and Changing Behavioral Health Unit (BHU) and Crisis Stabilization Unit (CSU) Bathroom Curtains	SUSPEND	Forward to BOD for Approval
Family Involvement in Treatment	SUSPEND	Forward to BOD for Approval
Food on the Unit	SUSPEND	Forward to BOD for Approval
Freedom of Movement	SUSPEND	Forward to BOD for Approval
Judicial Review Pursuant to a Writ of Habeas Corpus	SUSPEND	Forward to BOD for Approval
Management of Aggressive and Assaultive Behavior	MOVE TO PCS	Forward to BOD for Approval
Narrative of Organizational Chart	SUSPEND	Forward to BOD for Approval
Notification of County Serious Incident of Unusual Occurrences	SUSPEND	Forward to BOD for Approval
Notification of Responsible Persons	SUSPEND	Forward to BOD for Approval
Pastoral Care	SUSPEND	Forward to BOD for Approval
Patient Responsibilities	SUSPEND	Forward to BOD for Approval
Patient Rights	SUSPEND	Forward to BOD for Approval

ADMINISTRATION REVIEW CONSENT AGENDA
BEHAVIORAL HEALTH SERVICES POLICIES AND PROCEDURES
RECOMMENDED FOR DELETION DUE TO UNIT CLOSURE
March 18th, 2018

CONTACT: Scott Livingstone, COO

Policies and Procedures	Reason	Recommendations
Patient Satisfaction Surveys	SUSPEND	Forward to BOD for Approval
Release of Information	SUSPEND	Forward to BOD for Approval
Role of Medical Staff Leadership in Behavioral Health Services	SUSPEND	Forward to BOD for Approval
Non-Smoking Environment	SUSPEND	Forward to BOD for Approval
Solicitation of Patients_Referrals to self	SUSPEND	Forward to BOD for Approval
Suicide Risk Assessment and Management	SUSPEND	Forward to BOD for Approval
Telephone Use	SUSPEND	Forward to BOD for Approval
Unit Staff Meetings	SUSPEND	Forward to BOD for Approval
Visiting in Behavioral Health Unit	SUSPEND	Forward to BOD for Approval
Washer Dryer Use Policy	SUSPEND	Forward to BOD for Approval
		Forward to BOD for Approval
Behavioral Health Unit - Inpatient		Forward to BOD for Approval
BHU Multidisciplinary Treatment Plan	SUSPEND	Forward to BOD for Approval
Clinical Assessment	SUSPEND	Forward to BOD for Approval
Community Meeting	SUSPEND	Forward to BOD for Approval
Conservatorship	SUSPEND	Forward to BOD for Approval
Daily Environmental Safety Rounds	SUSPEND	Forward to BOD for Approval
Daily Schedule	SUSPEND	Forward to BOD for Approval
Direct Admissions to the BHU	SUSPEND	Forward to BOD for Approval
Discharge Planning	SUSPEND	Forward to BOD for Approval
Dress Code for Patients	SUSPEND	Forward to BOD for Approval
Environmental Safety Standards in BHU	SUSPEND	Forward to BOD for Approval
General Supervision of Patients_Patient Rounds	SUSPEND	Forward to BOD for Approval
Hose Use During Garden Activity	SUSPEND	Forward to BOD for Approval
Inpatient Unit Admission Criteria	SUSPEND	Forward to BOD for Approval
Levels of Observation	SUSPEND	Forward to BOD for Approval
Managing the Medical Record for BHU in the Emergency Department	SUSPEND	Forward to BOD for Approval
Notice of Certification and Advisement of Rights	MOVE TO PCS	Forward to BOD for Approval
Notification of MediCal Beneficiary of Denial of Benefits	MOVE TO PCS	Forward to BOD for Approval
One to One Observation of Patients	MOVE TO PCS	Forward to BOD for Approval
Orientation of New Patients	SUSPEND	Forward to BOD for Approval
Patient Belongings	SUSPEND	Forward to BOD for Approval
Patient Discharge Types	SUSPEND	Forward to BOD for Approval
Patient Transport for Off Unit Diagnostic Testing	SUSPEND	Forward to BOD for Approval
Psychiatric Advanced Directive	SUSPEND	Forward to BOD for Approval
Reise Hearing Refusal to Consent to Psychotropic Medications	SUSPEND	Forward to BOD for Approval
Report of Firearms Prohibition	SUSPEND	Forward to BOD for Approval
Scope of Service - Behavioral Health Unit	SUSPEND	Forward to BOD for Approval
Termination of Temporary Conservatorship	SUSPEND	Forward to BOD for Approval

ADMINISTRATION REVIEW CONSENT AGENDA
BEHAVIORAL HEALTH SERVICES POLICIES AND PROCEDURES
RECOMMENDED FOR DELETION DUE TO UNIT CLOSURE
March 18th, 2018

CONTACT: Scott Livingstone, COO

Policies and Procedures	Reason	Recommendations
Treatment of Patients	SUSPEND	Forward to BOD for Approval
Treatment Planning Policy	SUSPEND	Forward to BOD for Approval
Utilization Management	SUSPEND	Forward to BOD for Approval
Vital Signs	SUSPEND	Forward to BOD for Approval

Community Healthcare & Alliance Committee (No meeting held in March, 2019)

Finance, Operations & Planning Committee
(No meeting held in March, 2019)

Professional Affairs Committee
(No meeting held in March, 2019)

Audit, Compliance & Ethics Committee
(No meeting held in March, 2019)

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

February 28, 2019 – 2:30 o'clock p.m.
Classroom 7 – 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 2:30 p.m. on February 28, 2019.

The following Directors constituting a quorum of the Board of Directors were present:

Director Rocky J. Chavez
Director George W. Coulter
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock
Director Tracy M. Younger

Absent was Director Leigh Anne Grass

Also present were:

Steven Dietlin, Chief Executive Officer
Susan Bond, General Counsel
Scott Livingstone, Chief Operations Officer
Dr. Victor Souza, Chief of Staff
Dr. Mark Yamanaka, Incoming Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Vice Chairperson, Larry Schallock, called the meeting to order at 2:30 p.m. in Classroom 7 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 Nygaard to approve the agenda. Director Chavez seconded the motion. The motion passed (6-0-0-1) with Director Grass absent.

3. Public Comments – Announcement

   Vice Chairperson Schallock read the Public Comments section listed on the February 28, 2019 Regular Board of Directors Meeting Agenda.

   There were no public comments.

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

Vice Chairperson Schallock made an oral announcement of the items listed on the February 28, 2019 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter of Potential Litigation, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committee and approval of Closed Session Minutes.

5. Motion to go into Closed Session

It was moved by Director Reno and seconded by Director Coulter to go into Closed Session. The motion passed unanimously (7-0).

6. The Board adjourned to Closed Session at 2:35 p.m.

8. At 3:30 p.m. in Assembly Rooms 1, 2 and 3, Vice Chairperson Schallock announced that the Board was back in Open Session.

The following Board members were present:

Director Rocky J. Chavez
Director George W. Coulter
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock
Director Tracy M. Younger

Absent was Director Leigh Anne Grass

Also present were:

Noel Caughman, Board Counsel (via teleconference)
Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Ray Rivas, Chief Financial Officer
Carlos Cruz, Chief Compliance Officer
Aaron Byzak, Chief External Affairs Officer
Susan Bond, General Counsel
Dr. Victor Souza, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Vice Chairperson Schallock reported no action was taken in closed session.

10. Director Younger led the Pledge of Allegiance.

11. Vice Chairperson Schallock read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 24. Vice Chairperson Schallock requested that speakers adhere to the three minute time allotment.

12. Report from TCHD Foundation – Jennifer Paroly, Executive Director

Ms. Jennifer Paroly, TCHD Foundation Executive Director provided a brief update on past and present activities. She reported 2018 donations helped provide the 512 CT

Scanner which is a state-of-the-art imaging device that captures detailed 3D images and is one of only five in the state of California. The Foundation is also proud to have funded the ED expansion and upgrades to the Cath Lab that helped save many lives including that of Larry Hull who spoke at a recent Board meeting regarding his experience in the Emergency Department. Another piece of equipment that was funded by the Foundation this past year was the Coaxial Ophthalmoscope, Macro View Otoscope for the NICU. This scope eliminates shadows and facilitates a clear, precise examination of virtually any size pupil (specifically a newborn's retinas) to show disease of the eye itself or reveal abnormalities indicative of disease elsewhere in the body for our smallest patients.

Ms. Paroly reported the New Socks & Shoe Drive will be held on March 15, 2019 which is also *National Shoe the World Day*. A collection box will be placed at the main hospital entrance for staff and visitors to drop off donations.

Ms. Paroly stated the Diamond Ball will be held on Saturday, November 16, 2019 at the Park Hyatt Aviara Resort with proceeds supporting the state-of-the-art Cardiac & Cancer Care at Tri-City Medical Center.

Other upcoming events include the launch of our new Guardian Angel Program in March and the Physician Appreciation Dinner on April 6, 2019.

No action taken.

13. Report from Chief Financial Officer

Mr. Ray Rivas reported on the YTD Financials as follows (Dollars in Thousands):

- Net Operating Revenue – $206,514
- Operating Expense – $210,867
- EBITDA - $8,930
- EROE – ($175)

Mr. Rivas commented that the bright spot is we are $5.2 million better than we were at this time last year.

Other Key Indicators for the YTD driving those results included the following:

- Average Daily Census – 153
- Adjusted Patient Days – 58,924
- Surgery Cases – 3,806
- ED visits – 32,991

Mr. Rivas also reported on the current month financials as follows (Dollars in Thousands):

- Operating Revenue - $29,899
- Operating Expense - $31,201
- EBITDA - $826
- EROE – ($527)

Mr. Rivas commented on the fact that there were very high acuity patients this past month and our reimbursement is a fixed amount.

Mr. Rivas reported on current month Key Indicators as follows:

- Average Daily Census – 165
- Adjusted Patient Days – 8,813
- Surgery Cases – 524
- ED Visits – 4,812

Mr. Rivas reported on the following indicators for FY19 Average:

- Net Patient Accounts Receivable - $43.9
- Days in Net Accounts Receivable - 52.4

Director Reno inquired about the nThrive system. Mr. Rivas explained the nThrive system is a report writer or collection tool that audits every bill to ensure we are being paid correctly. Director Reno requested clarification on the process for "collections". Mr. Rivas stated Patient Financial Services is willing to work with any and all patients to avoid being sent to collections.

No action was taken.

14. New Business

a) Consideration to approve an Independent Physician Recruitment Agreement with Dr. Morgan Silldorff, Orthopedic Surgeon

Mr. Jeremy Raimo, Senior Director of Business Development provided a brief summary of Dr. Silldorff's background and experience. He stated Dr. Silldorff is a native of North County and is completing his joint fellowship at UCSD. Mr. Raimo stated Dr. Silldorff will be joining Orthopedic Specialists of North County where he was selected as their top choice for joints. Dr. Silldorff does primary joints very well and has also studied in training to do the most complex joint revisions.

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors find it in the best interest of the public health of the communities served by the District to approve the expenditure, not to exceed $835,000 in order to facilitate Morgan Silldorff, M.D. Orthopedic Surgeon practicing medicine in the communities served by the District through an Independent Physician Recruitment Agreement (not to exceed a 24-month income guarantee with a three-year forgiveness period) for a total not to exceed $835,000. Director Chavez seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Nygaard, Reno Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Grass**

15. Old Business - None

16. Chief of Staff

a. Consideration of February 2019 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on February 25, 2019.

It was moved by Director Reno that the Tri-City Healthcare District Board of Directors approve the February 2019 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on February 25, 2019. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Grass**

b. Consideration of Revised Rules & Regulations:

1) Anesthesiology
2) Radiology
3) Pathology

It was moved by Director Chavez that the Tri-City Healthcare Board of Directors approve the revised Rules & Regulations as presented and recommended by the Medical Executive as recommended by the Medical Executive Committee on February 25, 2019. Director Reno seconded the motion.

Director Reno commented that she found Pathology to have the finest Rules & Regulations of all and suggested Pathology be used as a template for other Departments and Divisions.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Grass**

c) Consideration of Revised Privilege Cards

1) Anesthesiology
2) Neonatology
3) NP-Interventional Radiology
4) OB/GYN
5) Orthopedic Surgery
6) Pathology

7) Pediatrics
8) Radiology

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors approve the Revised Privilege Cards as presented and recommended by the Medical Executive Committee on February 25, 2019. Director seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Grass**

18. Consideration of Consent Calendar

It was moved by Director Reno to approve the Consent Agenda. Director Nygaard seconded the motion.

It was moved by Director Younger to pull item 17 (2) D. 1) a) Compliance Officer Policy 535.

It was moved by Director Reno to pull item 17 (2) B. 2) Approval of an agreement to add Dr. Hussna Wakily to the currently existing Panel Agreement for ED On-Call Coverage-General Surgery for a term of 17 months, beginning February 1, 2019 through June 30, 2020.

It was moved by Director Nygaard to pull item 17 (2) D. 1) Approval of an agreement with nThrive for a term of 36 months, beginning March 1, 2019 through February 28, 2022, for an annual cost of $120,000 and a total cost for the term of $360,000 for patient accounting.

The vote on the motion to approve the Consent Calendar minus the items pulled was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Nygaard, Reno Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Grass**

19. Discussion of items pulled from Consent Calendar

Director Nygaard who pulled item 17 (2) D. 1) Approval of an agreement with nThrive for a term of 36 months, beginning March 1, 2019 through February 28, 2022, for an annual cost of $120,000 and a total cost for the term of $360,000 for patient accounting requested that management briefly describe the service.

Mr. Ray Rivas, CFO explained it is a patient accounting collection tool which also produces regulatory reports that are required for Medicare and our line of credit with MidCap. Mr. Rivas stated in terms of total dollars it is an additional $5,000/month

increase. Mr. Rivas stated we have looked at different vendors for over a year and nThrive is the best solution we have found.

It was moved by Director Nygaard to approve an agreement with nThrive for a term of 36 months, beginning March 1, 2019 through February 28, 2022, for an annual cost of $120,000 and a total cost for the term of $360,000 for patient accounting. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Nygaard, Reno Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Grass**

Director Reno who pulled item 17 (2) B. 2) Approval of an agreement to add Dr. Hussna Wakily to the currently existing Panel Agreement for ED On-Call Coverage-General Surgery for a term of 17 months, beginning February 1, 2019 through June 30, 2020 questioned if there is an additional cost involved for Dr. Wakily to join the Call Panel. Mr. Scott Livingstone, COO clarified there is no additional cost and it is simply the addition of a physician to the currently existing Call Panel.

It was moved by Director Nygaard to approve the agreement to add Dr. Hussna Wakily to the currently existing Panel Agreement for ED On-Call Coverage-General Surgery for a term of 17 months, beginning February 1, 2019 through June 30, 2020. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Nygaard, Reno Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Grass**

Director Younger who pulled item 17 (2) D. 1) a) Compliance Officer Policy 535 stated she wanted the policy clarified to reflect that the CCO should be hired and terminated by the CEO with the Board's concurrence. Mr. Dietlin commented that the organizational chart reflects that the CCO reports to the CEO with a dotted line to the Board of Directors. Vice Chairperson Schallock suggested the policy be approved as written and sent back to the Audit, Compliance & Ethics Committee for further review.

It was moved by Director Reno to approve Compliance Officer Policy 535 and forward to the Audit, Compliance & Ethics Committee for further review. Director Coulter seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Nygaard, Reno Schallock and Younger**
NOES:	**Directors:**	**None**

ABSTAIN: Directors: None
ABSENT: Directors: Grass

20. Reports (Discussion by exception only)

21. Comments by Members of the Public

There were no comments by members of the public.

22. Comments by Chief Executive Officer

Mr. Steve Dietlin, CEO had no comments.

23. Board Communications

Director Younger did not have any comments.

Director Coulter did not have any comments.

Director Chavez stated he very much appreciates the donor event put on by the Foundation earlier this week. He commented that it is important for Board members to attend these events and let the Foundation know we support them.

Director Nygaard did not have any comments.

Director Reno did not have any comments.

24. Report from Vice Chairperson

Vice Chairperson Schallock echoed Director Chavez's comments regarding the Donor Appreciation dinner and stated it was a very nice event.

25. There being no further business Vice Chairperson Schallock adjourned the meeting at 4:05 p.m.

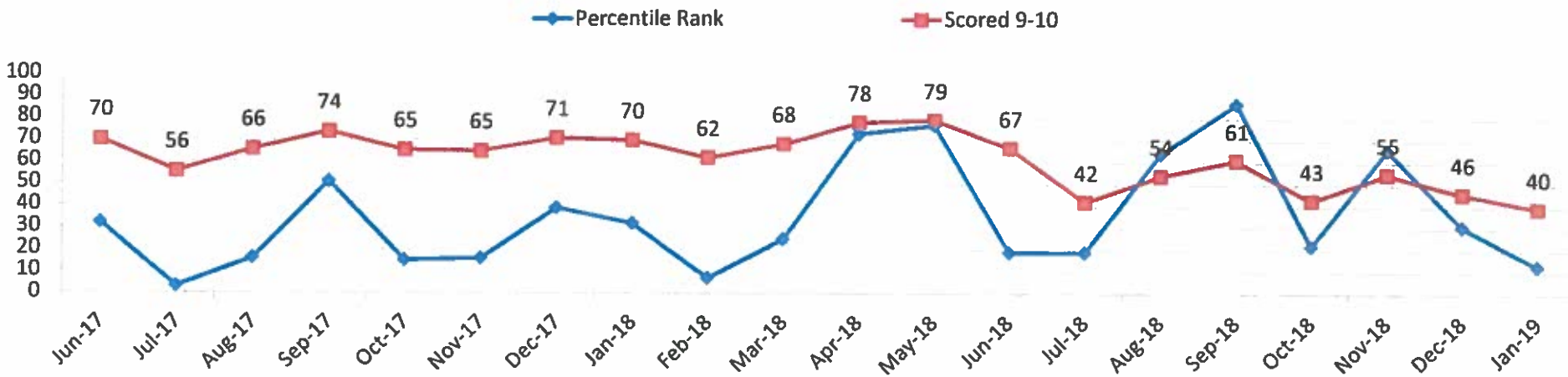
_____
Leigh Anne Grass
Chairperson

ATTEST:

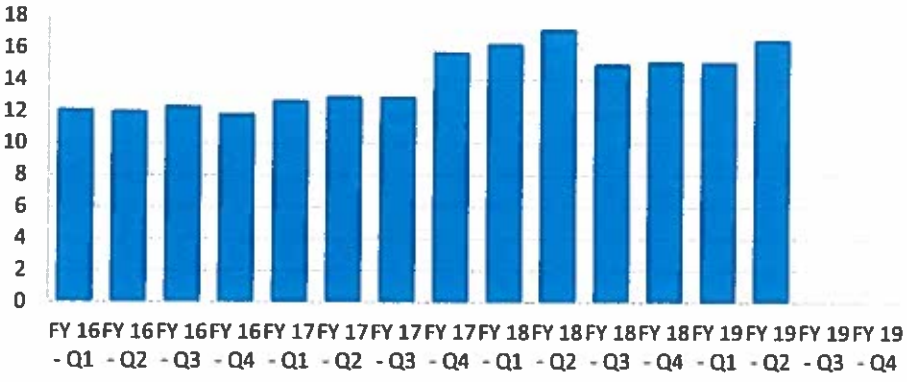
_____
Julie Nygaard, Secretary

Stakeholder Experiences

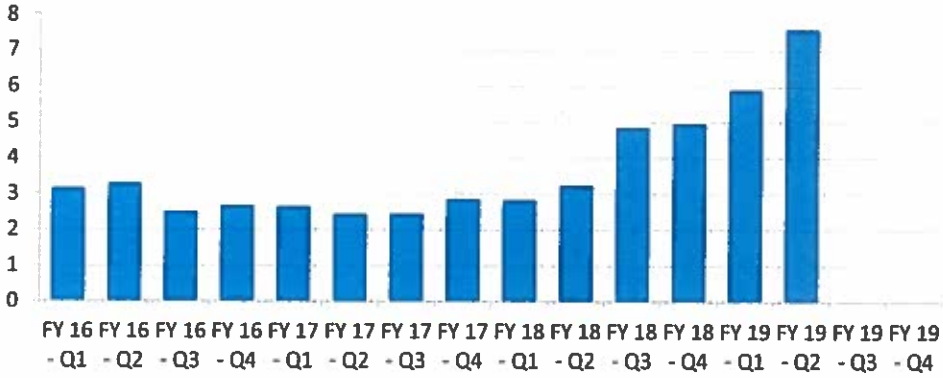
Overall Rating of Hospital (0-10)



Voluntary Employee Turnover Rate



Involuntary Employee Turnover Rate



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	19	27	18	24	22	16					173
FY18	26	23	23	20	27	27	22	23	24	20	20	28	191

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	10	14	3	7	7	9	10	4					64
FY17	14	6	7	13	7	15	14	8	12	7	10	6	84

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	19	16	12	16	12	16	17	13					121
FY18	11	12	12	14	16	18	23	12	15	15	16	20	118

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	20	23	18	22	17	21	19	16					156
FY18	15	20	20	16	23	15	15	19	23	11	20	17	143

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	27	35	38	31	23	40					256
FY18	48	37	33	32	26	38	29	24	30	38	33	38	267

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	9.7	-	-	-	-	-					4.0
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	14.5

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	6.5	4.7	5.7	5.3	6.8	8.4					6.7
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	10.0	11.0	11.6	8.7	10.1	8.9					10.2
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	12.9

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	146.4	149.6	143.7	153.2	164.8	166.3					155.0
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	177.3

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	186	202	170	187	185	166	170	150					1,416
FY18	210	222	194	206	184	166	209	169	186	156	163	188	1,560

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	8	10	6	8	3	15	6	9					65
FY18	12	11	11	11	11	18	16	5	7	16	15	20	95

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	3	13	13	6	11	17					70
FY18	4	7	7	3	4	3	2	4	8	2	7	8	34

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	8	8	6	8	4	14	8	10					66
FY18	8	7	7	11	3	14	11	10	4	10	8	5	71

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	1.9	1.78	1.78	1.7	1.72	1.73					1.78
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	1.76

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	51.0	48.5	50.3	49.5	52.3	56.5	58.9	56.7					53.0	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	45.8	48.9	

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	90.2	91.4	92.5	87.8	93.1	92.2					89.8	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	83.0	82.6	

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)	$119	$254	$342	$236	($527)	$99					($76)	$1,749
FY18	($394)	($429)	($224)	($171)	($2,571)	($383)	($1,242)	($542)	($337)	($679)	($408)	$3,118	($5,957)	

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%	0.41%	0.86%	1.19%	0.79%	-1.76%	0.34%					-0.03%	0.76%
FY18	-1.33%	-1.39%	-0.76%	-0.55%	-9.47%	-1.26%	-3.94%	-1.86%	-1.09%	-2.31%	-1.31%	9.07%	-2.49%	

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	$1,417	$1,561	$1,618	$1,544	$826	$1,468					$10,398	$12,541
FY18	$898	$864	$1,091	$1,146	($1,288)	$908	$81	$751	$963	$571	$900	$4,407	$4,451	

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%	4.90%	5.28%	5.65%	5.20%	2.76%	5.07%					4.42%	5.42%
FY18	3.03%	2.80%	3.69%	3.66%	-4.74%	2.99%	0.26%	2.57%	3.13%	1.95%	2.90%	12.82%	1.86%	

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	6.75	6.98	7.82	6.50	6.68	6.52					6.83	6.65
FY18	6.51	5.92	6.90	6.26	6.50	6.43	5.95	5.99	5.86	6.29	6.43	6.43	6.29	

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	$49.3	$48.1	$37.5	$29.5	$36.3	$32.9					
FY18	$58.5	$49.8	$42.3	$48.2	$58.6	$54.5	$54.7	$53.1	$49.4	$42.7	$41.5	$52.8	

Tri-City Medical Center ADVANCED HEALTH CARE FOR YOU

Building Operating Leases

Month Ending February 28, 2019

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)	10,761.42	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	$2.76	(a)	21,045.00	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)	10,272.45	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	$4.24	(a)	26,713.00	10/01/12	10/01/22	**Chemotherapy/Infusion Oncology Center** 3617 Vista Way, Bldg 5 Oceanside, Ca 92056
Total				**$181,779.47**			

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

Education & Travel Expense
Month Ending February 2019

Cost Center	Description	Invoice #	Amount	Vendor #	Attendees
7320	CAMS ONLINE TRAINING	012919EDU	135.00	27795	TAMERA FLECK
7781	SPEECH & SWALLOW OUTCOMES - RADIATION PATIENTS	122118EXP	350.00	83419	MICHELLE MCCADDEN
8340	ASPEN 2019 NUTRITION SCIENCE & GUIDELINES	021819EXP	425.00	79501	CHRISTINE CARLTON
8390	MEDICATION PROFILE FOR HIGH RISK PATIENTS WEBINAR	MPHRWB01201901910199	135.00	14365	TORI HONG
8390	340B WINTER COALITION	020419EXP	475.83	79349	TORI HONG
8700	HEALTH RECORD CONFIDENTIALITY WEBINAR	021219HASSELER	185.00	15106	PAULA HASSELER
8700	HEALTH RECORD CONFIDENTIALITY WEBINAR	021219SANCHEZ	255.00	15106	MELISSA SANCHEZ
8740	ANIA 2019 CONFERENCE	022219EDU	100.00	38603	GRETAL KOVAK
8740	ANIA 2019 CONFERENCE	021419EDU	125.00	83340	REBECCA KREIDER
8740	RESPONDING TO GOLDEN HOUR EMERGENCIES	020819EDU	149.25	77616	ELEANOR SANTIAGO
8740	ACLS RECERTIFICATION	021419EDU	150.00	69729	JIANHUA WU
8740	ACLS RECERTIFICATION	021419EDU	150.00	79450	SVJETLANA BASUROVIC
8740	ACLS RECERTIFICATION	021419EDU	150.00	83421	FLORENCE EYABI
8740	ACLS RECERTIFICATION	020119EDU	160.00	52607	MELISSA PICOTTE
8740	ACLS RECERTIFICATION	020119EDU	160.00	77478	KATE WILDERN
8740	ACLS RECERTIFICATION	022219EDU	160.00	78966	FELICIA NEUMEYER
8740	GRIEF & LOSS STRATEGIES TO HEAL	020119EDU	199.99	81769	KRISTINA DITULLO
8740	DBT CERTIFICATE COURSE	021419EDU	200.00	81645	CAROLYN SIDHU
8740	ACLS RECERTIFICATION	022219EDU	200.00	83422	STEVEN FAIRBAIRN
8740	BACHELORS IN HEALTH ADMINISTRATION	012519EXP	2,000.00	80985	MEGAN ROMERO
8740	RN TO BSN PROGRAM	021419EDU	2,500.00	82377	CYNTHIA LEON
8740	RN TO BSN PROGRAM	012519EDU	2,500.00	82554	JULIE CANTRELL
8740	MASTERS IN NURSING	012519EDU	5,000.00	80084	COURTNEY NELSON

**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.