TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
August 29, 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 19-018, 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. 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 services or programs (Discussion only, no action will be taken). Date of Disclosure: TBD		
	d. Approval of prior Closed Session Minutes	5 min.	
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)		

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
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 19-018, 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	Welcome – a) Mark Yamanaka, M.D., Chief of Staff Elect	5 min.	Board Chair
13	Welcome – a) Jeff Marks, TCHD Auxiliary President	5 min.	Board Chair
14	TCHD Auxiliary, Jeff Marks, President	10 min.	Standard
15	July 2019 Financial Statement Results	10 min.	CFO
16	New Business a) Consideration to certify SEIU-UHW as the exclusive bargaining representative for Cytotech Coordinator b) Consideration of a one-time exception to Board Policy 19-020 Business Expense Reimbursement; Ethics Training c) Consideration of Chairperson to cast the ballot for the LAFCO San Diego County Consolidated Redevelopment Oversight Board d) Consideration of nominations for the San Diego Local Agency Formation Commission Special District's Advisory Committee	 5 min. 5 min. 5 min. 5 min.	 Chair Chair Chair Chair
17	Old Business – None		
18	Chief of Staff a) Membership and Privileges granted for the physicians reflected in the July Credentialing Report – **Information Only**	 5 min.	 Chief of Staff
19	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.*** **(1) Administrative Committee** **a) Patient Care Policies & Procedures - July**	5 min.	Standard

	Agenda Item	Time Allotted	Requestor
	1) Chemotherapy Prescribing, Processing and Preparation Policy 2) Communicating with Physicians Using SBAR Policy 3) Communication with the Sensory Impaired and/or Persons with Language Barriers 4) Epidural or Intrathecal Catheter Infusion in the Non-Laboring Patient Procedure 5) Intracranial Pressure ICP Monitoring External Ventricular Drain EVD Care 6) Physician's Admission Responsibilities Policy 7) Restraints-Seclusion for Violent-Self-Destructive Behavior Policy 8) Standards of Care Adult 9) Stool Management-Rectal Tube SMS Procedure (DELETE) 10) Stroke Code, Emergency Department Procedure 11) Therapeutic Anticoagulation Management Policy **b) Administrative Policies & Procedures – July** 1) Secure Environment 204 2) Weapons Scanning in the Emergency Department **c) Engineering – July** 1) 6001 Decontamination of Equipment 2) 6002 Prevention of Exposure to Blood Borne Diseases **d) Food & Nutrition** 1) Nutritional Care and Assessment for Infants Admitted to NICU **e) NICU** 1) Nutritional Care and Assessment for Infants Admitted to NICU (DELETE) **f) Infection Control** 1) Influx of Infectious Patients Epidemic Influenza or Other Respiratory Transmitted Disease IC 15 0 **g) Medical Staff** 1) Credentialing Standards for Catheter Based Peripheral Vascular Interventional Procedures **h) Surgical Services** 1) Scheduling Surgical Procedures Policy **i) Women & Newborn Services** 1) Newborn Sepsis Care Guidelines **j) Formulary Requests** 1) Peramivir Monograph		
2)	**Administrative Committee** **a) Patient Care Policies & Procedures – August** 1) Administration of Pediatric Hepatitis B Vaccine and Hepatitis B Immunoglobulin HBIG HyperHEP B S/DA® to Newborns Standardized Procedure 2) Blood Glucose Newborn Monitoring Standardized Procedure 3) Discharge from Outpatient Post-Anesthesia Service Standardized Procedure 4) Emergency Department Standardized Procedure		

	Agenda Item	Time Allotted	Requestor
	5) Gastric Intubation Procedure 6) Local Anesthetic Prior to Intravenous Insertion Standardized Procedure (DELETE) 7) Organ Donation, Including Tissue and Eyes Policy 8) Restraints Used for Non-Violent Non-Self Destructive Behavior Policy 9) Universal Blood Saturation Screening for Critical Congenital Heart Disease (CCHD) Standardized Procedure 10) Witnessing a Patient Signature on Patient's Personal Documents **b) Administrative Policies & Procedures** 1) Absences and Tardies - 408 **c) Infection Control** 1) Aerosol Transmissible Diseases and Tuberculosis Control Plan 2) Scabies and Lice 3) Standard and Transmission-Based Precautions **d) Intensive Care Unit** 1) Scope of Services for Intensive Care Unit **e) NICU** 1) Cardio-Respiratory Monitoring in the NICU 2) Intrafacility Transport of the NICU Patient 3) Measuring Infant Length in the NICU **f) Rehabilitation** 1) Outpatient Medical Records 1001 **g) Pre-printed Orders** 1) Intraoperative Endoscopy Physician Orders 8711-4018 (DELETE)		
	(2) Board Committees		
	A. Community Healthcare Alliance Committee Director Chavez, Committee Chair *(No meetings held in July or August, 2019)*		CHAC Comm.
	B. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 1 *(No meeting held in July; August Committee minutes included in Board Agenda packets for informational purposes.)* 1) Approval to appoint Ms. Kathryn Fitzwilliam to a two-year term on the Finance, Operations & Planning Committee as recommended by the committee. 2) Approval of an agreement with Drs. Frank Corona, Martin Nielsen, Mark Yamanaka, Safouh Malhis as the ED On-Call Coverage Physicians for Pulmonary & ICU for a term of 24 months, beginning July 1, 2019 and ending June 30, 2021, at a daily rate of $1,500 for a total term cost of $1,096,500. 3) Approval of an agreement with Dr. Cary Mells as the Medical Staff Leadership Chair of the Physician Well-Being		FO&P Comm.

	Agenda Item	Time Allotted	Requestor
	Committee for a term of 24 months, beginning August 1, 2019 and ending July 31, 2021, not to exceed an annual amount of $36,000 per year, and a total of $72,000 for the term. 4) Approval of an agreement with Dr. Mark Yamanaka as Chief of Staff for a term of 24 months, beginning July 1, 2019 through June 30, 2021, for a TCHD stipend of $4,950 per month, $71,400 annually and $142,800 for 24 months; plus an educational allowance up to $10,000 for a total not to exceed $152,800 for the term, paid by TCHD. 5) Approval of an agreement with Dr. Victor Souza, Medical Director/Covering Physician for the Specialty Care Clinic and Progressive Care Unit for a term of 24 months beginning September 1, 2019 through August 31, 2021, not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $163, for an annual cost of $39,120 and a total cost for the term of $78,240. 6) Approval of an agreement with Dr. John LaFata, Coverage Physician for Home Health, for a term of 24 months, beginning September 1, 2019 through August 31, 2021, not to exceed an average of 10 hours per month or 120 hours annually, at an hourly rate of $169, for an annual cost of $20,280, and a total cost for the term of $40,560. 7) Approval of a Fifth Amendment Lease Renewal with Dr. Oscar Matthews, for an additional one-year term, beginning August 1, 2019 through July 31, 2020, at a fair market value rental rate of $2.14 per square foot, for a monthly revenue of $3,114.40 for a total revenue for the term of $37,373. 8) Approval of a Lease Agreement for office space inside Suite 100 in the Carlsbad Wellness Center MOB located at 6260 El Camino Real, Carlsbad, CA 92009, with Dean Vayser, DPM, for a 24-month term, at the rate of $857.50 per month, for a total revenue for the term of $20,580. 9) Approval of an agreement with COX for Metro-E services for TCMC for a term of 60 months for Tri-City Medical Center, and 36 months for OSNC, Tri-City Primary Care & Wellness, for a total cost for the term of $527,520. 10) Approval of an agreement with Cerner for network hardware/software/licenses/professional services for a term of 36 months, beginning September 1, 2019, through August 31, 2022, for a total cost for the term of $1,849,941.37. 11) Approval of an agreement with Stryker for video/Power for a term of 60 months, beginning October 2019 through October 2024, for an annual cost of $644,877.48 and a total cost for the term of $3,224,387.40 including taxes. 12) Approval of a new Hospitalist Services & On-Site Coverage Services Agreement with Coastal Hospitalists Medical Associates, Inc. beginning September 1, 2019 through August 31, 2019, at a monthly cost not to exceed $266,667, an annual		

	Agenda Item	Time Allotted	Requestor
	cost not to exceed $3,210,000, which includes an educational allowance up to $10,000 per year, and a total cost not to exceed $6,420,000 for the term.		
	C. Professional Affairs Committee Director Reno, Committee Chair *(No meeting held in July or August, 2019)*		PAC
	D. Audit, Compliance & Ethics Committee Director Schallock, Committee Chair Open Community Seats – 2 *(July Committee minutes included in Board Agenda packets for informational purposes; no meeting held in August, 2019)* 1) Approval to appoint Mr. Stanly Dale to a two-year term on the Audit, Compliance & Ethics Committee as recommended by the Committee. 2) Approval to appoint Mr. Carl Marcuzzi to a two-year term on the Audit, Compliance & Ethics Committee as recommended by the Committee. 3) Recognition of Leslie Schwartz for his two terms of service on the Audit, Compliance & Ethics Committee		Audit, Comp. & Ethics Comm.
	E. Ad Hoc Board Bylaw & Policies Committee *(Policy Number & Minor Changes Unless Noted as Revised)* 1) Board Policy 19-017 – Principal Investment Policy 2) Board Policy 19-022 – Maintenance of Confidentiality by Directors and Committee Members (changes) 3) Board Policy 19-026 – Requests for Inspection of Public Records (changes) 4) Board Policy 19-040 – Activities for Which Board Compensation is Available (changes) 5) Board Policy 19-041 – Board Policy on Public Information (changes) 6) Board Policy 19-042 – Duties of the Board of Directors 7) Board Policy 19-043 – External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms. 8) Board Policy 19-044 – Distribution of Tickets and Passes to District-Sponsored or Controlled Events and Donated Tickets and Passes (Changes) 9) Board Policy 19-046 – End of Life Option Policy		

	Agenda Item	Time Allotted	Requestor
	(3) Minutes – Approval of: May 16, 2019 – Special Meeting May 30, 2019 – Regular Meeting June 13, 2019 – Special Meeting (4:00 p.m.) June 13, 2019 – Special Meeting (6:00 p.m.) June 24, 2019 – Special Meeting June 27, 2019 – Regular Meeting		Standard
	(4) Meetings and Conferences – None (5) Dues and Memberships – a) Annual Facility License Renewal - $255,146.00		
22	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
23	Reports (Discussion by exception only) (a) Dashboard – Included (b) Construction Report – None (c) Lease Report – (May, 2019) (d) Reimbursement Disclosure Report – May, 2019) (e) Seminar/Conference Reports – AHA Meeting 1) Report(s) from Directors Nygaard and Schallock	0-5 min.	Standard
24	Comments by Members of the Public NOTE: Per Board Policy 19-018, 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
25	Comments by Chief Executive Officer	5 min.	Standard
26	Board Communications (three minutes per Board member)	18 min.	Standard
27	Report from Chairperson	3 min.	Standard
28	Total Time Budgeted for Open Session	1.5 hours	
29	Adjournment		

One Time Exception to
Board 19-020 Business Expense Reimbursement

Background

At the April 25, 2019 Board of Directors Meeting, the Board reviewed and approved Board Policy 19-020 Business Expense Reimbursement which in part states "Hotel accommodations may be secured/held by the Executive Assistant or the Board member however the Board member's personal credit card will be required at the time of check in for the hotel stay and any incidentals incurred. Upon completion of travel the Board Member will submit their itemized hotel bill and any additional reimbursable receipts to the Executive Assistant for reimbursement."

On May 22, 2019, Chairperson Grass sent an e-mail to all Board members that included the following language: "Upon hotel arrival and check-in, the Director will secure the room and incidental charges with their personal credit card. The Director will be responsible for paying for the room charges and any incidentals incurred, then submit the applicable receipts to the District for reimbursement."

On July 24, 2019 a Board Member failed to carry a personal credit card to the hotel to cover room charges and incidentals. The Board Chair provided a one-time exception to the policy to cover room charges and incidentals for said Board member.

Chairperson Grass is requesting Board approval for the aforementioned one-time exception to Board Policy 19-020 which she granted under emergency circumstances.

Approved on _____ day of August, 2019 by the following vote:

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY 19-020

POLICY TITLE: Business Expense Reimbursement; Ethics Training

I. POLICY

In compliance with applicable provisions of the Health and Safety Code and the Government Code, including the provisions of AB 1234, as they may be revised from time to time, it is the policy of Tri-City Healthcare District ("TCHD") to reimburse all members of the Board of Directors ("Directors") and the Chief Executive Officer (CEO) for actual and necessary expenses incurred in the performance of official duties on behalf of the TCHD as approved by the Board of Directors. Each Director and the CEO is accountable for expenses incurred when conducting business on behalf of TCHD and will adhere to the policies and procedures adopted by the Board. Since Government Code section 53235 provides that if a local agency provides any type of compensation, salary, or stipend to a member of a legislative body, or provides reimbursement for actual and necessary expenses incurred by a member of a legislative body in the performance of official duties, then all local agency officials shall receive training in ethics, completion of such training is a prerequisite to the receipt of reimbursement under this policy.

II. PURPOSE

To provide consistent guidelines addressing the approval and documentation requirements for the reimbursement of actual and necessary business expenses to TCHD Directors and the CEO.

III. SCOPE

TCHD will reimburse Directors and the CEO for actual and necessary business expenses pursuant to the guidelines set forth in this Policy. In order to receive reimbursement for such expenses, Directors and the CEO must comply with all requirements set forth below, except as may otherwise be set forth in the CEO's employment agreement. This Policy does not limit the authority of the CEO to pay for the actual and necessary costs for a Director to attend a business meeting on behalf of the District at the invitation of the CEO where no reimbursement is involved, and any costs incurred are consistent with the limits of this Policy and reported to the Board at its next regular meeting.

IV. PROVISIONS

A. Pre-Approval of Expenses.

In order to be eligible to receive reimbursement for expenses relating to an educational seminar or other external meeting, Directors must obtain Board approval pursuant to the following procedures prior to incurring such expenses:

1. The Director shall request Board approval at a regular meeting of the Board.

2. Prior to the regular meeting at which the Board will consider the approval, the Director must provide TCHD Administration with the following information, which shall be included on the Board Agenda:

   a. Name, purpose and location of meeting.

   b. Estimated reasonable cost of attendance (registration, travel/transportation, meals, lodging, etc.).

B. A Board member may request Board approval of expenses incurred for meetings, regulatory or business events attended prior to approval. Reimbursable events are as follows:

1. Meetings, Regulatory Hearings or business events that may have been requested by administration for board attendance.
2. Follow-up events that related to the above.

3. In the event a Director shall request to attend an educational seminar that would occur prior to the next Regular Board Meeting, the Board Chair may have the authority to approve or deny such request.

C. Accommodation Expenses/Travel Arrangements.

1. Direct Billing.

After Board approval has been obtained, the Executive Assistant may coordinate direct billing for advance registration fees for Directors using the TCHD's corporate credit. Directors may pay expenses specifically authorized for reimbursement under this policy using their personal credit card to be reimbursed upon submittal of an Expense Report Form, as set forth in Exhibit "A." Directors may make their own airfare arrangements via the Internet using their personal credit cards, or request assistance by the Executive Assistant for such bookings. Hotel accommodations may be secured/held by the Executive Assistant or the Board member however the Board member's personal credit card will be required at the time of check in for the hotel stay and any incidentals incurred. Upon completion of travel the Board Member will submit their itemized hotel bill and any additional reimbursable receipts to the Executive Assistant for reimbursement.

2. Reconciliation of Direct Billing Expenses.

Expenses shall not exceed the amounts authorized in section D, below. Any failure to timely comply with such requirements may result in

withdrawal of direct billing privileges, in the sole discretion of the Board Chair.

D. Reporting Requirements

1. Expense Form.

All requests by a Director or the CEO for reimbursement shall be submitted on TCHD's standard Expense Report Form (see Exhibit "A") with all required supporting documentation and receipts attached in the order they were incurred. This procedure will facilitate the auditing of the Expense Report Forms and provide for more efficient and timely processing. If there are any anticipated reimbursements from outside organizations, documentation of such should be noted on the Expense Report Form. If any such reimbursement is received following TCHD payment of expenses, the overpayment will be signed over to TCHD. TCHD follows the general rules of the IRS and California Government Code which requires i) that expenses be supported by receipts and that the persons involved and ii) that the business purpose of each expenditure be identified.

2. Supporting Documentation.

Supporting documentation should include, whenever applicable, the following:

c. Purpose/Reason for business expenses and identification of persons involved where applicable.

d. Airfare – reservation confirmation from Airlines or e-ticket.

e. Car Rental – car rental invoice.

f. Lodging – itemized hotel invoice.

g. Parking – receipt from parking garage/service.

h. Mileage – mileage report documenting miles traveled, origin and destination points and business purpose.

i. Meals – original itemized payment receipts, with persons included and business purpose noted on receipt.

j. Cash Gratuities – Board Members shall document and turn in a receipt to be approved pursuant to the procedures for approval set forth in Section 6 below.

k. All other expenses - receipts shall be included.

3. Timely Submission.

The Expense Report Form showing actual expenses, together with actual receipts, must be submitted within 60 days following the completion of travel. More timely submission may be requested from time to time for example at fiscal year-end to insure appropriate timely accounting to accrue. Reimbursement will not be made if the Expense Report Form is not submitted within 60 days of incurring the expense. In the case of travel advances, if the required documentation and receipts are not submitted within 60 days of incurring the expense, no further travel shall be approved until one year has elapsed from the date travel was completed and the appropriate expense report is received by TCHD.

4. Reports To TCHD Board.

Directors must prepare a written report (Seminar Evaluation Form) upon return from a seminar, conference or other form of event which the Director received or shall receive reimbursement from TCHD pursuant to this Policy. A verbal or written report must be presented at the next regular board meeting following the seminar, conference or other event. In the case of a written report, Directors shall make reasonable efforts to submit the report in time for inclusion in the next regular Board agenda packet. If an oral report is made, a written report shall be submitted within 60 days of the regular meeting.

5. Seminar Evaluation.

In addition to all other requirements set forth in this Policy, in order to share in the benefits of educational programs, each Director who attends an educational program (seminar, workshop, conference, etc.) at TCHD expense shall complete a Seminar Evaluation Form (see Exhibit "B"). The completed Seminar Evaluation Form shall be returned to the Executive Assistant for inclusion in the next regular Board agenda packet if possible, but in no event later than 60 days following the educational program.

6. One Over One Approval.

Once all of the foregoing requirements have been met, the requested reimbursement shall be approved. However, because no one is permitted to approve his or her own expenses, "One over One" approval, evidenced by the signature of the person responsible for such approval, must be given as follows:

a. TCHD Directors and CEO: TCHD Board Chairperson (or his or her designee) approval required.

b. TCHD Board Chairperson: Board Secretary or Board Assistant Secretary approval required.

7. Payment Of Reimbursement.

Completed Expense Request Forms meeting all of the foregoing requirements and approved by the appropriate TCHD Director or CEO will be processed and paid no later than two (2) weeks from the date of authorized submission of the completed Expense Request Forms to the Finance Department. Reimbursement will be directly, by check for actual and necessary business expenses incurred in the performance of official duties upon receipt of a properly documented Expense Report Form accompanied by receipts approved by the appropriate authorized person.

8. Reimbursement Of Excessive Advance.

If the amount advanced by TCHD for travel exceeds the actual expenditures set forth in the Expense Report Form, then the TCHD shall provide the TCHD Director or CEO with written notice that the travel advance exceeded actual expenses. Such notice shall set forth the amount overpaid and the date by which the travel advances must be repaid to the TCHD, which date shall be not more than 30 days from transmission or of the notice.

9. TCHD shall comply with the reporting requirements of California Government Code Section 53065.5.

10. Notwithstanding the foregoing, the Board may approve reimbursements when documentation or reports are submitted late or are unavailable, for good cause shown, so long as there is substantial compliance with the applicable provisions of state law.

E. Reimbursement Rates.

Directors and CEO shall receive reimbursement at the rates set forth in IRS Publication 463, or any successor publication. Notwithstanding the rates specified in IRS Publication 463, or any successor publication, the government and/ or group rates offered by a provider of transportation or lodging services for travel and lodging are hereby deemed reasonable for purposes of this Policy. A Director or CEO may only be reimbursed for expenses that fall outside of this Policy or the rates set forth below, if the expense is approved at a public meeting of the Board before the expense is incurred, or the CEO's contract so provides.

TCHD will use the following guidelines to determine actual and necessary expense for reimbursement:

1. Airfare.

Coach or economy class airline tickets are considered ordinary business expenses; first or business class tickets are not reimbursable under the Policy. Each Director is expected to assist TCHD in acquiring the best rate and greatest discount on airline tickets. Reimbursement will be the actual necessary airline fare.

Note: If a Director chooses to travel in his or her private automobile, rather than by airline, the Director will be reimbursed for mileage at the rates specified in this Policy, provided that such reimbursement does not exceed the cost of coach or economy airfare, plus normal cost for transportation to and from the airport at the point of departure and the airport at the destination. If two or more Directors travel in the same private automobile, the Director whose private automobile is used, will get full mileage reimbursement, provided that said mileage meets the requirements above as to each Director traveling together, and does not exceed the cost of coach or economy airfare plus normal cost for transportation to and from the airport at the point of departure and the airport at the destination.

2. Lodging.

Choice of lodging shall be determined by convenience to the seminar, conference, or other form of event location within reasonable economic limits. Lodging shall not be reimbursed or provided at TCHD expense if the meeting site is within 30 miles of the Director's legal residence without prior Board approval based upon unusual circumstances which make it impractical to travel to the site of a meeting on the date scheduled. Association or governmental discounts should be requested based on whichever provides a lower cost. If lodging is in connection with a conference or other educational activity conducted in compliance with this Policy, lodging costs shall not exceed the maximum group rate published by the conference or activity sponsor provided that the group rate is available at the time of booking, which is hereby deemed reasonable for purposes of this Policy. If the group rate is not available, Directors shall use comparable lodging, either at a rate not more than the maximum group rate published by the conference or the activity sponsor or at a rate not more than the lowest rack rate available for a single room. If Directors wish to take a guest, they must pay any rate differential over the single room rate.

If it is not practical to travel to the site of a meeting on the date the meeting is scheduled, the extra days lodging will be reimbursed. An extra day(s) lodging will be reimbursed if airfare savings are greater than the total cost of staying over and extra day(s).

3. Car Rental.

The size of the car rental shall be appropriate to the number of individuals traveling in the group and the intended business of the group. Association or Governmental discounts should be requested to minimize cost.

4. Car Rental Insurance.

TCHD is insured for collision and comprehensive coverage when renting vehicles. Directors shall decline these coverages when renting vehicles.

5. Parking Expense.

Actual necessary parking expenses while on company business will be reimbursed.

6. Mileage.

The reimbursement rate for use of personal vehicles is consistent with the current IRS mileage reimbursement rate for business miles deduction. Mileage will be calculated as the actual mileage incurred assuming a reasonable and direct route between origin and destination point is taken. Mileage to and from TCHD shall not be reimbursed for participation at Board and Committee meetings or any other activities at TCHD.

7. Other Transportation Expenses.

Actual and necessary expenses for taxi, bus, shuttle, and tolls are reimbursable. Directors are expected to use hotel courtesy cars or shuttles where practical before using taxis or rental car services.

8. Meals and Gratuities.

Directors will receive reimbursement for reasonable actual meal related expenses for each day of authorized travel. Federal Government daily reimbursement rates, as they may be revised from time to time may be used as a guide, but shall not strictly limit reimbursements. Alcoholic beverages are considered a personal expense. Directors are expected to eat at scheduled group meal functions whenever possible.

9. Dues and Professional Organizations.

TCHD will reimburse Directors for membership in no more than one professional organization pertinent to the performance of official duties and mutually beneficial to TCHD and the Director. TCHD may pay for these dues directly to the vendor on behalf of the Director or reimburse the Director via the expense report process.

10. Certification and Licenses.

Individual certification and licenses are considered the responsibility of the Director and are not reimbursed.

11. Continuing Education.

As approved by the Board of Directors at a public meeting, continuing education related to the Directors' performance of official duties in the form of seminar, workshop fees, etc. (and within TCHD's budget) is eligible for reimbursement or may be paid directly to the vendor. This includes any seminar, conference, workshop, etc. registration fees as described in 4. A. Approval of Expenses.

12. Other Business-Related Expenses.

Actual and necessary business entertainment is allowable provided that the persons entertained shall have a reasonable direct relationship to TCHD and a clear business purpose is established. Such entertainment should be limited to numbers and occasions that directly facilitate the business purpose.

Directors will be reimbursed for the actual and necessary cost of luncheons and dinners during the course of TCHD meetings if meals are not provided by TCHD.

TCHD promotes health and wellness and will reimburse Directors for use of hotel health/wellness facilities when traveling. A maximum reimbursement of $10.00 per day is allowed.

13. Facsimile transmission equipment; Telephone line.

The Board finds that placement of facsimile transmission equipment ("fax machines") at the residences of Directors improves the efficiency and effectiveness of communications between the District and the Directors and communications by Directors with other parties regarding matters directly related to Board business. The District will, upon request, purchase and maintain at District expense a fax machine at the residence of each Director during his/her term, subject to the requirements of law and this Policy.

The District will install and pay the cost of a telephone line for the residence of each Director. The telephone line should be used only for incoming and outgoing fax transmissions and local and long distance telephone calls which are directly related to District business. Neither the fax machine nor the telephone line should be used for personal business or any purpose not directly related to District business. Any charges for the telephone line or for local or long distance telephone calls using the line in

excess of $25.00 per month will be deemed for non-District-related use by the Director and timely reimbursement to the District for the excess will be the responsibility of the Director.

The fax machine is to remain connected to the telephone line at all times. The telephone line may not be used for connection to a computer modem or for connection to the Internet.

Failure to adhere to the terms of this Policy will be grounds for terminating a Director's participation in this program and removal of the fax machine and telephone line. Failure to reimburse the District within 60 days indicates failure to adhere to the terms of this Policy and will be grounds for terminating a Director's participation in this program, resulting in removal of the fax machine and telephone line.

Directors shall return the District fax machine, or purchase the equipment at fair market value as determined by the CEO or Chief Financial Officer, within 14 calendar days of the expiration of their term or shall face all applicable civil and criminal penalties with respect to the unauthorized possession of equipment owned by another party.

14. Non-Reimbursable Expenses.

When traveling, charges for honor bars, dry cleaning, movies and personal items, are not reimbursable.

F. Penalties.

In accordance with applicable law, as it may be revised from time to time, penalties for misuse of public resources or falsifying expense reports in violation of this Policy may include, but are not limited to the loss of reimbursement and/or direct billing privileges, restitution to TCHD, civil penalties for misuse of public resources, and prosecution for misuse of public resources.

V. TRAINING REQUIRED

A. Members of the Board of Directors and all committee members shall receive at least two (2) hours of ethics training every two (2) years, pursuant to the provisions of Government Code section 53234 et seq. ("Ethics Training") in order to be eligible for compensation or reimbursement of expenses.

B. All Members of the Board of Directors and all committee members shall provide a certificate to the Executive Assistant, indicating the dates upon which they attended an Ethics Training session(s), to satisfy requirements. Said certificate shall also include the name of the entity that provided the training. The Executive Assistant shall maintain the records, indicating the dates that each of the Members of the Board of Directors and each committee member, satisfied their requirements, and the entity which provided the training. These records shall be

maintained for at least five (5) years after the training, and are subject to disclosure under the Public Records Act.

C. Every Board Member shall receive at least two hours of sexual harassment prevention training and education within six months of taking office and every two years thereafter, as required by law.

D. The CEO or Executive Assistant shall provide members of the Board of Directors and committee members, information on the Ethics Training available to meet these requirements.

Reviewed by the Gov/Leg Committee: 6/8/05
Approved by the Board of Directors: 6/23/05
Reviewed by the Gov/Leg Committee: 8/10/05
Approved by the Board of Directors: 9/22/05
Reviewed by the Gov/Leg Committee: 1/4/06
Approved by the Board of Directors: 1/26/06
Reviewed by the Gov/Leg Committee: 11/8/06
Reviewed by the Gov/Leg Committee: 6/13/07
Approved by the Board of Directors: 6/28/07
Approved by the Board of Directors: 12/14/06
Reviewed by the Gov/Leg Committee: 10/10/07 & 11/07/07
Approved by the Board of Directors: 12/13/07
Reviewed by the Gov/Leg Committee: 07/15/09
Approved by the Board of Directors: 07/30/09
Reviewed by the Gov/Leg Committee: 8/12/09
Approved by the Board of Directors: 8/27/09
Reviewed by the Gov/Leg Committee: 5/5/10
Approved by the Board of Directors: 5/27/10
Reviewed by the Gov/Leg Committee: 12/01/10
Approved by the Board of Directors: 12/16/10
Reviewed by the Gov/Leg Committee: 11/14/12
Approved by the Board of Directors: 12/13/12
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14
Approved by the Gov/Leg Committee: 8/2/16 & 9/6/16
Approved by the Board of Directors: 9/29/16
Reviewed by Adhoc Bylaw & Policy Committee: 5/2019
Approved by Board of Directors: 5/30/2019

EXHIBIT "A"

Tri-City Medical Center

4002 Vista Way • Oceanside • CA • 92056

Reset Print

Business Expense Approval Request

Date 04/11/2014

Employee Name	Employee #	Phone No	Dept Name	Dept #

Seminar, Meeting, Institute to be attended	Location
Purpose	From / To Dates
Date to return to work	Total number of scheduled work days

Estimated Expenditure

Total Expense	Estimated / Actual Cost (Column A)	Pre-payment Required (Column B)	Remaining Cost (Column A minus B)
Registration			$0.00
Hotel # of days			$0.00
Transportation:			$0.00
Meals / Gratuity			$0.00
Other:			$0.00
Total	$0.00	$0.00	$0.00

Employee Signature	Date	Dept Director Signature	Date

Vice President Signature	Date	Approved	Disapproved

Required Pre-Payment (Attach all completed documentation to support payment)

Payee #1		Payee #2	
Address:		Address:	
City / State:		City / State:	
GL Acct #	Amt	GL Acct #	Amt

Summary of actual expenses after attendance (Attach all supporting documentation)

Date								TOTAL
Registration								$0.00
Airfare/Rail								$0.00
Hotel								$0.00
Car Rental								$0.00
Taxi/Shuttle								$0.00
Parking/Toll								$0.00
Mileage								$0.00
Meals								$0.00
Misc								$0.00
Totals	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Employee Signature	Date		Less Pre Payments by TCMC	
Authorization Signature	Date		Amount Due Employee	
Accounts Payable Usage			Amount Due TCMC	

8650-1006

SEMINAR EVALUATION FORM
Exhibit "B"

[insert updated form]

SEMINAR TITLE_____

LOCATION_____ DATES_____

1. Identify reason for attending seminar:_____

2. List three major topics of the seminar. Rate them as to your evaluation of priorities. Provide a brief explanation of key information covered under each topic.

   a. _____

   b. _____

   c. _____

3. What was the most important topic covered in the seminar?_____

4. Who was/were the main speakers/s/and their topics?_____

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

CALL FOR BALLOTS

July 5, 2019

TO: Independent Special Districts of San Diego County

FROM: Tamaron Luckett, Executive Assistant
San Diego County Local Agency Formation Commission

SUBJECT: Call for Ballots |
San Diego County Consolidated Redevelopment Oversight Board

This notice serves as a call for ballots pursuant to California Government Code 56332(f) with respect to electing one special district representative among the three nominated candidates to serve on the San Diego County Consolidated Redevelopment Oversight Board. All independent special districts in San Diego County are eligible to cast one vote through their presiding officers or their alternates as designed by the governing bodies.

The official ballot is attached. Ballots must be signed by the presiding officers or their designees and returned to San Diego LAFCO no later than **Friday, August 30, 2019**. A ballot received without a signature will not be counted. Should LAFCO receive a quorum of 30 ballots by the August 30th deadline the nominee with the most votes will be appointed. Should LAFCO not receive a quorum of ballots by the deadline an automatic 60-day extension to October 30th is required.

Last, and consistent with adopted policy, the Special Districts Advisory Committee formed a Nominating Committee to review all three candidates' qualifications and consider making a recommendation as part of the balloting process. The Nominating Committee believes all three candidates are equally qualified, and as such recommends each independent special district cast their ballot as they see fit.

Ballots and/or any related questions should be directed by e-mail to Tammy Luckett at tamaron.luckett@sdcounty.ca.gov.

Attachment: as stated

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

ATTACHMENT A

SAN DIEGO COUNTY CONSOLIDATED REDEVELOPMENT OVERSIGHT BOARD
ELECTION BALLOT and VOTE CERTIFICATION

VOTE FOR ONLY ONE NOMINEE

William R. (Bob) Ayres (Grossmont Healthcare District) [ ]

Mark Baker (Lakeside Fire Protection District) [ ]

Mitch Thompson (Otay Water District) [ ]

I hereby certify that I cast the votes of the _____
(Name of District)

for the Consolidated Redevelopment Oversight Board Election as:

[ ] the presiding officer, or

[ ] the duly-appointed alternate board member.

_____
(Signature)

_____
(Print name)

_____
(Title)

_____
(Date)

NOTE: The Nominating Committee believes all three candidates are equally qualified and recommends each special district proceed with voting as they see fit. Additionally, a candidate's forum is tentatively scheduled for August 15, 2019 as part of the quarterly meeting of the San Diego Chapter of the California Association of Special Districts (SDCSDA). Separate confirmation of the candidate's forum will be provided by SDCSDA.

Return Ballot and Vote Certification Form to:
San Diego LAFCO
Tamaron Luckett
9335 Hazard Way, Suite 200
San Diego, CA 92123
(858) 614-7755 (office) · (858) 614-7766 (FAX)
Email: tamaron.luckett@sdcounty.ca.gov

San Diego County
Local Agency Formation Commission

Regional Service Planning | Subdivision of the State of California

Agenda
8-13-19

August 12, 2019

TO: Independent Special Districts in San Diego County

FROM: Tamaron Luckett, Executive Assistant

SUBJECT: **Call for Nominations | San Diego Local Agency Formation Commission Special Districts Advisory Committee**

This notice serves as a call to nominations pursuant to Government Code Section 56332(1) to solicit eight special districts members to serve on the Special Districts Advisory Committee.

The advisory committee consists of 16 members that serve four-year terms. Candidates' eligibility for nomination to LAFCO's advisory committee: (1) may be either a district elected or appointed officer and a staff member; and (2) the number of candidates representing the same agency shall be limited to one. The new term of the advisory committee member expires October 2023. The eight incumbent's terms expire as follows:

Term expire	Incumbent	District
October 2019	Jack Bebee	Fallbrook Public Utility District
October 2019	Fred Cox	Rancho Santa Fe Fire Protection District
October 2019	Tom Kennedy	Rainbow Municipal Water District
October 2019	Tom Pocklington	Bonita-Sunnyside Fire Protection District
October 2019	Mark Robak	Otay Water District
October 2019	Greg Thomas	Rincon del Diablo Municipal Water District
October 2019	Robert Thomas	Pomerado Cemetery District
October 2019	Kimberly Thorner	Olivenhain Municipal Water District

State law specifies only the presiding officer or their alternate as designated by the governing board must sign the nomination form. Attached is nomination form **(Attachment A)**.

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

ATTACHMENT A

NOMINATION OF THE SPECIAL DISTRICT REPRESENTATIVES FOR THE SAN DIEGO LOCAL AGENCY FORMATION COMMISSION SPECIAL DISTRICTS ADVISORY COMMITTEE

The _____ is pleased to nominate _____ as a
(Name of Independent Special District) (Name of Candidate)

Candidate for the San Diego Local Agency Formation Commission as a special district advisory committee member.

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

- The nominee is either a district elected or appointed officer and a staff member.

_____
(Signature)

_____ _____
(Print Name) (Date)

_____
(Print Title)

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

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR GRANTING MEMBERSHIP & PRIVILEGES
OF THE MEDICAL STAFF FOR JULY, 2019

July 25, 2019 – 5:00 o'clock p.m.
Administrative Conference Room
4002 Vista Way, Oceanside, CA 92056

A Meeting was held at the location noted above at Tri-City Medical Center, 4002 Vista Way, Oceanside, California at 5:00 p.m. on July 25, 2019 to consider granting membership and privileges of the Medical Staff for July, 2019 per Medical Staff Policy 8710-550.

The following individuals were present:

Chairperson Leigh Anne Grass
Dr. Mark Yamanaka, Chief of Staff
Steven Dietlin, Chief Executive Officer

Also present was:

Teri Donnellan, Executive Assistant

Dr. Yamanaka presented the Medical Staff Credentials Report for July, 2019. He noted there were no "red flags". Dr. Yamanaka noted a correction to the Proctoring Recommendations related to Dr. Jessica Gomez who is an Ophthalmologist and incorrectly listed for OB/GYN Release from Proctoring rather than Ophthalmology.

Chairperson Grass, Dr. Yamanaka and Mr. Dietlin unanimously agreed to grant membership and privileges for the physicians reflected in the July Credentialing Report as recommended by the Medical Executive Committee on July 22, 2019.

There being no further business the meeting adjourned at 5:20 p.m.

_____
Leigh Anne Grass, Chairperson

_____
Mark Yamanaka, Chief of Staff

_____
Steven L. Dietlin, CEO

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
July 10, 2019

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 07/26/2019 – 06/30/2021)

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 07/26/2019 through 06/30/2021:

- **BACH, Dianne MD/Anesthesiology (ASMG)**
- **BEY, Thomas MD/Radiology (San Diego Imaging)**
- **CHAN, Jeffrey MD/Anesthesiology (ASMG)**
- **DAIRO, Brandon MD/Pain Management (Pacific Pain)**
- **HANLEY, Matthew MD/Orthopedic Surgery FELLOW – Assist ONLY (San Diego Sports Medicine)**
- **KHOSLA, Ankaj MD/Radiology (San Diego Imaging)**
- **McCUTCHEON, Claire MD/Internal Medicine (Coastal Hospitalists)**
- **TABOREK, Alexander MD/Anesthesiology (ASMG)**
- **WONG, Amy DPM/Podiatry (Tri-City Podiatry)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 4
July 10, 2019

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 08/01/2019 –07/31/2021)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 08/01/2019 through 07/31/2021, 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:

- AMINLARI, Ardalan, MD/Ophthalmology/Refer and Follow
- BIEDERMAN, Bruce, MD/Diagnostic Radiology/Active
- CASTREJON, Joseph, MD/Family Medicine/Refer and Follow
- CHEUNG, Philip, MD/Anesthesiology/Active
- DOUGLASS, Alan, MD/Endocrinology/Refer and Follow
- FRASIER, Bradley, MD/Urology/Active
- HAAK, Logan, MD/Ophthalmology/Active
- HEINLE, Erin, MD/Anesthesiology/Active
- KARACHALIOS, Michael, MD/Diagnostic Radiology/Provisional
- KORFF, Gary, MD/Family Medicine/Refer and Follow
- MALHOTRA, Arati, MD/Pediatrics/Active
- MIROW, Arvin, MD/Psychiatry/Active
- MOAZZAZ, Payam, MD/Orthopedic Surgery/Active
- NIELSEN, Amy, DO/Neurology/Active
- OH, Bismark, MD/Emergency Medicine/Active
- OLSON, Scott, MD/Interventional Neuroradiology/Active
- ORR, Robert, MD/Cardiology/Active Affiliate
- PAROLY, Warren, MD/Oncology/Active

Attachment B

- PATEL, Sheila, MD/Family Medicine/Active Affiliate
- SAMANI, Pargol, MD/Cardiology/Provisional
- SHIH, Jimmy, MD/Diagnostic Radiology/Provisional
- SLOWIK, Sharon, MD/Wound Care/Active
- TRACY, David, DDS/Oral & Maxillofacial Surgery/Active Affiliate
- VARSHNEY, Neeta, MD/Ophthalmology/Active
- WAILES, Robert, MD/Pain Medicine/Active Affiliate

RESIGNATIONS: (Effective date 07/31/2019 unless otherwise noted)

Automatic:

- Bahari, Abbas, MD/Neurological Surgery

Voluntary:

- DUPREE, Margaret, MD/Dermatology
- HIGGINS, Steven, MD/Cardiology
- LI, Terry, MD/Emergency Medicine
- MARQUART, Elizabeth, MD/Emergency Medicine

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
July 10, 2019

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given six months from the last reappointment date to complete their outstanding proctoring, and given an additional six month period after that one. These practitioners failed to meet the proposed deadline and are approved for an additional 6 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by ***January 31, 2020*** would result in these privileges automatically relinquishing.

- **JACOBS, Karl, MD** — **Psychiatry**
- **KUSHNARYOV, Anton, MD** — **Otolaryngology**
- **MACEWAN, Jennifer, MD** — **Otolaryngology**
- **MCGAHAN, Michele, MD** — **Diagnostic Radiology**
- **ONAITIS, Mark, MD** — **Cardiothoracic Surgery**
- **PIETILA, Michael, MD** — **Family Medicine**

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 **October 31, 2019** would result in these privileges automatically relinquishing.

- **CLARKSON, Chunjai, MD** — **Obstetrics & Gynecology**
- **GANDHI, Dhruvil, MD** — **General and Vascular Surgery**
- **GROVE, Jay, MD** — **General Surgery**
- **NGUYEN, Vu, MD** — **Dermatology**
- **PENRY, Jackson, MD** — **Radiology**
- **RUELAZ, Robert, MD** — **Cardiology**

STAFF STATUS CHANGE

- **RAJAMANICKAM, Anitha, MD** — **Cardiology**
  Change in Status: From Provisional to Active Staff

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
July 10, 2019

PROCTORING RECOMMENDATIONS (Effective 7/26/2019, unless otherwise specified)

• BERTHELSEN, Steven DPM	Podiatry
• BRAR, Karanbir MD	Internal Medicine
• GOMEZ, Jessica MD	OB/GYN
• KABRA, Ashish MD	Cardiology
• MOUSSAVIAN, Mehran DO	Cardiology
• ZHAO, Zhong MD	Internal Medicine

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT
July 15, 2019

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 7/26/2019 – 4/30/2021)

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 7/26/2019 through 4/30/2021:

- **DeMASCO, Michael PA-C/Allied Health Professional (TeamHealth)**
- **FREIWALD, Adam PA-C/Allied Health Professional (TeamHealth)**
- **HAIGLER, Heather PA-C/Allied Health Professional (TeamHealth)**
- **RIVERA, Stephen PA-C/Allied Health Professional (Orthopedic Specialists of North County/Tri-City)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT – 1 of 4
July 15, 2019

Attachment B

BIENNIAL REAPPRAISALS: (Effective Dates 8/1/2019 – 7/31/2021)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 8/1/2019 through 7/31/2021, 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:

- **ALLEN, Danielle, AuD/Allied Health Professional**
- **COCO, Kathleen, CNM/Allied Health Professional**
- **HAMILTON, Jr., James, PA-C/Allied Health Professional**
- **KAUR, Manpreet, PA-C/Allied Health Professional**
- **KIMBER, James, PA-C/Allied Health Professional**
- **MEMEO, Kelly, NP/Allied Health Professional**
- **SAVIC, Jessica, PA-C/Allied Health Professional**
- **TEBON, Renee, PA-C/Allied Health Professional**
- **WALLACE, Stephanie, PA/Allied Health Professional**

ANNUAL EVALUATIONS:

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

- Allen, Danielle M., AuD
- Allen, Matthew G., PAC
- Alston, Vickie S., CNM
- Brockman, Joe B., PA-C
- Carlton, Vivian W., PAC
- Crespo, Christopher N., PAC
- Elamparo, Kaye L., NP
- Forbes, Beth, RNFA
- Garbaczewski, Stephanie H., PAC
- Hammonds, Tommy D., PA-C
- Hermann, Linda, PAC
- Hermanson, Kathleen H., PA

Attachment B

- Huang, Stephanie K., PAC
- Hunt, Cris T., AuD
- Jaramillo, Elizabeth C., AuD
- Kaur, Manpreet, PAC
- King, John F., AuD
- Kolt, Thomas L., PAC
- Kwan, Jaclyn E., PAC
- Martinez, Melinda W., PAC
- Mateo, Marie E., CNM
- Murphy, Kayla, CNM
- Myers, Shannon E., AuD
- Perlman, Tamara L., CNM
- Renne, Brittany A., AuD
- Rice, William M., PAC
- Schillinger, Stephan B., PAC
- Schroeder, Mary L., CNM
- Scott, Katie L., PAC
- Stabler, Holly, PAC
- Tebon, Renee, PAC
- Varner, Alicia N., OT
- Venor, Kristen A., CNM
- Weichert, Rachel A., AuD, CNIM

RESIGNATIONS: (Effective date 07/31/2019 unless otherwise noted)

- **FREHNER, Lindsey, PAC/Allied Health Professional**
- **LISTER, Crystal, CNM/Allied Health Professional**
- **MCDONOUGH, Mark, PhD/Allied Health Professional**
- **STAHL, Hollis, PAC/Allied Health Professional**
- **WEARY, Yong, CNM/Allied Health Professional**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 2 of 3
July 15, 2019

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given six months from the last reappointment date to complete their outstanding proctoring, and given an additional six month period after that one. These practitioners failed to meet the proposed deadline and are approved for an additional 6 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by ***January 31, 2020*** would result in these privileges automatically relinquishing.

- **FREHNER, Lindsey, PA** — **Allied Health Professional**
- **MILLER, Cortney FNP** — **Allied Health Professional**
- **STABLER, Holly, PA** — **Allied Health Professional**
- **VARNER, Alicia OT** — **Allied Health Professional**
- **VIERRA, Erin NP** — **Allied Health Professional**

ADDITIONAL PRIVILEGE REQUEST (Effective 7/26/2019, unless otherwise specified)

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

- **KELLY, Katherine CNM** — **Allied Health Professional**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 3 of 3
July 15, 2019

Attachment C

PROCTORING RECOMMENDATIONS (Effective 7/26/2019, unless otherwise specified)

- **FISHER-GAMEZ, Lori NP, RNFA** — **Allied Health Professional**

ADMINISTRATION REVIEW CONSENT AGENDA
July 1st, 2019

CONTACT: Barbara Vogelsang, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Chemotherapy Prescribing, Processing, and Preparation Policy	3 Year Review, Practice Change	Forward to BOD for Approval
2. Communicating with Physician Using SBAR Policy	3 Year Review, Practice Change	Forward to BOD for Approval
3. Communication with the Sensory Impaired and-or Persons with Language Barriers	3 Year Review, Practice Change	Forward to BOD for Approval
4. Epidural or Intrathecal Catheter Infusion in the Non-Laboring Patient Procedure	Practice Change	Forward to BOD for Approval
5. Intracranial Pressure ICP Monitoring External Ventricular Drain EVD Care of	NEW	Forward to BOD for Approval
6. Physician's Admission Responsibilities Policy	3 Year Review, Practice Change	Forward to BOD for Approval
7. Restraints-Seclusion for Violent-Self-Destructive Behavior Policy	3 Year Review, Practice Change	Forward to BOD for Approval
8. Standards of Care Adult	2 Year Review, Practice Change	Forward to BOD for Approval
9. Stool Management-Rectal Tube SMS Procedure	DELETE	Forward to BOD for Approval
10. Stroke Code, Emergency Department Procedure	Practice Change	Forward to BOD for Approval
1. Therapeutic Anticoagulation Management Policy	Practice Change	Forward to BOD for Approval
Administrative Policies & Procedures		
1. Secure Environment 204	NEW	Forward to BOD for Approval
2. Weapons Scanning in the Emergency Department	NEW	Forward to BOD for Approval
Engineering		
1. 6001 Decontamination Of Equipment	3 Year Review, Practice Change	Forward to BOD for Approval
2. 6002 Prevention Of Exposure To Blood Borne Diseases	3 Year Review, Practice Change	Forward to BOD for Approval
Food and Nutrition		
1. Nutritional Care and Assessment for Infants Admitted to NICU	3 Year Review, Practice Change	Forward to BOD for Approval
NICU		
1. Nutritional Care and Assessment for Infants Admitted to NICU	DELETE	Forward to BOD for Approval
Infection Control		
1. Influx of Infectious Patients Epidemic Influenza or Other Respiratory Transmitted Disease IC 15.0	3 Year Review, Practice Change	Forward to BOD for Approval
Medical Staff		
1. Credentialing Standards for Catheter-Based Peripheral Vascular* Interventional Procedures	Practice Change	Forward to BOD for Approval
Surgical Services		
1. Scheduling Surgical Procedures Policy	Practice Change	Forward to BOD for Approval

ADMINISTRATION REVIEW CONSENT AGENDA
July 1st, 2019

CONTACT: Barbara Vogelsang, CNE

Policies and Procedures	Reason	Recommendations
Women and Newborn Services		
1. Newborn Sepsis Care Guidelines	2 Year Review, Practice Change	Forward to BOD for Approval
Formulary Requests		
1. Peramivir Monograph	Add To Formulary	Forward to BOD for Approval

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 11/11 **SUBJECT:** Chemotherapy Prescribing, Processing and Preparation

REVISION DATE(S): 05/13, 06/14, 07/15

~~Department~~ Patient Care Services Content Expert Approval:	~~05/16~~11/17
Clinical Policies ~~and~~ & Procedures Committee Approval:	~~06/16~~12/17
Nurse Executive ~~Council~~ Committee Approval:	~~07/16~~01/18
Division of Oncology Approval:	~~07/16~~03/19
Pharmacy ~~and~~ & Therapeutics Committee Approval:	~~06/16~~05/19
Medical Executive Committee Approval:	~~08/16~~06/19
Administration Approval:	07/19
Professional Affairs Committee Approval:	~~09/16~~ n/a
Board of Directors Approval:	09/16

A. **PURPOSE:**

1. All chemotherapy prescribed for Tri-City Healthcare District (TCHD) patients will be processed according to the following policy to ensure accuracy and safety in prescribing, processing and preparation of chemotherapeutic agents.

B. **CHEMOTHERAPY PRESCRIBING PROCEDURE:**

1. Chemotherapy will encompass anti-neoplastic agents used to treat cancer including monoclonal antibodies, oral tyrosine kinase inhibitors as well as traditional cytotoxic chemotherapy.
2. Orders written for chemotherapy agents shall meet the following criteria:
   a. Written on **either** the ~~standard,~~ pre-printed "**Standard** Chemotherapy Order Form" **or the regimen specific order forms.**
      i. Exception: TCHD Outpatient Infusion Center (OIC) may use institution specific Chemotherapy Orders.
      ii. Outpatient chemotherapy orders are invalid for use upon hospital admission. Orders must be rewritten **either** on the ~~standard,~~ pre-printed "**Standard** Chemotherapy Order Form" **or the regimen specific order forms.**
      iii. Telephone and verbal orders between physicians~~/Allied Health Professionals (AHP)~~ and physician assistant/nursing will not be accepted unless **order is** to hold or stop chemotherapy administration.
      iv. Changes to orders regarding chemotherapy drug name, dosing parameters, route, or patient name/2nd identifiers will only be accepted by pharmacy if re-written by the physician~~/AHP~~ on the Chemotherapy Order Form.
         1) Exception: A pharmacist may modify an existing Chemotherapy Order Form with "verbal/telephone order read back".
         2) Pharmacists may shorten multi day continuous infusions from over 24 hour to 22 hours for logistical purposes without a "verbal/telephone order read back".
      v. Corrected carboplatin doses based on the Calvert equation may be calculated by the pharmacist and documented on the original order. The pharmacist must read back the change to the physician~~/AHP~~.
   b. Complete orders must include:
      i. Patient's full name and second patient identifier (medical record number~~,~~ **or date of birth [DOB]) per Patient Care Services Policy: Identification, Patient.**
      ii. Date
      iii. Diagnosis

iv. Regimen name and cycle number
v. Protocol name
vi. Appropriate criteria to treat (i.e based on relevant laboratory results and toxicities)
vii. Allergies
viii. Reference to the methodology of the dose calculation or standard of practice equations (i.e. calculation of creatinine clearance)
  1) For carboplatin calculated with the Calvert equation this includes:
    a) Target **area under curve** (AUC)
    b) Creatinine Clearance and equation used to calculate if different than Cockcroft-Gault
    c) Serum Creatinine used if different than current lab
    d) Actual, ideal or adjusted weight used to calculate dose
ix. Height, weight and any other variables used to calculate the dose (i.e. **body surface area** [BSA])
  1) Inpatient chemotherapy: height and weight should be measured within 48 hours from the start of the new cycle.
  2) Outpatient chemotherapy: weight should be measured at the beginning of each new cycle. Height must be measured at the beginning of each new regimen.
x. Dosage
  1) Doses may not include trailing zeros; use a leading zero **(0)** for doses less than **one (1)** mg
  2) Doses will use the metric system and include dose/m^2, dose/kilogram or AUC ~~(area under the curve)~~ when appropriate. The actual calculated dose will be included
  3) Written as the amount per dose per day (e.g. cisplatin 20 mg/m^2 daily x 5 days, or cytarabine 3000 mg/m^2/dose every 12 hours on days 1,3, and 5)- never written as total amount needed per course of therapy as this could be interpreted as daily dose
xi. Route and rate (if applicable) for administration
xii. Length of infusion (if applicable)
xiii. Supportive care treatments appropriate for the regimen (including premedications, hydration, growth factors and hypersensitivity medications)
xiv. Sequence of drug administration (if applicable)
xv. Cumulative dose for medications with dose ceilings including daunorubicin, doxorubicin, doxorubicin liposomal, epirubicin, bleomycin, mitomycin C

c. Written using the generic name of the agent and free of any unapproved abbreviations used to identify the agent being prescribed. The pharmacist may clarify chemotherapy orders and write the generic name next to any commonly used abbreviation or brand names
d. Free of any number prefixes such as "5-fluorouracil", which could be misinterpreted as part of the order dose or schedule requirements
e. Signed by a physician~~/AHP~~ (**medical doctor** [MD] or **Doctor of Osteopathic Medicine** [DO]) of Oncology or those who have been granted privileges to order chemotherapy before processed by pharmacy
  ~~i. Signed by person drafting order if different than person signing order.~~
  i. Note: Pharmacy will not accept orders from Nurse Practitioners (NPs) ~~and~~ or Physician Assistants (PAs) for any chemotherapy agent regardless of indication or use.
  ii. New orders must be written prior to each new chemotherapy cycle.
    1) Exception: Outpatient Infusion Center- Orders must be reviewed and re-signed yearly.

f. Accompanied by a copy and/or name of a readily available reference or the protocol name and number used in determining the prescribed regimen if the regimen is unfamiliar to the pharmacist.

3. Exceptions
   a. Physicians~~/AHPs~~ that are without chemotherapy privileges may write for chemotherapy only if they have been granted privileges by the medical staff to do so as related to their specialty including but not limited to:
      i. Ectopic pregnancy
      ii. Rheumatoid arthritis
      iii. Systemic lupus erythematosus
      iv. Certain dermatologic conditions
      v. Certain ophthalmic procedures
      vi. Other auto-immune conditions as identified in the literature
      vii. Androgen deprivation therapy for prostate cancer
   b. All orders must be written on a standard pre-printed "Chemotherapy Order Form" and subject to all other requirements stated above.
      i. Use of standard pre-printed form is not required only if:
         1) Oral agent is prescribed for a non-malignant condition and may be ordered via **computerized provider order entry** (CPOE).
         2) Androgen deprivation therapy is prescribed by an urologist or oncologist for prostate cancer.
         ~~2)~~**3) IM methotrexate is ordered for ectopic pregnancy via CPOE**
      ii. Outpatient oral chemotherapy may be continued in-house by an attending physician~~/AHP~~ via CPOE. Pharmacist shall verify that patient is currently on oral chemotherapy regimen.
   c. Non-systemic chemotherapy such intrathecally, intravesically or directly in-to an organ (i.e. chemoembolization) may be ordered and administered by a qualified physician~~/AHP~~ in other areas of the hospital (interventional radiology, operating room). Use of standard pre-printed "Chemotherapy Order Form" is not required

C. **CHEMOTHERAPY PROCESSING PROCEDURE:**

1. The pharmacist will confirm that the order has been prescribed according to the criteria above.
2. The pharmacist shall contact the physician~~/AHP~~ to request that any order not meeting these criteria be changed.
3. All addendums or changes to original orders must be documented on a Chemotherapy Order Form.
4. Changes to the order made by the physician~~/AHP~~ (as above) must be double checked by a second pharmacist.
5. If there is a discrepancy in the medication order, nursing will be notified of the problem and the possible delay in the delivery of the medication.
6. Once the prescribing criteria have been met, the pharmacist is responsible for verifying the accuracy of the order by:
   a. Confirming the two **(2)** patient identifiers
   b. Reviewing the diagnosis and prescribed regimen (drug name, dose, route and frequency)
   c. Calculating the patients' BSA, unit conversions and patient-specific dose
   d. Reviewing diluents, drug volumes, rate of administration, drug concentration requirements, drug stability, administration times, infusion guidelines and supportive care medications
   e. Verifying appropriate labs have been ordered and are within acceptable ranges for the ordered chemotherapy medications or if treatment modifications are indicated
   f. Confirming correct time interval has elapsed between treatments
   g. Reviewing drug allergies and sensitivities along with adverse drug effect histories

h. Current medication profile should be evaluated for potential drug interactions with antineoplastic therapy

7. Upon completion of the verification process, the pharmacist will prepare a chemotherapy work sheet for use in preparing the prescribed regimen. One worksheet must be filled out for each patient. The following information should be documented:
   a. Patient name second identifier (i.e. DOB and/or medical record number)
   b. Height, weight, body surface area
   c. Diagnosis, allergies, doctor's name and regimen name
   d. Full generic medication name, dose/m^2 or AUC, route, frequency and any special medication instructions that are different then institutional standards
   e. Appropriate cycle number and day along with corresponding date of treatment
   f. Cumulative dose for medications with dose ceilings
8. The order shall be entered into the electronic ~~medical~~ **health** record **(EHR)** under the patient's medication profile.
9. ~~-~~A second pharmacist must verify the accuracy of the regimen, chemotherapy work-sheet and corresponding entries in medication profile and initial the work sheet to signify approval.
   a. Changes in subsequent doses should be noted on the chemotherapy worksheet and must be double checked and initialed by a second pharmacist.
   b. Explanation of reason for changing subsequent doses shall also be documented.
10. On the day of treatment, the verifying pharmacist must check the following:
   a. Dose changes based on weight:
      i. Cytotoxic chemotherapy: The dose is within 5% of treatment plan dose based on the current weight.
      ii. Monoclonal antibodies: The dose is within 10% of treatment plan dose based on the current weight.
      iii. Any questions regarding weight that could affect the treatment regimen will be brought to the physician~~'s/AHP's~~ attention.
   b. Chemotherapy orders have not changed between the original regimen verification and the actual day of treatment and all computerized order entries are correct.
   c. Appropriate labs are drawn within the appropriate time interval and are regimen specific.
      i. Labs will be evidence based when national guidelines (e.g. **American Society of Clinical Oncology [**ASCO**]/ National Comprehensive Cancer Network [**NCCN**]**) exist or determined by practitioner
      ii. Guidelines for timing of labs:
         1) In chemotherapy naïve patients (no prior chemo)- lab results should be no older than **seven** (7) days.
         2) For patients currently receiving chemo with the following frequencies:
            a) Every **seven** (7) days – lab results should be within **two** (2) calendar days
            b) Every **fourteen** (14 days) and beyond – lab results can be within **three** (3) calendar days (i.e. 72 hours)
         3) Daily (consecutive days of chemo) – labs should be drawn on day **one** (1).
         4) Older labs may be accepted at the pharmacists' discretion.
      iii. Any abnormal lab values that could affect the treatment regimen will be brought to the physician's~~/AHP's~~ attention.
      iv. In the absence of treatment parameters, the lab values of ANC ≤ 1500 cells/µL, platelets ≤ 100,000/uL total bilirubin ≥ 1.4 mg/dL, CrCl <60 mg/dL (if drug renally cleared) and any other laboratory values specific to prescribed chemotherapy that are not within normal limits will be approved with physician~~/AHP~~ before preparation of dose.
   d. Confirm the cycle has been checked and signed off by two **(2)** pharmacists.
   e. The pharmacist that performs steps a- **through** e above will initial the chemotherapy worksheet signifying that this part of verification has been done.

f. A second pharmacist will verify steps a- **through** f above and initial chemotherapy worksheet.

11. The verification process must be followed completely before any dose can be prepared.
12. Exceptions
    a. For ~~TCMD~~ **TCHD** OIC, the second pharmacist verification as outlined ~~in C.11.f~~ **above** can be omitted.

D. **CHEMOTHERAPY PREPARATION AND DISPENSING PROCEDURE:**

1. The technician responsible for preparing the doses must gather the order, chemotherapy worksheet, patient-specific labels, medication, and associated supplies.
2. The technician is responsible for recording the following for preparation records:
    a. Patient name and one other identifier
    b. Time and date the product was prepared
    c. Medication, concentration and volume used
    d. The lot number/expiration date from the medication vial and **intravenous (IV)** diluent bag.
3. The technician must initial the chemotherapy worksheet, product label and preparation records and perform all calculations associated with the compounding process.
4. If an oral chemotherapy drug is to be physically manipulated or repackaged, the process must be done in a biological safety cabinet (vertical flow hood) to prevent inhalation exposure.
5. All intravenous chemotherapy will be prepared using a Closed System Transfer Device (CTSD) whenever possible in a Biological Safety Cabinet using Hazardous Drug Preparation guidelines.
6. All parenteral chemotherapy medications will be spiked and primed in the chemo hood if dispensed as IV piggyback.
7. The syringes for each drug and/or solution used in preparing the product (including syringes used to dilute drug vials) must be pulled back to indicated the measured volume or shown to the pharmacist before injecting into IV solution.~~.~~
8. The pharmacist, working independently must verify the following:
    a. The current cycle and verification boxes have been signed off on the chemotherapy work sheet.
    b. The patient specific labels match the chemotherapy worksheet.
    c. The correct medication has been chosen
    d. The drug was reconstituted correctly using the correct volume and diluent
    e. The volume of drug used was accurately measured for the prescribed dose
    f. The label is correct and includes at least:
        i. Patient's full name and second patient identifier (i.e. DOB or medical record number)
        ii. Full generic drug name
        iii. Drug administration route
        iv. Total dose to be given
        v. Total volume required to administer dosage
        vi. Date of administration
        vii. Date and time of preparation
        viii. Date and time of expiration if not for immediate use
        ix. Special handling instructions and caution statements (i.e. intrathecal use only)
        x. Final concentration of product on syringe labels (i.e. doxorubicin 50mg/ 25mL)
        xi. All minibag or large volume parenterals include volume of each component as well as a total volume
        xii. Rate of administration
    g. Final container integrity and correct type of final container (e.g. syringe/and or minibag type) are appropriate for the specific chemotherapy.
    h. All intrathecal doses
        i. Must not be prepared during preparation of any other agents
        ii. Labeled with an identifiable intrathecal medication label

iii. Must be placed in a separate transport bag
iv. Be delivered only with other medications intended for administration intrathecally

i. Maximum syringe size dispensed should be 35 mL
i. Any IV push dose in syringe should be less than three quarters full to minimize the risk of chemo spill.

j. An overfill volume of 0.05 ml will be added to all subcutaneous doses

9. Upon completing the chemotherapy preparation process, the final product shall be affixed with patient specific labels
10. All hazardous chemotherapeutic agents regardless of route and indication shall be dispensed from the pharmacy with an auxiliary Chemotherapy Warning label
11. Any IV line that has been primed with active drug will be dispensed from the pharmacy with appropriate auxiliary label
12. The pharmacist must sign their initials on the chemotherapy work sheet, patient specific label and preparation records to signify product verification.
    a. The pharmacist must ensure the technician has initialed all aforementioned places as well.
13. All chemotherapy doses are placed in a sealable chemotherapy bag
14. Delivery
    a. Must be put into a chemotherapy cooler containing a spill kit for transportation out of pharmacy.
        i. Chemotherapy leaving the hospital must be double bagged.
    b. Chemotherapy will only be delivered to designated oncology floors.

E. FORM(S):

~~D.~~1. **Chemotherapy Orders 8711-3222 Form - Sample**

F. RELATED DOCUMENT(S):

1. **Patient Care Services Procedure: Hazardous Drugs**
~~a.~~2. **Patient Care Services Policy: Identification, Patient**

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

~~15.~~1. Neuss, M. N; et al. (2013) Updated American Society of Clinical Oncology/Oncology Nursing Society Chemotherapy Administration Safety Standards Including Standards for the Safe Administration and Management of Oral Chemotherapy. *Journal of Oncology Practice.*
~~16.~~2. American Society of Health-System Pharmacists. ASHP guidelines on preventing medication errors with antineoplastic agents. Am J Health-Syst Pharm. 2002; 59:1648–68.

Chemotherapy Orders 8711-3222 Form - Sample

☐ Inpatient ☐ Outpatient Cycle#______________

DIAGNOSIS/REGIMEN/MNEMONIC:______________________________

ALLERGIES:______________________________

CURRENT Height ______(in)________ (cm) Weight ________(kg)________ (lbs) BSA _______ (M^2) CrCl_______

Cumulative Dose (If Applicable)______________________________

CHEMOTHERAPY AGENTS

Note: Diluent/Volume/and Rate of Administration per Standard of Practice unless otherwise stated in Chemo Instructions

Start Chemo Date:	Agent	Mg/M^2 dose	Mg dose	Route of Administration	Frequency (continuous, every _ hrs, day 1,3,5, etc.)	Duration (X_days, X_doses)
				☐ Infusion ☐ Sub Q ☐ IVPB ☐ PO ☐Intrathecal ☐ IVP ☐		
				☐ Infusion ☐ Sub Q ☐ IVPB ☐ PO ☐Intrathecal ☐ IVP ☐		
				☐ Infusion ☐ Sub Q ☐ IVPB ☐ PO ☐Intrathecal ☐ IVP ☐		
				☐ Infusion ☐ Sub Q ☐ IVPB ☐ PO ☐Intrathecal ☐ IVP ☐		
				☐ Infusion ☐ Sub Q ☐ IVPB ☐ PO ☐Intrathecal ☐ IVP ☐		

Chemo Instructions or reasons for dose modifications: ______________________________

____

____

Pre-medications: ______________________________

____

Hydration: ______________________________

Anti-emetics: ______________________________

Lab/Diagnostic Test(s): ______________________________

☐ Notify MD with Lab/Diagnostic test(s) prior to chemo administration

☐ Access Mediport ☐ Place PICC Line

☐ Heparinize Mediport PRN ☐ Infuse via Periph IV

Nurse's – Signature Date Time	Physician's – Signature Date Time

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056
8711-4010

CHEMOTHERAPY ORDERS

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Affix Patient Label

8711-3222 Revised (04/15) PHYSICIAN'S ORDERS Board Approved 04/15

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 10/06	**SUBJECT:** Communicating with Physicians/Allied Health Professionals (AHP) Using the SBAR Process
REVISION DATE: 07/09~~;~~, 09/12	~~POLICY NUMBER: IV.F.1~~

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

A. **POLICY:**

1. The SBAR (Situation Background Assessment Recommendation) process shall be utilized to communicate with physicians/AHP, the Rapid Response Team, and Code Team members regarding patient status or a critical situation.

B. **PROCEDURE:**

1. Prior to calling the physician/AHP, follow these suggestions:
   a. Assess patient
   b. Discuss situation with resources (i.e. Assistant Nurse Manager (ANM) or designee, resource nurse, rapid response nurse)
   c. Review the chart for appropriate physician/AHP
   d. Know the admitting diagnosis and date of admission
   e. Read the most recent progress notes and review charting from the nurse who worked the prior shift
   f. Have available when speaking with physician/AHP:
      i. Patient's chart
      ii. List of current medications, allergies, intravenous (IV) fluids
      iii. Most recent vital signs
      iv. Most recent lab results
      v. Code status
2. When calling the physician/AHP, follow the SBAR process:
   a. (S) Situation: What is the situation you are calling about?
      i. Identify self, unit, patient, and room number.
      ii. Briefly state the problem, when it began, and how severe.
   b. (B) Background: Pertinent background information related to the situation may include the following:
      i. The admitting diagnosis and date of admission
      ii. List of current medications, allergies, IV fluids
      iii. Most recent vital signs
      iv. Lab results: provide the date and time test was completed and results of previous tests for comparison

v. Other clinical information
vi. Code Status
vii. Relevant past medical history

c. (A) Assessment: Pertinent physical assessment findings
d. (R) Recommendation: What is the nurse's recommendation? Examples may be:
   i. Transfer patient to critical care
   ii. Come to see the patient at this time
   iii. Talk to the patient or family about code status
   iv. Any diagnostic tests needed
   v. A change in treatment order

3. Document the change in patient's condition and physician/AHP notification in the medical record.

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

1. ~~Sample~~ SBAR Report to Physician

~~SAMPLE~~ SBAR Report to Physician

SBAR report to physician about a critical situation (Ask physician "Are you familiar with this patient?")

S	**Situation** **I am calling about** <patient name and location> **The patient's code status is** <code status> **The problem I am calling about is < state what you are calling about>** (I am afraid the patient is going to arrest) **I have just assessed the patient personally:** **Vital signs are: Blood pressure ___/___, Pulse ___, Respiration ___ and temperature ___** **I am concerned about the:** Systolic blood pressure because it is less than 90 mm/Hg or greater than 200 mm/Hg Heart rate because it is less than 50 or greater than 130 beats per minute Respiratory rate because it is less than 8 or greater than 28 breaths per minute or threatened airway Oxygen saturation level is less than 92% despite oxygen therapy at _____liters via NC or _____ Temperature because it is less than 35.5 or greater than 40 degrees Celsius **Urine output** is less than 50 mL in 4 hours **Acute significant bleed**, new, repeated or prolonged seizures **Level of consciousness**, sudden unexplained agitation and confusion **Change in skin tone** (pale, dusky, gray, or blue) **Failure to respond** to treatment for an acute problem/symptom **The patient must be stabilized or a decision to transfer to a higher level of care must be made within 30 minutes.**
B	**Background** **The patient's mental status is:** Alert and oriented to person place and time. Confused and cooperative or non-cooperative. Agitated or combative Lethargic but conversant and able to swallow. Stuporous and not talking clearly and possibly not able to swallow. Comatose. Eyes closed. Not responding to stimulation. **The skin is:** Warm and dry Pale Mottled Diaphoretic Extremities are cold/warm **The patient is not or is on oxygen.** The patient has been on ____(l/min) or (%) oxygen for ____minutes (hours) The oximeter is reading ____% The oximeter does not detect a good pulse and is giving erratic readings.
A	**Assessment** **This is what I think the problem is** <state what you think is the problem> The problem seems to be **cardiac infection neurologic respiratory** _____ I am not sure what the problem is but the patient is deteriorating. **The patient seems to be unstable and may get worse, we need to do something.**
R	**Recommendation** **I suggest or Request that you** <say what you would like to see done> Transfer the patient to critical care Come to see the patient at this time Talk to the patient or family about code status Ask the on-call family practice resident to see the patient now **Are any test needed:** Do you need any test like: CXR, ABG, ECG, CBC, Labs {i.e. CBC, C7, C12, Magnesium CPK, Trop Other test? _____ **If a change in treatment is ordered then ask:** How often do you want vital signs? How long do you expect this problem will last? If the patient does not get better when would you want us to call again? **Are there any new medication orders?**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 11/88	**SUBJECT:** Communication with the Sensory Impaired (Blind/Deaf)
REVISION DATE(S): 09/91, 07/94, 10/99, 06/03, 06/05, 07/07, 08/08, 11/09, 11/11, 05/12	~~**POLICY NUMBER: II.H**~~

Patient Care Services Content Expert Approval:	~~03/18~~01/19
Clinical Policies & Procedures Committee Approval:	~~05/15~~02/19
Nurse Executive Council:	03/19
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~06/15~~, 03/19
Administration Approval:	07/19
Professional Affairs Committee Approval:	~~07/15~~ n/a
Board of Directors Approval:	07/15

A. **DEFINITIONS**:

1. **Deaf or Hard Hearing ~~Impaired~~: Refers to an** ~~A hearing impaired~~ individual **who** has difficulty hearing and/or discriminating oral conversation either in a face-to-face situation or over the telephone. ~~An i~~**Individuals who are deaf and hard of hearing may have Limited English Proficiency (LEP) and may require interpreters, or other auxiliary aids and services to communicate effectively** ~~with this impairment may require a hearing aid, telephone amplifier, Telecommunication Device for the Deaf/TeleTYpewriter (TDD/TTY) or sign language interpreter~~.
2. **Visually Impaired** (visual impairment, partial sight, low vision, legally blind or totally blind): A visually impaired individual has some difficulty seeing and reading information and may require special assistance and/or supportive tools including non-visual resources.
3. **Companion: Means a family member, friend or associate of a patient or prospective patient, who along with the patient, is an appropriate person with whom the hospital may communicate with. The patient must give permission for the companion to receive information per the Patient Care Services (PCS) Policy: Privacy Code.**

~~2.~~4. **Auxiliary Aids and Services: This term includes qualified interpreters on-site or through video remote interpreting (VRI) services; written materials; telephone handset amplifiers; assistive listening devices; closed caption television; text telephones (TTYs), or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing.**

B. **POLICY:**

1. In accordance with regulatory standards, the following provisions have been established and will be implemented by staff caring for the patient with communication impairment. **TCHD will give consideration to the requests of individuals with disabilities in determining what types of auxiliary aids and services are necessary.**
2. Deaf or Hard of Hearing ~~Impaired~~
   a. **Determine if the patient needs translation services per the PCS Policy: Interpretation and Translation Services for guidance on when and how to provide~~r~~ interpretation services.**
   b. **As part of its patient registration process, TCHD shall evaluate any deaf or hard of hearing patient to determine what auxiliary aid(s) or service(s) would be most appropriate for that patient. Any auxiliary aid(s) or service(s) will be communicated**

and explained to subsequent providers as care continues throughout the duration of the patient's stay.

i. The outcome of this evaluation should be documented in the electronic health record (EHR)

c. TCHD shall place a sign in the Patient's room indicating that the patient is deaf and requires auxiliary aids and services to communicate. This will facilitate communication between the patient and all staff who enter the room.

~~d. If a patient declines interpretation assistance, the offer and refusal of interpreting services must be clearly documented in the patient's EHR. It is essential that the person requiring interpreting services specifically indicate their refusal; do not allow another person to refuse on their behalf.~~

e. After being informed of the availability of interpreters who are qualified to interpret medical information at no charge, patients may refuse the TCHD's interpretation service and select an individual of their choice to assist with their communication needs. Any costs incurred in this situation will be the responsibility of the patient.

~~a.~~i. A patient's waiver of TCHD's interpretation service must be knowing and voluntary, and the person refusing services must sign a waiver form to that effect. An interpreter may be necessary to ensure that the refusal is knowing and voluntary.

1) See Waiver of Interpretation Services Form

ii. ~~Patient r~~Refusal of TCHD's interpretation service must be documented in the ~~electronic~~ health~~medical~~ record. ~~i~~In addition ~~to~~ the name of the individual that the patient has selected to perform interpretation should be documented.

~~b.~~iii. Staff members may access a TCHD medical information interpreter if at any time they feel there is a communication barrier with the interpreter selected by the patient and may have a hospital-designated interpreter monitor the communication.

f. As part of the evaluation process, TCHD will re-assess the services being provided to the patient throughout the patient's stay to ensure that the services are providing effective communication to the patient.

g. A deaf individual who does request an American Sign Language interpreter on-site will be provided one as available.

~~c.~~h. The patient or the patient's companions will be allowed to utilize their own videophone (VP) in the same manner that a hearing person would utilize an audio phone unless it poses a risk to patient safety.

~~i. Sign language charts are available in the Tri-City Medical Center Telephone Directory and on the intranet under "Patient Information."~~

~~ii. Video remote services and/or TDD/TTY through hospital designated provider shall be provided for the hearing impaired and are located in the Private Branch Exchange (PBX).~~

~~1) See instructions for Video Remote Services on the Intranet~~

~~iii. Community resources such as sign language interpreters are available upon request~~

~~d.~~i. Visually Impaired

i. Visually impaired patients shall be provided with adaptive devices, such as squeeze balls for call lights.

1) Squeeze balls can be obtained from the Engineering Department.

ii. All documents that patients are asked to read or sign shall be read aloud to visually impaired patients, questions shall be addressed, and patient verbalization of understanding documented.

C. **DOCUMENTATION**

1. Nursing or departmental staff shall record the patient's communication method in the medical record.

D. **FORM(S):~~/RELATED DOCUMENTS~~**

~~Video Remote Services Instructions~~

1. **Waiver of Interpretation Services 8610-NEW Sample**
2. ~~**Interpreter Request Form for Deaf Community Services**~~

E. RELATED DOCUMENT(S):

1. **Patient Care Services Policy: Interpretation and Translation Services**
2. ~~**TCHD Interpretation and Translation Resources Quick Reference & User Guide**~~ **(Deleting packet and separating into individual documents.)**
3. **Interpretation Resources and How to Access Them**
4. **Servicing the Deaf and Hard of Hearing Helpful Hints**
5. ~~1.~~ **Video Remote Interpretation (VRI) Resources~~Services Instructions~~**
   - ~~2.~~a. **VRI Device Deployment**
   - b. **VRI Schedule**
   - c. **VRI Language List**
   - d. **VRI Super User Guide**
   - e. **VRI User Guide**

~~E.~~F. REFERENCES

1. National American with Disabilities Act (ADA) www.usdoj.gov/crt/ada/adahom1.htm
2. Federal Interagency Working Group on Limited English Proficiency: www.justice.gov/crt/lep/
3. Joint Commission Hospital , Supporting Effective Communication, Cultural Competence, and Patient Centered Care 2011-2012
4. **United States Department of Justice: ADA Requirements: Effective Communication, https://www.ada.gov/effective-comm.htm**
5. ~~3.~~ **Patient Protection and Affordable Care Act, § 1557**

SAMPLE

Patient Name: _____

I understand my right to receive interpreting services free of charge, and acknowledge that I was offered access to these services. Tri-City Healthcare District (TCHD) staff also explained that using minors, friends and/or a person that has not been trained as an interpreter is not advisable.

Please check an option below:

_____ I decline interpretations services.

_____ ~~I do not need an interpreter. I am able to speak in English.~~

_____ I will use a family member or friend to interpret.

_____ I decline TCHD offered interpretations services and will use an interpreter service of my choice at my own cost.

Please list special requests here:

_____
_____
_____
_____

_____ _____ ____/____/____ _____AM/PM
Name: Patient/Representative | Signature: Patient/Representative | Date | Time

If signed by a person other than the patient, indicate relationship to patient: _____
Examples: Spouse, Partner, Legal Guardian

If patient is unable to sign, state reason: _____

_____ _____ ____/____/____ _____AM/PM
Witness – TCHD Representative (print name) | Signature • *Firma* | Date • *Fecha* | Time • *Hora*

INTERPRETATION (Complete if Interpretation provided)

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

_____ _____ ____/____/____ _____AM/PM
Interpreter ID number or Name | Interpreter Signature (if present) | Date | Time

❑ Patient refuses TCHD's interpretation services and selects as interpreter: _____
Name and relationship to patient

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

XXXX-XXXX

Waiver of Interpretation Services
Page 1 of 1

Affix Patient Label

(Rev. xx/xx)

DEAF COMMUNITY SERVICES
OF SAN DIEGO, INC.

DELETE

(DCS Only)
Job #:
Interpreter(s) Assigned:

Phone: 619 / 398-2488
Fax: 619 / 398-2490
Videophone: 619 / 550-3464
scheduler@dcsofsd.org
DEAFCOMMUNITYSERVICES.ORG

SIGN LANGUAGE INTERPRETER REQUEST FORM

Service Date: _____ Start Time: _____am/pm

Day of the Week: _____ Medical Check-In Time: _____am/pm

End Time: _____am/pm

Name of Deaf Person(s): _____

Nature of Appointment: _____

Medical Record #: _____

Insurance ID #: _____

Other:_____ DOB:_____

Please Indicate # of Participants:		
	Deaf/ Hard-of-Hearing:	Hearing:
Adults:		
Minors (17 & Under):		

Appointment Location: _____

_____

_____

(Please include: Business Name, Full Address, Bldg #, Room #, etc...)

Site Contact Information:

Name: _____ E-mail: _____

Phone: _____ Fax: _____

Requestor Information: ☐ Same As Site Contact

Name: _____ E-mail: _____

Phone: _____ Fax: _____

Number of Interpreters Needed: ____ Preferred Interpreter(s): _____ ☐ Male ☐ Female

Additional Information: _____

_____

_____

Mail Invoices to the Address Below:

Company Name: _____ Attn: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ E-mail: _____

PO #: _____ (If Applicable)

Preferred Method of Billing: ☐ Mail ☐ E-mail ☐ Fax

Tri-City Medical Center
Oceanside, California

Interpretation Resources and How to Access Them

In-House Healthcare Interpreter 760.802.2656	Spanish/English interpretation and translation. Interpreters are available per schedule. Call the number to request service. **Current schedule: 6:00 AM – 6:30 PM, 7-days a week.**
~~Dual-Role~~ Bilingual Employees	~~Dual-role~~ **Bilingual** employees are assessed and qualified individuals that can communicate in a language other than English and can serve as interpreters within their department and hospital-wide only during emergency situations. The level of service that they can provide depends on their assessment score ~~(more information on pages 14- 15).~~: • **Non-clinical** • **Bilingual** • **Bilingual Clinical**
Telephone Interpreters **760.769.1889** **~~855.273.6410~~**	Interpretation via telephone is available in over 200 languages. The current contracted service provider is **InDemand Interpreting**~~Language Services Associates (LSA) and the service is called *InterpreTalk*~~. Telephones are available throughout the hospital and should ONLY be used to provide interpretation services. You may also reach this service by dialing this number (unique to TCMC) from any telephone.
Video Remote Interpreters (VRI) **IMPORTANT:** Please return equipment to its station after each use and plug it into an electrical outlet so the computer remains charged and ready to use.	~~**Stratus** **InDemand Inpreting** VRI **devices**contracted service (iPads) • Mobile unit(s)~~ are available at every nurses' station. American Sign Language and Spanish are offered 24/7, 365 days. ~~As of the date on this document, fifteen o~~**O**ther languages are available during hours that are specified on the language selection screen. ~~Note that CDI/LSA is a team two interpreters, a Certified Deaf Interpreter and an American Sign Language interpreter. For ASL use the ASL only button.~~ ~~LSA also offers VRI services (on PCs). Mobile units can be found in PBX (this shared unit. PBX is located in the basement across from surgery scheduling) and the ER. American Sign Language and Spanish are offered 24/7, 365 days.~~

Face-to-face interpreters for American Sign Language (ASL)	Signs of Silence Interpreting Services: **760.580.3562** Deaf Community Services of San Diego: **619.398.2488** ~~(fillable form is also available on the Intranet for scheduling).~~ In emergency situations. Interpreters can generally be available within 30-45 minutes.

Tri-City Medical Center
Oceanside, California

Servicing the Deaf and Hard of Hearing

Free language assistance services are available for individuals who are Deaf of hard of hearing.

"It is incumbent upon the hospital to anticipate and assess such experiences and communication needs and arrange to provide on-site interpreter services during the communication intensive periods. The hospital should discuss the reasonably foreseeable health care activities and manage the logistics of communication access with the deaf individual and his/her health care providers immediately upon admission." - The National association of the Deaf.

For Medical Interpretation:

- **Face-to-Face contracted services**
  Contact information on **page 3**.

  Contracted in-person sign language interpretation and other forms of communicating with the Deaf and hard of hearing. Recommended for communication intensive periods, difficult situations (such as surgery), clinical sessions, when there are cognitive issues, etc.

  Unit staff may call and request service, which can be scheduled ahead of time. An interpreter then comes to TCMC and can usually be available within 30-45 minutes.

  When the interpreter comes in, have him/her check-in with at the Staffing office. A temporary ASL Interpreter badge will be given to the interpreter. At the end of the session, the interpreter returns badge to the Staffing and checks out.

- **Video Remote Interpreting (VRI)**
  Immediate, 24/7/365 contracted service useful for general, non-intensive communication periods. **VRI devices~~Stratus equipment (iPads on rolling poles)~~** are available at every nurses' station. **A roaming device is located in PBX for any area without a designated device.** ~~**Additional equipment** (larger rolling cart with laptop and keyboard) with LSA application can be found in PBX and the ER.~~

  ~~**Other equipment is currently available for a trial period.**~~

For General Interpretation - Relay Services:

Useful for setting appointments, coordinating with insurance, billing, answering general questions, especially when the person is outside of TCMC (regardless of who initiates the call, the Deaf/hard of hearing person or TCMC staff):

- TTD/Video relay in English: **1-800-735-2929** or **711** from any phone~~ or video phone~~.
- TDD/Video relay in Spanish: **1-800-855-3000** from any phone~~ or video phone~~.

~~Video Phone:~~

- ~~A deaf or hard of hearing person at TCMC is able to communicate directly with another person that has a video phone.~~
- ~~A deaf or hard of hearing person at TCMC is able to communicate with any telephone number via a relay operator that "relays" that information verbally to the hearing person, then types that person's message, which can be read on our computer screen.~~
- ~~Persons outside of TCMC can communicate with the deaf/hard of hearing person by calling the TCMC designated number.~~
- ~~TCMC staff can use VRI service included in this unit.~~

~~This shared video phone will soon be located~~

~~in the PBX office and can be used with~~ ~~on page~~
~~Ethernet (best) or Wi-Fi connections. Details~~

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**EPIDURAL OR INTRATHECAL CATHETER INFUSION IN THE NON-LABORING PATIENT**
Purpose:	To outline nursing management for the adult inpatient with an indwelling epidural or intrathecal catheter for narcotic administration.
Equipment:	~~1.~~ Portless Epidural/Intrathecal Administration Set ~~2.~~ Transparent dressing ~~3.~~ Alaris infusion pump ~~4.~~ Epidural/Intrathecal insertion kit ~~5.~~ Epidural/Intrathecal anesthetic/analgesic solution as ordered by anesthesiologist ~~6.~~ Blood pressure cuff ~~7.~~ Pulse oximeter ~~8.~~ Oxygen delivery equipment & suctioning equipment readily available at bedside ~~9.~~ Narcan® (Naloxone) ~~10.~~ Kelly clamp ~~11.~~ Narcotic administration record/Assessment Record ~~12.~~ Medication lock box ~~13.~~ Medication lock box key

A. **DEFINITION(S):**

1. Epidural Infusion: A continuous infusion into the epidural space.
2. Epidural Bolus: An intermittent injection via the indwelling epidural catheter.
3. Intrathecal Infusion: A continuous infusion into the intrathecal space.
4. PCEA infusion: patient controlled epidural analgesia.

B. **POLICY:**

1. The anesthesiologist~~/~~ **or** physician~~/Allied Health Professional (AHP)~~ and the assigned Registered Nurse (RN) share the responsibility for the observation and monitoring of patients receiving epidural or intrathecal anesthesia.
2. The pharmacy department is responsible for the preparation of the epidural anesthetic/analgesic solution.
3. Only the anesthesiologist~~/~~ **or** physician~~/AHP~~ may insert the epidural or intrathecal catheter. The lot number and brand of the kit will be documented on the procedure form by the nurse assisting with the procedure.
   - ~~3.~~**a. The nurse assisting with the procedure will ~~P~~provide positioning assistance and emotional support to the patient during the epidural initiation procedure.**
4. The patient will not be transferred to the next level of care until the epidural setup is connected, and the Alaris pump has been programmed and verified by two (2) RNs.
5. All epidural infusions must be on a dedicated infusion pump with only one module attached, and the intravenous (IV) solution contained in a~~n~~ medication lock box.
6. Electronic channel label shall be selected via guardrails or channel labels.
7. **Ensure patient has IV access.**
   - ~~7.~~**a.** IV access shall be maintained for at least **eight (8)** hours after last dose of epidural medicine or discontinuance of epidural/intrathecal catheter.

C. **PROCEDURE ~~FOR BAG INFUSION DELIVERY~~:**

~~1. Initiation:~~

1. Obtain physician's~~/AHP's~~ order for epidural or intrathecal solution.

Patient Care Services Content Expert	Clinical Policies & Procedures	Nurse Executive Committee	Department of Anesthesiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
04/07, 06/09, 07/15, 01/16, 08/17	07/11, 08/15, 05/16, 11/18, 02/19	08/11, 05/16, 03/19	10/16, 05/19	02/07, 11/16, 05/19	10/11, 11/16, 06/19	07/19	11/11, 01/17, n/a	11/11, 01/17

~~a.~~2. **Verify correct patient per Patient Care Services (PCS) Policy: Identification, Patient**
3. **Set-up:**
   a. **Bag Infusion Delivery:**
      ~~b.~~i. Spike the epidural/intrathecal solution, or bag with the yellow striped portless tubing after verification of correct dose with 2nd RN, prime the tubing, and thread the tubing through the epidural pump ~~with the medication lock box~~ according to manufacturer's instructions.
         ~~c.~~1) The epidural will be connected to the infusion tubing and Alaris pump on the sterile field if medication is available.
      ~~d.~~ii. Attach the medication lock box.
      iii. Lock the box containing the epidural/intrathecal solution with the medication lock box key stored in the Pyxis.
   b. **Syringe Delivery Device for Patient Controlled Epidural Analgesia (PCEA)**
      ~~e.~~i.
4. **Initiation:**
   a. Program the pump, using Guardrails, to the dosing parameters ordered by the anesthesiologist~~/~~ **or** physician~~/AHP~~ with 2nd RN to verify settings.
      i. For PCEA, the nurse will confirm epidural solution concentration and pump settings as ordered by anesthesiologist or physician~~/AHP~~ (i.e. rate mL/hr, bolus amount/ml). Lockout must be documented in patient care record and verified by 2 RN's.
   ~~f.~~b. Start the infusion.
   ~~g.~~c. Activate the lockout on the Alaris pump controls, located on the back of the infusion device.
   ~~h.~~d. Return the medication lock box key to Pyxis
   ~~i.~~e. Document on electronic health record (EHR) with **two (2)** RNs.
   ~~j.~~f. ~~Provide positioning assistance and emotional support to the patient during the epidural initiation procedure.~~
~~2.~~5. Maintenance:
   a. Administration of bolus or increase:
      i. Boluses must be given through infusion pump, do not break the closed system.
      ii. Program infusion rate on pump per anesthesiologist~~/~~ **or** physician's~~/AHP's~~ order verified with second RN.
      iii. After the bolus, reprogram pump to continuous infusion rate as ordered by anesthesiologist~~/~~ **or** physician~~/AHP~~. Verify with 2nd RN.
      iv. Document on EHR
   b. Instruct patient, significant other/family:
      i. Type of pain management.
      ii. Frequency and nature of monitoring:
      ~~1)~~**iii.** Avoid touching or manipulating catheter or tubing.
      ~~2)~~**iv.** Avoid excessive moving around or overstretching upper extremities.
      ~~3)~~**v.** Do not get insertion site wet.
      ~~iii.~~**vi.** Notify RN if catheter is accidentally removed or if any part becomes disconnected.
      ~~iv.~~**vii.** Notify RN if signs of nausea, vomiting, pain, itching, pruritis, severe headache, neck pain, backache, bladder fullness, numbness or tingling or decreased movement or strength in lower extremities.
   c. Changing Infusion Bag:
      i. Hang pre-mixed solution containing the same medication as ordered by the anesthesiologist/physician after verifying with a 2nd RN.
   d. Changing the Syringe:
      i. **Insert the pre-mixed syringe containing the same medication as ordered by the anesthesiologist/physician~~/AHP~~ after verifying with a 2nd RN.**
~~3.~~6. Assessment:

a. Assess for complications that may be associated with epidural initiation.
   i. Local anesthetic toxicity: Assess for drowsiness, light-headedness, tinnitus, circumoral paresthesia, metallic taste in mouth, slurred speech, blurred vision, unconsciousness, cardiac dysrhythmia, and cardiac arrest. Notify anesthesiologist~~/~~ **or** physician~~/AHP~~ immediately if any of these symptoms are noted. Initiate cardiopulmonary resuscitation as needed.
   ii. High Spinal: Assess for numbness or weakness of the upper extremities, dyspnea, weak speech or inability to speak, apnea and loss of consciousness. Notify anesthesiologist~~/~~ **or** physician~~/AHP~~ immediately if any of these symptoms are noted. Initiate cardiopulmonary resuscitation as needed.
   iii. Hypotension: Position patient in lateral position, notify anesthesiologist~~/~~ **or** physician~~/AHP~~, and administer intravenous fluid bolus if ordered.

b. Assess and document sedation level, pain level, pulse oximetry, blood pressure, heart rate, and respiratory rate every **one** (1) hour ~~times two (2); every two (2) hours times six (6); then every four (4) hours~~ until epidural or intrathecal catheter is discontinued. ~~**If stable, resume previous vital signs order.**~~

~~iv. If dose is increased or bolus given, assess and document every one (1) hour times two (2); every two (2) hours times six (6); then every four (4) hours until epidural or intrathecal catheter is discontinued.~~

~~b.~~**c.** Assess epidural or intrathecal catheter or tubing:
   i. Every **four** (4) hours, verify the portless tubing is connected to the epidural or intrathecal catheter.
   ii. Every shift, verify catheter, infusion tubing, epidural or intrathecal pump, and epidural or intrathecal solution are properly labeled.

~~c.~~**d.** Assess insertion site:
   i. Every **four** (4) hours, verify catheter site is clean, dry and intact without signs of edema, drainage or infection.

~~d.~~**e.** Monitor sensory and motor function of lower extremities every **four** (4) hours, and before and after catheter removal.

~~e.~~**f.** Monitor for the following possible side effects every **four** (4) hours, and see physician orders for appropriate intervention as needed:
   i. Change in level of consciousness~~.~~
   ii. Nausea and vomiting
   iii. Itching, pruritis
   iv. Urinary retention
   v. Loss of motor function, strength, and sensation of lower extremities
   vi. Before and after ambulation
   ~~vi.~~**vii.** Before and after epidural catheter removal

~~f. Assess and document sedation level, pain level, pulse oximetry, blood pressure, heart rate, and respiratory rate documented every 1 hour times 2; every 2 hours times 6 then every 4 hours until epidural or intrathecal catheter is discontinued. If stable, resume previous vital signs order.~~

g. If disconnection from the catheter tubing is suspected, cover with sterile gauze, and notify Anesthesiologist. Do not use ~~or~~ alcohol or attempt to reconnect.

D. **PROCEDURE FOR SYRINGE DELIVERY DEVICE FOR PCEA:**

1. Obtain physician's/**AHP's** order for epidural or intrathecal solution
2. Obtain solution filled syringe from Pharmacy and connect the yellow striped portless tubing to the syringe after verifying correct dose with **second** (2^{nd}) RN. Prime tubing.
3. For PCEA, the nurse will confirm epidural solution concentration and pump settings as ordered by anesthesiologist/ **or** physician **(AHP)** (i.e. rate mL/hr, bolus amount/ml). Lockout must be documented in patient care record and verified by **two** (2) RN's.
4. Insert the syringe into the Alaris pump

5. Program the Alaris pump, using Guardrails, to the dosing parameters ordered by the physician/**AHP** and verify settings with 2nd RN.
6. Start the infusion.
7. Engage the lockout feature on the Alaris pump.
8. Return the medication lock box key to Pyxis.
9. Document on the electronic health record (EHR) with two RNs for Patient controlled anagesia (PCAs) and epidurals.
10. Provide positioning assistance and emotional support to the patient during the epidural initiation procedure.

E. **REMOVAL OF EPIDURAL OR INTRATHECAL CATHETER:**

1. Verify written physician/~~AHP~~ order to remove catheter.
2. **Review the patient's coagulation status and ensure the results are within normal limits.**
   a. **Check prothrombin time (PT) levels and platelet level where applicable. For elevated PT levels, or platelet level less than 1050,000, consult ~~physician~~Anesthesiologist prior to removal.**
   ~~a.~~**b. Record neurological exam of the lower extremities every one (1) hour times two (2), every two (2) hours times two (2), every four (4) hours times two (2) after removal of the catheter.**
~~2.~~**3.** Place patient in relaxed position.
~~3.~~**4.** Assess patient for back pain, back tenderness and baseline motor strength and sensation prior to removal of the catheter.
~~4.~~**5.** Assess site for hematoma, drainage and signs of infection.
~~5.~~**6.** Stop infusion and clamp tubing. Document final volume readings.
~~6.~~**7.** Perform hand hygiene **and don gloves**.
~~7.~~**8.** Remove dressing while maintaining pressure on tubing just above insertion site. Do not use alcohol. (Alcohol is neurotoxic to epidural space.)
~~8.~~**9.** Gently and steadily remove catheter with one slow motion while holding 2x2 gauze over the site. If patient develops pain or parasthesia or resistance is met, stop procedure, place a sterile dressing over site to secure epidural or intrathecal line, and notify anesthesiologist/ **or** physician/~~AHP~~.
~~9.~~**10.** Verify catheter tip is intact and rounded once catheter is removed.
~~10.~~**11.** If tip is missing:
   a. Notify physician/~~AHP~~.
   b. Place the catheter with the missing tip in a specimen bag and label with the patient's name, date of removal
   c. Give the specimen bag with the tip to the **Assisted Nurse Manager** (ANM)/relief charge.
~~11.~~**12.** Place sterile dressing over the area and apply pressure for at least **two** (2) minutes.
~~12.~~**13.** Evaluate patient's motor strength and sensation. Notify physician/~~AHP~~ for decreased motor strength and/or sensation.
~~13.~~**14.** Document procedure and patient response.
~~14.~~**15.** Waste unused medication per the **PCS Procedure:** Wasting Narcotics, **Documentation in the Pyxis Machine** ~~procedure and lock box~~.
~~15.~~**16.** Return lock box and Alaris pump to **sterile processing department** (SPD).
~~16.~~**17.** Return medication lock box key to unit Pyxis.
~~17. Special considerations for anticoagulated patients:~~
   ~~a. Check prothrombin time (PT) levels and platelet level where applicable. For elevated PT levels, or platelet level less than 50,000, consult physician prior to removal.~~
   ~~b. Record neurological exam of the lower extremities every one (1) hour times two (2) hours, every two (2) hours times two (2) hours, every four (4) hours times two (2) hours after removal of the catheter.~~

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

1. **Patient Care Services Policy: Identification, Patient**

2. **Patient Care Services Procedure: Wasting Narcotics, Documentation in the Pyxis Machine**

~~F.~~G. **REFERENCE(S):**

~~1. Besuner, P. (2007). Association of women's health, obstetric and neonatal nurses - Templates for Protocols and Procedures for Maternity Services, 2nd Edition. Washington, DC.~~

~~2.~~1. Cohen, S.P. & Dragovich, A. (2007, December). Intrathecal anesthesia. *Anesthesiology Clinics*, 25(4). Retrieved http://www.mdconsult.com

~~3.~~2. Grant, P.J. & Wesorick, D.H. (2008, March). Perioperative medicine for the hospitalized patient. *Medical Clinics of North America*, 92(2). Retrieved from http://www.mdconsult.com

~~4.~~3. ~~Gregoretti, C. et al (2007, March). Regional anesthesia in trauma patients. *Anesthesiology Clinics*, 25(1). Retrieved from http://www.mdconsult.com~~

~~5.~~4. **Elesvier Clinical Skills. Epidural Catheter Insertion, Management and Removal. Retrieved September 18th, 2017.** ~~Mosby's Skills. (2014) Medication administration patient controlled analgesia. Retrieved from TCMC intranet.~~

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**INTRACRANIAL PRESSURE (ICP) MONITORING: EXTERNAL VENTRICULAR DRAIN (EVD), CARE OF**
Purpose:	To assist staff in caring for the patient with intracranial pressure monitoring with an external ventricular drain. An external ventricular drain is a drain inserted into the ventricular space of the brain for measuring intracranial pressure and cerebrospinal fluid (CSF) drainage.
Supportive Data:	Intracranial pressure monitoring is a specific procedure, which differs from any other type of neurological drain used within the care system currently and requires specific knowledge.
Equipment:	Betadine swab sticks Personal protective equipment (PPE): gloves, caps, masks, eye protection or face shields, sterile gloves, sterile gowns Sterile gauze (10-pack 4x4s) Intracranial access tray with drill External drainage system, including tubing, drip chamber, and drainage bag Ventricular catheter Transducer (without manual flush device attached) Preservative-free sterile normal saline in 10mL syringes Blue microclave Hair clippers (if hair clipping is required before EVD placement Local anesthetic Sedation agents (if needed) Intravenous (IV) access device Equipment pole Leveling device Monitoring cables Sterile dressing Sterile towels Sterile drapes Suction equipment CSF specimen tubes (for collection of CSF) Sterile 10mL luer lock syringe (for collection of CSF)
Issue Date:	**NEW**

A. **DEFINITIONS:**

1. Glasgow Coma Scale: a neurologic scale used to reliably and objectively assess the conscious state of a person.
2. Cerebral Perfusion Pressure (CPP): the difference between the mean arterial pressure (MAP) and the ICP, representing the pressure gradient driving cerebral blood flow. CPP = MAP – ICP.
3. Ventricle: one of four connected fluid-filled cavities in the center of the brain.

B. **POLICY**

1. An external ventricular drain and a comprehensive neurological assessment shall be performed every one (1) hour, or per physician orders, including:
   a. Glasgow Coma Scale
   b. Insertion site, including redness, skin integrity, signs/symptoms of infection, signs of CSF leakage.

Patient care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Committee	Division of Neurosurgery	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
02/18 NEW	04/18	04/18	~~07/18 09/18 12/18~~ 03/19	n/a	06/19	07/19	n/a	

c. Quality (color and clarity) and quantity of CSF drainage, and any changes from previous assessment.

2. Notify neurosurgeon for signs/symptoms of infection, meningeal irritation, absence of CSF fluid drainage, suspected drainage obstruction, damp dressing suggestive of CSF leakage, or change in baseline neurological status (i.e. cognition, motor, sensory, level of consciousness, or focal deficit).
3. Minimize noxious stimuli, such as loud noises, bright lights, and jarring movements.
4. Monitor the patient for changes in ICP and CPP. Monitor patients with an increased ICP more frequently.
5. Monitor and record ICP and CPP hourly.
   a. Notify neurosurgeon of gradual or sudden increase in ICP with or without neurologic changes.
6. Assess and document ICP waveform tracing once every shift and when changes in the waveform occur.
   a. Assess for presence of P1, P2 and P3 waves.
   b. Notify neurosurgeon of change or loss in ICP waveform.
7. Monitor the patient for signs of infection.
8. Measure and record all drainage as part of intake and output. If the CSF is being continuously drained, record and monitor the output every hour.
9. Transducer will be level to Foramen of Monro (external auditory canal).
   a. Affix transducer to EVD zero point on drainage system.
10. Zero the transducer using aseptic technique when connections between the transducer and the monitoring cable are interrupted, connections between the monitoring cable and the monitor are interrupted, or values do not fit the clinical picture.
11. Height of CSF drainage chamber on EVD will be according to CMH_20 marking or per neurosurgeon order.
12. When changing the patient's position, take steps to keep the rate of CSF drainage consistent and prevent changes in ICP.
    a. Maintain the reference level of the EVD at the foramen of Monro.
    b. Ensure that the CSF drainage tubing is clamped during repositioning, nursing interventions, patient transport, and patient coughing or vomiting.
    c. Ensure that the prescribed pressure levels are maintained.
    d. Ensure that others do not change the position of the patient or the bed.
13. Check the system and insertion site for cracks, breaks, or openings in the system or fluid leaks every 4 hours.
14. Maintain the drainage system in an upright position.
15. The EVD drainage device will be open or clamped per MD orders. ICP is measured with EVD closed to the drain.
16. The drainage system will be temporarily clamped closed when level of the patient changes in relationship to device. This includes during patient transport and when the patient is being moved from one surface to another.
17. Set the alarm parameters based on the ICP and CPP goals established by the neurosurgeon.
18. Change the dressing only as ordered by neurosurgeon.
19. Change the collection bag when it is 2/3 full, using aseptic technique and after performing hand hygiene and donning a mask and sterile gloves.
20. CSF sampling from the EVD will ONLY be done with physician order, and sample will be obtained from sampling port below drainage drip chamber.
21. Only the neurosurgeon may remove/discontinue the EVD.

C. **PROCEDURE:**

1. Assembling the EVD System
   a. Perform hand hygiene and don PPE (gloves, cap, and mask).
   b. After opening the outer packaging of the supplies, remove gloves, perform hand hygiene, and don sterile gloves.

c. Hang EVD system on equipment pole, secure EVD system to equipment pole by tightening securement clamp.
d. Ensure that all tubing connections remain sterile, and tighten all connections. Do not force connections.
e. Remove vented air cap from end of transducer and attach syringe filled with sterile, preservative-free normal saline. Slowly flush the transducer stopcock, tubing and drainage system using aseptic technique. Turn the stopcocks as needed to prime the entire system, including the chamber.
    i. Ensure that the fluid completely fills the tubing.
    ii. Observe whether droplets exit the tubing and whether bubbles are present.
    iii. Replace distal stopcock vented air cap with sterile blue non-vented cap.
    iv. Turn transducer stopcock to off position (perpendicular to direction of fluid flow).
    v. Remove the syringe and replace with a new sterile saline flush syringe (physician may request additional flushing of system prior to connection to ventricular catheter
    vi. Turn transducer stopcock to open position (parallel to fluid flow).
    vii. Stopcock (where transducer and drainage tubing meet) should remain off to drainage chamber until after connection to ventricular catheter (unless otherwise ordered).
f. Flush distal CSF sampling port with syringe filled with sterile, preservative-free normal saline
    i. Ensure distal stopcock is in neutral positon
    ii. Clamp white slide clamp above CSF sampling port
    iii. Cleanse CSF sampling port with alcohol swab
    iv. Attach syringe filled with sterile, preservative-free normal saline and flush distal segment of tubing.
    v. Remove syringe and place port protector on CSF sampling port.
    vi. Unclamp white slide clamp above CSF sampling port.
g. Connect the monitor cable to the EVD transducer.
h. Zero the transducer.
i. Ensure stopcocks to drain chamber and drain bag are turned from the neutral position to the off position.
j. After aseptic preparation of the tubing, ensure that the external flush and drainage system remains sterile while the practitioner inserts the EVD. Label the pressure tubing, indicating the date and time and initial it.

2. Zeroing transducer
    a. Perform hand hygiene.
    b. Place the patient in the supine position with his or her head and neck in the neutral position and the head of the bed elevated 30 degrees or as prescribed.
    c. Ensure that the transducer is placed at the level of the foramen of Monro (approximately at the level of the external auditory meatus, which represents a point of communication between the third and lateral ventricles).
        i. Mark the spot used to level the transducer with a surgical marker to ensure consistency in ICP measuring.
        ii. Ensure that the drip chamber is set to the prescribed pressure level above the foramen of Monro.
        iii. Height of CSF drainage chamber will be according to MD order per CM H20 marking.
        iv. Ensure that the drip chamber is set to the prescribed pressure level.
        v. When adjusting the height of the CSF drainage chamber, ensure that the drainage stopcock is off to the patient.
    d. Turn the transducer stopcock off to the patient.
    e. While maintaining aseptic technique, remove the syringe (if pre-insertion) or non-vented cap (post-insertion) from the distal end of the transducer to open the transducer to air.

f. Zero the monitor per the manufacturer's instructions. Observe the digital reading until it displays a value of zero.
g. Replace sterile, preservative-free normal saline syringe (pre-insertion) or a new, sterile, non-vented cap (post-insertion) on the transducer stopcock.
h. Turn the stopcocks so the system is open to the transducer.
i. Evaluate the waveform and ICP and compare them to previous findings.
j. Discard supplies and perform hand hygiene.
k. Document the procedure in the patient's record.

3. Assisting with EVD Insertion
   a. Perform hand hygiene and don gloves.
   b. Comply with Universal Protocol: Perform a time-out to verify correct patient, correct site, and correct procedure.
   c. Maintain aseptic technique when handling the transducer tubing and external drainage system during EVD insertion.
   d. Ensure that the patient is in position for ventricular catheter placement.
      i. Assist as needed to immobilize the patient's head during insertion to prevent movement.
   e. Assist the neurosurgeon as directed with antiseptic preparation of the insertion site, as needed.
      i. Area shall be prepped with betadine or betadine/alcohol solution.
      ii. Allow the solution to dry completely.
      iii. Chlorhexidine should not be used on the EVD insertion site.
   f. Ensure that all health care personnel near the patient perform hand hygiene and don PPE (sterile gloves, sterile gown, surgical cap, mask, and eye protection) to prevent cross contamination.
   g. Assist the neurosurgeon as directed with draping the insertion site with sterile drapes.
   h. Assist the neurosurgeon as directed with EVD insertion.
      i. If using Fiberoptic ventricular catheter, zero the catheter when ordered and record the three digit reference number.
         1) Fiberoptic catheters are zeroed only ONCE before insertion.
   i. After the EVD is inserted and CSF flow is ensured, assist the neurosurgeon with attaching the distal end of the drainage system to the catheter using aseptic technique.
      i. Record the ICP value and waveform after insertion.
   j. Assist the neurosurgeon with applying a sterile dressing. Label the dressing with date and time of application. Secure the catheter to minimize manipulation and the risk of inadvertent removal.
      i. Benzoin or skin prep may be used around the site to assist with dressing adherence.
   k. Label the tubing at the connection site closest to the patient and at the connection site closest to the source when there are different access sites or several bags. Labeling will reduce the chance of misconnection, especially in circumstances where multiple IV lines or devices are in use.
   l. Trace tubing or catheter from the patient to point of origin
      i. Before connecting or reconnecting any device or infusion,
      ii. At any transition (e.g., new setting), and
      iii. As part of the hand-off process.
   m. Do not force connections.
   n. Assess the patient's neurologic status during the insertion procedure.
   o. Check vital signs immediately after making any connection.
   p. Discard supplies, remove PPE, and perform hand hygiene.
   q. Document the procedure in the patient's record.
4. Monitoring/Documenting ICP
   a. Perform hand hygiene.

b. Place the patient in the supine position with his or her head and neck in the neutral position and the head of the bed elevated 30 degrees or as prescribed.
c. Ensure that the external transducer is level with the foramen of Monro before determining the ICP.
d. If continuous ventricular drainage is ordered, turn the distal stopcock off to the collection system to stop CSF drainage to view the ICP waveform on the monitor, and for greatest accuracy.
    i. Carefully monitor the patient for neurologic deterioration when CSF is not draining continuously.
    ii. Allow ICP reading to stabilize for thirty seconds to one minute before recording ICP.
    iii. If ICP continues to uptrend after being clamped to EVD drainage bag for over one minute, notify neurosurgeon immediately and perform a neurological assessment.
e. Monitor and record the ICP value and observe the waveform characteristics.
f. If continuous ventricular drainage is ordered, turn the distal stopcock to original position to resume ventricular drainage.
g. Calculate the CPP.
h. Assess ICP waveform trends.
i. Perform hand hygiene.
j. Document the procedure in the patient's record.

5. Draining CSF from the EVD
    a. Perform hand hygiene.
    b. Verify the correct patient using two identifiers.
    c. Explain the procedure to the patient and ensure that he or she agrees to treatment.
    d. Ensure that the height of the drip chamber is at the prescribed level.
        i. When adjusting the height of the pressure level, ensure that the drain stopcock is off to the patient.
    e. Ensure that the clamps between the drip chamber and the EVD collection bag are closed.
    f. Check the CSF drainage and ICP monitoring orders.
        i. If intermittent drainage is ordered, check the ICP value to determine if the ordered parameter is met. If it is met,
            1) Turn the distal stopcock of the transducer tubing off to the transducer.
            2) Alternately open and close the drainage stopcock between the ventricular catheter and the drip chamber, allowing a small amount of CSF to drain with each opening; observe the ICP.
        ii. If continuous drainage is ordered, open the drainage stopcock between the ventricular catheter and the drip chamber to both the transducer and the drip chamber, allowing CSF to drain. Monitor the patient for signs of increased ICP and overdrainage or underdrainage.
    g. When drainage is completed, turn the distal stopcock off to the EVD system; observe the amount drained and the ICP value and waveform characteristics.
        i. If the patient's CSF is being continuously drained, turn stopcock off to drain and record ICP value and the amount of drainage every hour.
    h. Observe the color and clarity of the CSF drainage.
    i. Perform hand hygiene.
6. Sampling CSF from the EVD
    a. Verify orders for CSF sampling.
    b. Perform hand hygiene and don sterile gloves, mask, and eye protection or face shield.
    c. Verify the correct patient using two identifiers.
    d. Explain the procedure to the patient
    e. Assess ICP and ICP waveform prior to collection procedure.

f. CSF testing may include glucose, cell count, protein, culture and sensitivity, and Gram stain. If a comparison of serum glucose and CSF glucose is prescribed, obtain the serum glucose sample and the CSF sample at the same time.
g. Trace tubing or catheter from the patient to point of origin (1) before connecting or reconnecting any device or infusion, (2) at any transition (e.g., new setting), and (3) as part of the hand-off process.
h. Drain contents of the EVD drainage chamber and allow for accumulation of CSF fluid.
    i. Ensure there is an adequate volume of CSF drainage in the drip chamber for sampling.
i. Turn the transducer/drainage stopcock off to the drain before drawing a sample (this prevents negative pressure being exerted on the brain while the sample is being retrieved). Monitor the patient for ICP changes while the tubing is clamped.
j. Cleanse the CSF sampling port (microclave) below the EVD drip chamber with Betadine swabs, scrubbing for 3 minutes. Do NOT use alcohol or CHG. Allow the solution to dry.
k. Turn the distal stopcock below the drip chamber off to the collection bag (down).
l. Attach the 10 mL sterile syringe to microclave sampling port and slowly withdraw the ordered sample volume.
m. Aseptically remove blue screw top from specimen tube(s) and transfer the CSF to the specimen tube(s). Replace blue cap on specimen tube(s).
n. Turn the stopcocks to resume monitoring or drainage as prescribed.
o. In the presence of the patient, label each specimen with patient label, your Cerner login, date, time, and source of specimen ("CSF").
p. Prepare each specimen for transport.
    i. Place the labeled specimen in a biohazard bag.
    ii. If the specimen requires ice for transport, place the specimen in a biohazard bag, and then place the bag with the specimen into a second biohazard bag filled with ice slurry.
q. Reassess patient, ICP and ICP waveform.
r. Notify Neurosurgeon of any changes from pre-sample baseline.
s. Discard supplies, remove PPE, and perform hand hygiene.
t. Immediately transport each specimen to the laboratory. Do NOT send specimen via tube transport system.
u. Document the procedure in the patient's record.

7. Removal of EVD
    a. Only MD may remove ventric catheter

D. REFERENCES:

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Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 12/01

SUBJECT: Physician's Admission Responsibilities

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

~~**POLICY NUMBER: I.N**~~

Patient Care Services Content Expert Approval:	**04/19**
Clinical Policies & Procedures Committee Approval:	~~**04/15**~~**05/19**
Nurseing Executive Committee Approval:	~~**04/15**~~**05/19**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	~~**05/15**~~**06/19**
Administration Approval:	**07/19**
Professional Affairs Committee Approval:	~~**06/15**~~ **n/a**
Board of Directors Approval:	**06/15**

A. **POLICY:**

1. Admitting Orders
   a. Physicians' orders must be obtained within one hour for routine elective admissions, direct admissions, and admissions from the Emergency Department (ED) to Acute Care Services, Forensic Unit, or Women and Newborn Services (WNS). ED admissions to Intensive Care Unit (ICU) and Telemetry shall arrive on the unit with orders from the physician.
   b. Minimum content for orders includes:
      i. Admit
      ii. Admitting diagnosis
      iii. Diet
      iv. Activity
      v. Lab work
      vi. Medication Orders
      vii. Admission status (observation, inpatient)
      viii. Level of care (ICU, Telemetry, Medical/Surgical)
   c. When initial admitting orders have not been received from a physician within one hour, the following chain of command is activated.
      i. Assistant Nurse Manager (ANM)/Relief Charge Nurse or Designee.
      ii. Administrative Supervisor.
      iii. Chief of Division, Department Chair, or in his/her absence, the Chief of Staff shall be notified to ensure that patient care will be provided promptly.
      iv. When no orders have been received for one hour the patient shall be admitted to the service of a physician appointed by the Chief of Division, Department Chair or in his/her absence, the Chief of Staff. In such cases, the department director/designee is to be notified as soon as possible.
2. The attending physician maintains responsibility for the direction of patient care by providing the following:
   a. Clear and legible orders.
   b. Clinical direction to healthcare professionals regarding medical plan of care.
   c. Collaboration with healthcare professionals on a regular basis pertaining to the plan of care, prognosis, and discharge planning.
   d. Collaboration with patient and family members.

e. Complete and adequate documentation per the Medical Staff Bylaws.
f. Availability to healthcare professionals when questions arise regarding specific symptoms and/or physician orders.
g. Coverage when not available.
    i. Ensure the healthcare professionals are informed when not available.
h. Participation in patient care, conferences.
i. Assistance in preventing/clarifying conflict with consultants.
j. Communication regarding patient's condition.

3. The consulting physicians collaborate with the attending physician to prevent conflicts in patient care orders or clinical direction.
4. Medical Directors, Medical Staff Officers, Department/Division Chairs/Chiefs, and Medical Staff Committees interact with the Patient Care Services Departments as follows:
    a. Work in cooperation with the Patient Care Services Departments by:
        i. Being readily available to the Management Team.
        ii. Participating as active team members in standards review.
        iii. Identifying, solving and assisting with conflict resolution as needed.
    b. The Chief Nurse Executive (CNE) will serve as the formal liaison between the Medical Staff and Patient Care Services departments either by direct participation and committee work or by designating a qualified healthcare professional.
    c. Healthcare professionals are responsible to maintain communication with physicians regarding patient's conditions.
    d. Medical Directors shall meet regularly with the clinical/operations manager of the respective departments to review quality improvement data, and refer problems for resolutions to appropriate Medical Staff Committees/Departments/Divisions, if indicated.
5. The list of current Medical Staff leaders and committees is maintained in the Medical Staff Office.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 1/06

SUBJECT: Restraints/Seclusion for Violent/Self-Destructive Behavior

REVISION DATE(S): 06/07, 08/09, 10/09, 09/10, 12/11, 02/12

Patient Care Services Department Approval:	~~04/18~~04/19
Clinical Policies & Procedures Committee Approval:	~~05/15~~05/19
Nurse Executive Committee Approval:	~~05/15~~05/19
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~06/15~~06/19
Administration Approval:	07/19
Professional Affairs Committee Approval:	~~07/15~~ n/a
Board of Directors Approval:	07/15

A. **PURPOSE:**

1. To provide a consistent standardized organizational-wide policy for the use of violent/self-destructive behavior restraint and/or seclusion.

B. **PHILOSOPHY:**

1. Tri-City Healthcare District acknowledges restraint may be necessary for certain patient populations. Restraint or seclusion is limited to emergencies in which there is an imminent risk of patient physically harming himself/herself or others and nonphysical interventions would not be effective.
2. The ultimate goal is to minimize the use of restraints and achieve a restraint-free environment. In the event seclusion or restraint of a patient becomes necessary, Tri-City Medical Center (TCMC) supports a philosophy, which will protect the patient's health and safety and preserves his/her dignity, rights and well-being. Restraints of any type should not be used as a punishment, retaliation, coercion, or for the convenience of staff, and should be discontinued as soon as possible. All patients are given information regarding patients' rights upon admission.
3. The type of physical intervention selected considers information learned from the patient's initial assessment, which outlines interventions that have helped him/her in crisis situations in the past which could minimize the use of restraint or seclusion. The use of restraint or seclusion is not based on a patient's restraint or seclusion history or solely on history of dangerous behavior.

C. **DEFINITIONS:**

1. Restraint – Direct application of physical force to a patient, with or without the patient's permission, to restrict his or her freedom of movement. The force may be human, mechanical devised or a combination thereof.
   a. Physical Restraint: Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to movie his/her arms, legs, body, or head freely.
   b. Chemical Restraint: A drug or medication used as a restriction to manage the patient's violent/aggressive behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. A PRN order does not determine the use of that drug as a restraint. Criteria for "standard treatment or dosage" are treating a specific patient's clinical condition of symptoms, not behaviors, which

enable the patient to function more effective and appropriately (not a restraint) rather than reduce that patient's ability to interact with the world around them (restraint).

i. Emergency Medication: It may be necessary to use psychotropic agents to control severe agitation. Medications ordered and taken voluntarily on a PRN basis as indicated for the psychiatric condition being treated are not considered chemical restraint. Emergency medication given against a patient's will is not considered a chemical restraint if it is for the treatment of acute symptoms of a psychiatric illness.

2. Seclusion – The involuntary confinement of a patient *alone* in a room or area from which the patient is physically prevented from leaving. Seclusion is a form of restraint that may be used only for the management of violent or self destructive behavior.
3. Time-out - A strategy which directs patient from the general milieu to a quiet area to provide a less stimulating environment. A responsible RN implements time-out based on assessed need when time-out is documented as an intervention on the patient's plan of care. Time-out is voluntary; it is designed as a least restrictive behavior management technique. Time-out becomes a form of physical restraint if the patient is prevented from leaving the time-out area.
4. Physical Escort – A physical escort would include a "light" grasp to guide the patient to a desired location. If the patient can easily remove or escape the grasp, this would not be considered physical restraint. However, if the patient cannot easily remove or escape the grasp, this would be considered physical restraint.
5. Physical Holds – The regulation permits the physical holding of a patient for the purpose of conducting routine physical examinations or tests. However, patients do have the right to refuse treatment. This includes the right to refuse physical examinations or tests. Holding a patient for being violent or self destructive or to force psychotropic medications is considered restraint, but if patient consents to injection then it is permitted to hold patient if patient allows.
6. Practitioner – any physician, dentist, or podiatrist who is a Medical Staff member and/or who exercises clinical privileges at TCMC as context requires, unless otherwise expressly limited.
7. Qualified/Specially Trained Staff – Staff who are trained and who have demonstrated competency in the use of restraint and/or seclusion in accordance with their scope of licensure and patient population served. The Qualified/Specially trained RN has additional training and demonstrates competency in the First Hour assessment and documentation process.

D. **EXCLUSIONS:**

1. The specific device used to restrain a patient does not in itself determine whether the restraint standards apply. Rather, it is the device's intended use (such as physical restriction), its involuntary application, and/or the identified patient need that determines whether use of the device triggers the implementation of the restraint policy.
2. For the purposes of this policy, the following are not considered restraint:
   a. Standard practices that include limitations of mobility or temporary immobilization during medical, dental, diagnostic, or surgical procedures, and the immediate post-procedure care processes when these practices are considered an inherent part of the procedure (i.e., surgical positioning, IV arm boards, papoose, protection of surgical and treatment sites in pediatric patients).
   b. Adaptive support in response to assessed patient needs (i.e., orthopedic prescribed devices, postural support, table top chairs).
   c. Protective equipment such as helmets.
   d. Hand mitts (gloves only) to keep from scratching self (if pinning wrists down with mitts, hand or fingers are immobilized, this is considered a restraint).
   e. Devices that permit the patient to participate in activities without the risk of physical harm.
   f. Forensic and correctional restrictions imposed by correctional authorities and used solely for security purposes (i.e., handcuffs, shackles).
   g. Restraint use for non-violent/non-self-destructive behavior to which the restraint standards for non-violent/non-self-destructive behavior apply.

E. **PRECAUTIONS:**

1. Restraint of patients with deformities may preclude proper application of restraining devices.
2. Restraining of patient in the prone position may predispose the patient to suffocation. Prone restraint is prohibited.
3. Certain vulnerable patient populations are at a greater risk of experiencing adverse effects from restraint use including but not limited to those who are cognitively impaired, physically impaired, elderly and/or those with a history of sexual or physical abuse that would place them at greater psychological risk.
4. Patients at risk for entrapment, including physical, mental and behavioral or medication impairment.
5. A patient in a room that is not under continuous observation by staff is at greater risk for self – injury or adverse occurrences.

F. **ORDERS:**

1. All restraint and seclusion are applied and continued pursuant to an order by the practitioner who is primarily responsible for the patient's ongoing care, or his or her designee.
2. In the case of emergency, a patient may be placed in restraint/seclusion at the discretion of the Registered Nurse (RN)
3. As soon as possible but no longer than one hour after the initiation of restraint or seclusion by a RN, he or she:
   a. Notifies and obtains an order (telephone or written) from the practitioner
   b. Consults with the practitioner about the patient's physical and psychological condition
   c. Supplies staff with guidance in identifying ways to help the patient regain control so that restraint or seclusion can be discontinued as soon as safely possible.
4. The practitioner does the following:
   a. Reviews with the staff the physical and psychological status of the patient
   b. Determines whether restraint or seclusion should be continued
5. Telephone and written orders for restraint and seclusion are limited to the following:
   a. 4 hours for patients ages 18 and older
   b. 2 hours for children and youth ages 9 to 17
   c. 1 hour for children under age 9
6. Orders for restraint or seclusion are not written as a standing order or on an as needed basis (that is, PRN).
7. When restraint or seclusion is terminated before the time-limited order expires, the original order cannot be used to reapply the restraint or seclusion if the patient is at imminent risk or physically harming themselves or others, and non-physical interventions are not effective.
   a. Each application of restraint must be considered a separate episode in which all assessment and documentation procedures are applied.
8. If restraint or seclusion needs to continue beyond the expiration of the time-limited order, a new order for restraint or seclusion is obtained from the practitioner primarily responsible for the patient's ongoing care, treatment, and services, or his or her designee.
9. Orders for violent/self-destructive restraint and/or seclusion must include: restraint and/or seclusion start and end time, action justifying restraint, type of restraint, criteria for release, ~~contributing diagnosis and new medications.~~ **and location of restraints.**

G. **INITIATION/DOCUMENTATION:**

1. The practitioner primarily responsible for the patient's ongoing care, treatment, and services, or his or her designee or a qualified~~/specially trained RN or~~ Physician's Assistant (PA), evaluates the patient in person within 1 hour of the initiation of restraint or seclusion.
2. At the time of the in-person evaluation, the practitioner/ ~~RN/~~PA does the following:
   a. Works with the patient and staff to identify ways to help the patient regain control
   b. Revises the patient's plan of care, treatment, and services as needed
      i. If necessary, the practitioner provides a new written order and documents

ii. The immediate situation
iii. The patient's reaction to the intervention
iv. The patient's medical and behavioral condition
v. The need to continue or discontinue the restraint or seclusion.

3. If the First hour face-to-face evaluation is conducted by a qualified~~/specially trained RN or~~ PA, the attending practitioner who is responsible for the care of the patient shall be consulted within one hour after completion of the evaluation.
   a. Another one-hour face-to-face patient evaluation is not required when the original order is renewed.
4. ~~When the use of violent/self-destructive restraints occurs in the other acute inpatient areas, after handling the immediate situation, the staff shall consult with the Behavioral Health Unit staff. A qualified/specially trained RN shall assist the acute inpatient staff to ensure that safety procedures, monitoring tools and notifications occur per policy~~.
5. Alternatives and nonphysical interventions including redirecting the patient's focus or employing verbal de-escalation should be attempted prior to initiating restraints/seclusion. Refer to examples of alternative interventions on Appendix A.
6. If alternatives and non-physical interventions are not effective, the least restrictive restraint shall be used in order from least to most restrictive based on the assessment of the RN.
7. The RN is responsible for assessing the patient before restraint use is initiated.
8. The RN shall document initiation of restraint in the medical record on the appropriate restraint electronic form~~ or paper restraint flowsheet~~. The following shall be documented:
   a. Restraint reason i.e., Violent/Self Destructive Behavior Restraint
   b. Restraint Initiation Date and Time
   c. Type of Restraint: Locked device/Hard Restraints, Physical Hold
   d. Restraint Location: i.e. left or right upper or lower extremity
   e. Action justifying use of Restraint
   f. Description of other behavior requiring restraint
   g. Pre-restraint alternatives attempted
   h. Effectiveness of Pre-restraint alternatives
   i. Education provided to patient/family education
   j. Patient's rights denied

H. **ONGOING MONITORING/DOCUMENTATION:**

1. Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:
   a. 4 hours for adults 18 years of age or older;
   b. 2 hours for children and adolescents 9 to 17 years of age; or
   c. 1 hour for children under 9 years of age
2. If a patient remains in restraint or seclusion for the management of violent or self-destructive behavior 24 hours after the original order, the practitioner who is responsible for the care of the patient must conduct a face-to-face patient evaluation before writing a new order for the continued use of restraint or seclusion.
3. If the patient's practitioner, or his or her designee, is not the practitioner who gives the order, the patient's practitioner is notified of the patient's status if the restraint or seclusion is continued.
4. Patients in restraint and seclusion shall be monitored continuously by in-person observation by an assigned staff member who is competent and trained.
5. An individual in seclusion without restraints may be continuously monitored using simultaneous video and audio equipment, if consistent with the patient's condition or wishes.
6. A trained and competent RN assesses the patient every 15 minutes while the patient is in restraint or seclusion for signs of any injury associated with applying restraint or seclusion, nutrition and hydration, skin/circulation and range of motion in extremities (release one restraint at a time, beginning with the ankles), hygiene and elimination, physical and psychological status and comfort and readiness for discontinuation of restraint to ensure the release at the earliest

possible time. Vital signs will be monitored every 15 minutes, or as clinically indicated. The RN documents the assessment in the medical record on the appropriate restraint electronic form or paper restraint flowsheet.

7. In some cases, vital signs taken every 15 minutes may be excessive or disruptive to patient care. Document a valid rationale for the decision regarding vital signs not assessed every 15 minutes.
8. The staff helps patients meet behavioral criteria for discontinuing restraint or seclusion.

I. **DEBRIEFING:**

1. The patient and, if appropriate, the patient's family shall participate with staff members who were involved in the episode and who are available in a debriefing about each episode of restraint or seclusion. The debriefing shall:
   a. Occur as soon as possible and appropriate but no longer than 24 hours after the episode.
   b. Identify what led to the incident. ~~and what could have been handled differently.~~
   c. Ascertain that the patient's physical ~~well-being~~**well-being**, psychological comfort, and right to privacy were addressed.
   d. Counsel the patient for any trauma that may have resulted from the incident.
   e. Result in modification of the patient's plan of care, treatment, and services if indicated.

J. **COMPETENCY AND EDUCATION:**

1. All direct patient care staff in keeping with their scope of practice, shall be assessed for competence before participating in the application and monitoring of behavioral restraint/seclusion, and shall undergo education and training in the proper and safe use of restraint/seclusion during initial orientation and annually thereafter.
2. Training requirements include but are not limited to:
   a. The determination of who has authority to order restraint and seclusion
   b. The determination of who has authority to discontinue the use of restraint or seclusion
   c. The determination of who can initiate the use of restraint or seclusion
   d. The circumstances under which restraint or seclusion is discontinued
   e. The requirement that restraint or seclusion is discontinued
   f. A definition of restraint
   g. A definition of seclusion
   h. A definition or description of what constitutes the use of medications as a restraint
   i. A determination of who can assess and monitor patients in restraints or seclusion
   j. Time frames for assessing and monitoring patients in restraints or seclusion
3. Agency or other temporary staff who work in direct patient care roles shall be given a self-learning module to complete before participating in the application or monitoring process of restraint or seclusion. In addition, there shall be a qualified staff member assigned as a resource, when the initiation of restraint is necessary on an assigned patient to ensure that the proper safety procedures, orders and monitoring are implemented.
4. Practitioners shall be educated in the use of restraint.
5. ~~Qualified/specially trained RN shall undergo education and training regarding the First Hour Assessment and demonstrate annual competency.~~

K. **STAFFING:**

1. Staff assignments shall be based on qualifications, physical design of the environment, patient diagnosis, concurrent conditions, patient acuity, age, and developmental functioning of the patient. These elements shall be addressed in the staffing mix of the unit.

L. **DISCONTINUATION/DOCUMENTATION:**

1. As early as feasible in the restraint or seclusion process, the patient is made aware of the rationale for restraint or seclusion and the behavioral criteria for discontinuation.

2. When the patient meets his or her behavioral criteria for restraint discontinuation, all four restraints shall be released at the same time.
3. Restraint or seclusion is discontinued as soon as the patient meets his or her behavioral criteria.
4. Document discontinuation of restraint in the medical record on the appropriate restraint electronic form or paper restraint flowsheet.
5. Document patient's rights restored

M. **PATIENT/FAMILY EDUCATION:**

1. The following education shall be provided to the patient and his/her family (with patient consent):
   a. Clinical reason for restraint
   b. Purpose and use of restraint
   c. Monitoring and care that shall be provided to patient
   d. Criteria necessary for termination of restraint
   e. Any other information necessary to assure the safety and comfort, dignity, preservation of rights and well-being of the patient
2. In cases in which the patient has consented to have the family kept informed about his or her care, treatment, and services and the family has agreed to be notified, staff attempts to contact the family promptly to notify them of the restraint or seclusion episode.

N. **PLAN OF CARE:**

1. The plan of care will be modified according to the use and discontinuation of restraints.

O. **NOTIFICATION:**

1. The hospital shall report required information to Centers for Medicare and Medicaid Services (CMS) per regulations. See the examples below:
   a. Each death that occurs while a patient is in restraint or seclusion
   b. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
   c. Each death known to the hospital that occurs within one week after restraint or seclusion was used.
2. Regulatory Compliance shall document in the patient's medical record the date and time the death was reported to CMS.

P. **PERFORMANCE IMPROVEMENT:**

1. Data shall be collected on all occurrences of restraints and seclusion and submitted to the Restraint Committee and reviewed by the ~~Joint Commission~~ **Regulatory Compliance** Committee to identify opportunities to maintain patient safety, reduce restraint use and to identify opportunities for performance improvement
2. Performance improvement seeks to identify opportunities to introduce preventive strategies, alternatives to use, and process improvements that reduce the risks associated with restraint use.

Q. **RELATED DOCUMENT(S)~~ATTACHMENT(S)~~:**

~~2.~~1. ~~**Appendix A: Alternatives to Restraint**~~
~~3.~~2. **Restraint Education/Competency for Violent/Self-Destructive Behavior**

~~Q.~~R. **REFERENCE(S):**

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

Separating from policy and linking as a separate related document

~~APPENDIX A:~~ ALTERNATIVES TO RESTRAINT

A. Psychosocial Alternatives

- Diversion activities such as: TV, soothing music, books, or folding washcloths
- Family interaction
- Orientation today, time and place
- Pastoral visit
- Reassurance
- Reading
- Relaxation techniques
- Interpreter services
- Quiet area
- One-on-one discussion
- Encourage verbalization of feelings
- Validate patient's feelings
- Respect patient's need for personal space
- Decreased stimulation
- Change in environment
- Re-establishing communication
- Setting limits
- Use de-escalation and verbal redirection techniques
- Sitter

B. Environmental Alternatives

- Commode at bedside
- Decreased noise
- Music/ TV
- Night light
- Room close to nursing station
- Call light within reach
- Place personal items within reach
- Keep in low position and locked in place
- Sensory aids available (glasses, hearing aid)
- Decreases stimulation
- Providing quiet area
- Physical activity
- Orientation to surroundings

C. Physiological Alternatives

- Toileting
- Address hygiene needs and comfort measures
- Fluids/nutrition/snack
- Positional devices
- Pain intervention
- Assisted ambulation
- Re-positioning
- Rest/sleep
- Providing assistance
- Additional warmth
- Room temperature at comfort level
- Check lab values
- Pharmacy consult

Separating from policy and linking as a separate related document

Restraint Education/ Competency Based Upon Scope of Practice

Restraints for Violent/Self-Destructive Behavior						
	Registered Nurse	CNA/ NA ACT/MHW/RT	Security	Behavioral Health Liaison	Qualified/specially trained RN	Regulatory
Pre-Restraint Alternatives	✓	✓			✓	
Initiation	✓				✓	
Orders	✓				✓	
Ongoing Monitoring	✓	✓			✓	
Observation	✓	✓	✓	✓	✓	
Patient Care	✓	✓			✓	
Vital Signs	✓	✓			✓	
Assessment/Reassessment	✓				✓	
Discontinuation	✓				✓	
Documentation (PIRP, Careplan)	✓				✓	
Release and/or Re-secure	✓	✓	✓		✓	
Complete 1 hour face-to-face evaluation					✓	
Debriefing	✓		✓	✓	✓	
Report restraint related death to CMS						✓
Document CMS notification in Patient's medical record						✓

✓= Required for scope of practice

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDS OF CARE ADULT

I. **PREAMBLE:**

A. Health care providers at Tri-City Medical Center (TCMC) shall ensure that each adult patient and their family are treated equally, with dignity, and respect. Cultural, racial, language, life-style customs, and ethnic diversity of each patient shall be considered when providing care. Adult patients shall receive care based on disease, injury prevention, health promotion, health restoration and/or health maintenance. The nursing process shall be used to implement all patient care. Health care providers shall use TCMC Administrative Policy Manual, Patient Care Services Policies (PCS), PCS Procedures, ~~Mosby's~~ Online **Skills**~~Procedures~~, and unit specific Standards of Care, policies and procedures to provide patient care.

II. **DEFINITION(S):**

A. Scope and Standards of Practice: "Describe what nursing is, what nurse do, responsibilities for which nurses are accountable, and the outcomes of that practice (American Nurses Association (ANA))".

B. Standards of Care: "Authoritative statements by which the nursing profession describes the responsibilities for which its practitioners are accountable (ANA, p.77)". "Standards of care describe a competent level of nursing care as demonstrated by the nursing process (ANA, p. 78) and are examples of the nursing professional expected roles and responsibilities for providing patient care.

C. Nursing Process: "The essential core of practice for the Registered Nurse (RN) to deliver holistic, patient-focused care. The nursing process as outlined by the ANA (2016) includes the following:

1. Assessment: "A systematic, dynamic way to collect and analyze data about a client i.e., patient. Assessment includes not only physiological data, but also psychological, sociocultural, spiritual, economic and life-style factors".
    a. An assessment includes subjective and objective data
        i. Subjective – what the patient says
        ii. Objective – observation based on assessment findings
2. Diagnosis: A nurses' clinical judgment about the client's response to actual or potential health conditions or needs.
3. Outcomes/Planning: "Based on the assessment and diagnosis. Outcomes are measurable and achievable short – and long-range goals".
    a. Planning: Care Plan i.e., Plan of Care: A comprehensive outline of care to be delivered to attain expected outcomes
4. Implementation: "Nursing care is implemented to the care plan. This is "continuity of care from the patient during hospitalization and in preparation for discharge needs".
5. Evaluation: The process of determining both the "patient's status and the effectiveness of nursing care. It is a process that involves continuously evaluation of the patient and the modifications to the Plan of Care".

D. Patient: Recipient of nursing care.

E. Health Care Providers: Individuals with special expertise who provide health care services or assistance to clients

F. Significant Others: Family members and/or those significant to the client

Patient Care Services Content Expert ~~Department~~ Review	Clinical Policies &~~and~~ Procedures Committee	Nurse Executive ~~Council~~ Committee	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
02/16, 03/19	11/16, 05/19	01/17, 05/19	n/a	n/a	03/17, 06/19	07/19	10/17, n/a	03/13, 10/17

G. Reasonable and a timely manner: Defined as within 4 hours after completion of assessments or care provided.

III. **POLICY:**

A. "Registered nurses use the nursing process to plan and provide individualized care to their patients. Nurses use the theoretical and evidence-based knowledge of human experiences and responses to collaborate with patients to assess, diagnose, identify outcomes, plan, implement, and evaluate care. Nursing interventions are intended to produce beneficial effects, contribute to quality outcomes, and above all, do no harm. Nurses evaluate the effectiveness of their care in relation to identified outcomes and use evidence-based practice to improve care (ANA, 2010)".

IV. **GENERAL NURSING ASSESSMENT:**

A. Standards of Care: Vital Signs:
   1. Vital signs shall include:
      a. Temperature, documented in Celsius
      b. Blood Pressure (BP)
      c. Heart Rate (HR)
      d. Respiratory Rate (RR)
      e. Oxygen Saturation (SpO2)
      ~~f. Pain Level~~
   2. Vitals signs shall be obtained on admission, transfer to a unit, at discharge, per physician's orders and as follows:
      a. Intensive Care Unit (ICU): every 2 hours and as needed (PRN)
      b. Telemetry: every 4 hours while patient is awake and PRN
      c. Acute Care Services (ACS): every 8 hours and PRN
      ~~d. Behavioral Health Unit (BHU): daily or as ordered by physician~~
      ~~e.~~**d.** Emergency Department: **every 2 hours or more frequently for Emergency Severity Index (ESI) of 1 and 2**~~per unit specific policy~~
      ~~f.~~**e.** Progressive Care Unit (PCU): Obtain vital signs based on the ordered Patient Admission Status i.e., ACS, Telemetry, Postpartum, and Rehabilitation
   3. Document values in the medical record

B. Standards of Care: Pain Assessment:
   1. Assessment: Pain - A general pain assessment shall be performed as outlined in the Pain Management Policy ~~consist of the following:~~

C. Standards of Care: Intake and Output:
   1. Intake and output shall be monitored as ordered and as follows:
      a. ICU: at least every hour and PRN
      b. Telemetry: at least every four hours and PRN
      c. ACS: at least every 8 hours and PRN
         i. Oncology: at least every 6 hours and PRN
      d. PCU: Obtain intake and output based on the ordered Patient Admission Status i.e., ACS, Telemetry, Postpartum, and Rehabilitation
      ~~e. BHU:~~
         ~~i. Monitor food intake every shift and PRN~~
         ~~ii. Monitor intake volume and output as ordered by physician~~
         ~~iii.~~i. ~~Night shift shall assess bowel movements every morning with daily vital signs~~
   2. Intake and output shall be documented in the medical record after collecting and as follows:
      a. Prior to transfer to another level of care
      b. Prior to the end of the shift
      c. As ordered by a physician
      d. Zero/clear infusion pumps every shift and prior to transferring to another level of care
      e. ~~BHU: document intake and output every shift~~

3. Review patient's intake and output for baseline urine output
    a. Patients 14 years and older assess a minimum of 0.5 mL per kilogram per hour (example if the patient weighs 70 kg multiply 70 x (times) 0.5 equals 35 mL per hour or per physician order. Notify physician for abnormal findings.

D. Standards of Care: Height and Weight
1. All patients shall be weighed on admission if not contraindicated and every seven days thereafter until discharge. Exceptions are as follows.
    a. All ICU patients shall be weighed daily in the AM
    b. Patients with the following diagnoses shall be weighed daily in the AM at or prior to 0600 after voiding, if indicated
        i. Acute and chronic kidney failure e.g., renal failure, renal insufficiency, acute renal injury
        ii. Heart Failure this includes patients with cardiomyopathy receiving diuretics
        iii. Post cardiovascular surgery patients
    c. Patients receiving nutrition support - i.e., enteral or parenteral feedings shall be weighed every 3 days after admission.
    d. Medications shall be calculated using the patient's admission weight unless ordered otherwise by a physician.
    e. Patient's weight shall be documented in the medical record in kilograms.
    f. Patient's height shall be documented in the medical record in centimeters.
        i. Height shall be obtained on admission; stated, estimated or measured.

E. Standards of Care: Aspiration Assessment:
1. Assess on admission, initial shift assessment, and PRN as outlined in ~~Mosby's~~**Online Skills**: Aspiration Precautions Procedure
    a. Perform a swallow screening PRN based on assessment findings as outlined in the Swallow Screening in the Adult Patient Procedure
    b. Maintain head of bed (HOB) at 30 to 45 degrees and as ordered, unless contraindicated
    c. Ensure suction equipment is readily available at the bedside at all times.

F. Standards of Care: Patient Safety:
1. The health care team shall provide measures to ensure patient safety.
2. Patient safety shall be assessed per the following:
    a. The RN shall observe the patient's physical condition on admission and/or transfer to their unit, prior to and after transport to procedures and as needed.
    b. Patients shall be identified per Patient Care Services (PCS): Identification, Patient Policy.
    c. Orders shall be obtained, reviewed, and implemented per PCS: Physician Orders Policy.
    d. Critical test values shall be reported per PCS Procedure: Critical Results and Critical Test/Diagnostic Procedures.
    e. Patient's specimens shall be handled per PCS: Specimen Handling Procedure or by selecting the appropriate ~~Mosby's~~ Online **Skills** Specimen Collection Procedure.
    f. Electronic or medical equipment brought to TCMC shall be evaluated, used, and stored per PCS: Medical Equipment Brought into the Facility Policy.
        i. Respiratory Care Practitioner shall be responsible for setting up home CPAP equipment.
    g. Patients shall be assessed for falls per PCS: Falls Risk Procedure.
    h. Hand-off Communication shall be provided per PCS: Hand-off Communication Policy and unit specific hand-off policies.
    i. Medication shall be reconciled per PCS: Medication Reconciliation Policy.
    j. Line connectors for IVs, epidurals, or enteral feedings cannot be used for a type other than the type intended.

k. All alarms shall be reviewed for appropriateness as outlined in the Clinical Alarm Management policy.

V. **SYSTEM REVIEW:**

A. All adult patients will have a general system review in all systems completed and documented. Detailed system assessments shall be completed and documented as indicated by the patient's condition as outlined in this document.

B. Standards of Care I: Assessment:

1. All patients admitted to inpatient nursing areas shall be assessed by a RN as outlined in this document.
2. Admission and/or Transfer Assessment
   a. All patients admitted or transferred to a higher level of care shall have a brief assessment to identify patients' safety considerations, general well-being and immediate needs initiated within the following time frames
      i. ICU Patients: approximately 15 minutes upon arrival to unit
      ii. Telemetry Patients: approximately 30 minutes upon arrival to unit
      iii. ACS Patients: approximately 1 hour upon arrival to unit
      iv. ~~BHU Patients: within 1 hour of admission to the unit~~
      v. Emergency department per unit specific policy
      vi. PCU Patients: Based on the ordered level of care (i.e., Medical Surgical, Telemetry, Postpartum, and Rehabilitation)
3. Admission Head to Toe Assessment:
   a. The RN shall perform a head to toe assessment as follows:
      i. ICU Patients: approximately 1 hour after the patient's arrival to the unit
      ii. Telemetry Patients: approximately 2 hours after the patient's arrival to the unit
      iii. ACS Patients: approximately 3 hours after the patient's arrival to the unit
      iv. PCU Patients: Based on the ordered level of care (i.e., Medical Surgical, Telemetry, Postpartum, and Rehabilitation)
4. Admission Assessment- Patient History
   a. All inpatients shall have the Admission Assessment-Patient History completed and documented within 24 hours of admission to the unit.
5. Medication Patient History
   a. All patients shall have a Medication Patient History completed as soon as possible upon arrival to the unit per the Medication Reconciliation Policy.
6. Initial Shift Assessment (including upon Transfer to the unit)
   a. The RN shall perform a head to toe assessment as follows:
      i. ICU Patients: approximately 1 hour of the start of the shift
      ii. Telemetry Patients: approximately 2 hours of the start of the shift
      iii. ACS Patients: approximately 3 hours of the start of the shift
      iv. PCU Patients: Based on the ordered level of care (i.e., Medical Surgical, Telemetry, Postpartum, and Rehabilitation)
7. Reassessment:
   a. After completion and documentation of an admission, initial shift or transfer head to toe assessment, all patients will be reassessed as follows. Document only the reassessment changes in the electronic health record
      i. ICU: approximately 4 hours after completion of the initial assessment and every 4 hours thereafter
      ii. Telemetry: approximately 6 hours after completing the initial shift assessment
      iii. ACS: approximately 8 hours after completing the initial shift assessment
      iv. PCU Patients: Based on the ordered level of care (i.e., Medical Surgical, Telemetry, Postpartum, and Rehabilitation)
      ~~v. BHU:~~
         ~~1) Not required every shift~~

~~2) Shall be performed and documented when clinically indicated~~

8. Night Shift Reassessments
   a. During the night shift, the reassessment shall be performed during the shift and no later than with the AM vital signs.
   b. If the patient refuses a reassessment, document their refusal in the medical record.
9. PRN Focus assessment (i.e., system specific assessment) shall be completed as follows:
   a. Change in patient's condition from the initial shift assessment or reassessment
   b. Response to treatment provided to a patient
   ~~c. BHU: when clinically indicated~~

C. Standards of Care I.1: Assessment Neurological System Review
1. Neurological: System Review
   a. Assess the following:
      i. Orientation Assessment
      ii. Level of consciousness
      iii. Affect/Behavior
      iv. Characteristics of Speech
      v. Characteristics of Communication
      vi. Extremity movement and strength right and left upper and lower
      vii. Facial symmetry
      viii. Hearing
      ix. Pupil checks (pupil description, size, reaction to light, and accommodation)
         1) Pupil Checks
         2) Pupil checks shall be performed as follows to establish a baseline:
            a) On admission, initial shift assessments, and PRN
            b) As ordered by physician
2. Neurological: Detailed System Review
   a. The National Institute of Health Stroke Scale (NIHSS) will be performed by RNs who have met TCMC's criteria.
   b. A NIHSS assessment is required for:
      i. Patients admitted with signs and symptoms of a Cerebral Vascular Accident (CVA) or Transient Ischemic Attack (TIA)
      ii. Inpatients admitted or inpatient presenting with new signs and symptoms of a CVA or TIA
   c. A **complete** NIHSS assessment will be ~~completed~~ **performed in the Emergency Department (ED), ICU, Telemetry, ACS** as follows:
      i. Upon arrival to the ED
      ii. Admission
      iii. Transfer
      iv. Every shift
      v. Every four (4) hours for the first seventy-two (72) after diagnosis
         1) Recommended times 0400, 0800, 1200, 1600, 2000, and midnight
         ~~iii.~~**2) Discharge**
         ~~1) Emergency Department (ED)~~
            ~~a) On arrival to the department; complete a NIHSS assessment~~
            ~~b) Complete items 1,5, and 6 per unit policy or as ordered~~
         ~~2) ICU~~
            ~~a) Admission and transfer~~
            ~~b) Initial shift assessment perform a complete NIHSS assessment~~

~~c) Reassessments perform NIHSS items 1, 5, and 6 every four hours for 72~~
~~i) Recommended times 0400, 0800, 1200, 1600, 2000, and midnight~~
~~3) Telemetry, ACS and PCU~~
~~a) Perform a NIHSS on admission, initial shift assessment and transfer. Assess items 1, 5, 6 at 0400, 1200, 1600 and midnight for 72 hours~~
~~b) Assess the patients pupils and when:~~
~~4) Stroke Unit~~
~~a) Admission, discharge or transfer from other Acute Care units perform a complete NIHSS assessment~~
~~b) Initial shift assessment perform a complete NIHSS assessment and then complete items 1, 5, and 6 every four hours for 72 hours~~
~~i) Recommended times 0400, 0800, 1200, 1600, 2000, and midnight~~
~~c)~~**a)** ~~Transfer from ICU or Telemetry perform a complete NIHSS assessment and then complete 1, 5, and 6 for the duration of the 72 hours initiated in ICU or Telemetry~~

~~c.~~**d.** Modified Rankin Assessment:
i. A Modified Rankin Assessment shall be completed on admission **and discharge**.

~~d.~~**e.** Neurological: Assessment: Spinal Cord Injury
i. All patients with a spinal cord injury shall have the following assessed every four (4) hours.
ii. Neurological: System Assessment
iii. Neurological: Detailed Assessment
iv. Assess motor and sensory function from level of spinal cord injury using dermatomes.

~~e.~~**f.** Neurological: Spinal Cord Injury Nursing Interventions
i. To decrease worsening of neurological deficits, the following interventions shall remain in place unless otherwise ordered by a Physician:
1) Immobilization (stabilization) of the injury as soon as possible
2) Reposition patient as follows:
a) Changing position in bed: full log roll with a second nurse to stabilize the patient's neck
3) Assist patient out of bed as ordered or as follows:
a) Full log roll with assistance
b) Dangle patient's legs
c) Ask patient to use arms to push up to a sitting position
d) Assist patient to chair or with ambulation as ordered
4) Mattress to remain flat at all times (reverse Trendelenburg with physician order); do not place a pillow, rolled blanket or towel under the patient's head
5) Bed rest only (transport off unit in bed or stretcher, do not use a wheelchair)
6) Use slide board when transferring and stabilize neck with second nurse
7) Observe autonomic dysreflexia precautions
8) Avoid bowel and bladder distention
9) Apply supportive devices as ordered prior to getting patient out of bed

~~f.~~**g.** Neurological: Intracranial Pressure (ICP) Monitoring: ICU
i. Neurological assessment per physician order or every hour and PRN

~~g.~~**h.** Neurological: ICP Nursing Interventions
- i. Post an intracranial pressure tracing every shift and PRN with changes in patient status in the patient's chart.
- ii. Shut device off to drain when recording ICP value and obtaining tracing
- iii. Document ICP and Cerebral Perfusion Pressure (CPP) every hour and PRN
- iv. Fluid may be removed but never instilled
- v. All fluid filled ICP monitoring devices shall have the transducer air/fluid interface leveled at the Foramen of Monroe (2 fingers breadths above the ear)
- vi. Do not attach flush devices to the ICP monitoring system
- vii. All ICP monitoring devices shall have sterile, occlusive dressing at insertion site

~~h.~~**i.** Neurological: Comatose Patients in the ICU
- i. Comatose and pharmaceutically paralyzed patients shall have their eyes taped shut with non-allergic tape to prevent corneal abrasion or injury unless otherwise ordered. Obtain an order to administer lubricating eye ointment to both eyes.

~~i.~~**j.** Neurological: Neuromuscular Blockade (NMB): ICU
- i. Assess patient per ~~Mosby's~~ **Online Skills** Peripheral Nerve Stimulator.

D. Standards of Care I.2: Assessment Cardiovascular System Review:

1. Cardiovascular System Review
   - a. Cardiovascular symptoms
   - b. Assess the following:
     - i. heart sounds in all auscultatory areas; note regular or irregular
     - ii. Nail Bed color
     - iii. Check capillary refill
     - iv. Check edema location and grade
     - v. Palpate bilateral peripheral pulses: radial and dorsalis pedis
     - vi. skin temperature
     - vii. A presence of cardiovascular implantable electronic devices i.e., permanent pacemaker or defibrillator
2. Cardiovascular: Detailed System Review
   - a. All patients admitted to ED, ICU, and Telemetry shall have the following assessed on admission initial shift, and reassessment.
     - i. Heart sounds note S1,S2 or presence of abnormal sounds
     - ii. Cardiac rhythm
     - iii. Jugular venous distension
   - b. Pacemaker Temporary
     - i. Check temporary transvenous/epicardial pacer stimulation and sensitivity thresholds every shift. Check thresholds with physician for patients with underlying complete heart block or extreme bradyarrhythmias. Assess the following:
       - 1) Type
       - 2) Function
       - 3) Percent paced
       - 4) Connection status i.e., on or off
       - 5) Presence of atrial, ventricular or both wires
       - 6) Mode
       - 7) Rate
       - 8) Output settings
       - 9) Site, dressing
       - 10) Side effects i.e., coughing of hiccups, or muscle twitching
       - 11) Distal pulses for transvensous femoral site

c. Lead Placement and Rhythm interpretation for ED, ICU, and Telemetry; this includes PCU patients with Telemetry orders
   i. Standard lead selection shall be leads II and V1. V1 shall be used to assess Supraventricular Tachycardia's, Bundle Branch Blocks, and wide QRS complexes
   ii. Cardiac rhythm ECG shall be monitored continuously unless otherwise ordered.
   iii. A six (6) second ECG strip shall be recorded, interpreted and posted in the patient's chart on:
      1) Admission
      2) Transfer
      3) At the beginning of the shift and per unit specific policies and procedures
      4) As needed with rhythm and rate changes
      5) Alarms shall be set per the Clinical Alarm Management policy
      6) Heart rate alarms shall be set 10-20 beats above or below the patient's baseline heart rate.
      7) The following shall be documented in the electronic health record (EHR), if present:
         a) Ventricular heart rate
         b) Lead interpreted
         c) Wave form measurements of the following:
            i) PR Interval
            ii) QRS Interval
            iii) QT Interval
         d) Presence of ectopic beats
         e) Documentation of the following is recommended but not required:
            i) ST segment elevation or depression
            ii) Morphology of P waves and T waves
            iii) presence of U waves
   iv. ED: Cardiac Monitoring
      1) All patients requiring cardiac monitoring shall be placed on a cardiac monitor on arrival to the unit
      2) All patient requiring cardiac monitoring shall be transported with an ECG monitor and RN
   v. ICU: Cardiac Monitoring
      1) All patients shall be placed on a cardiac monitor on arrival to the unit
      2) All patients shall be transported with an ECG monitor and RN
   vi. Telemetry: Cardiac Monitoring
      1) All patients shall be placed on a cardiac monitor as outlined in the Management of Telemetry Patients unit specific policy.
      2) PCU patients with Telemetry admission orders shall follow the requirements outlined in Telemetry unit specific policy. t
      3) All patients shall be transported with an ECG monitor and RN unless otherwise ordered. Review the following unit specific policies:
         a) Management of Telemetry Patients
         b) Admission and Discharge Criteria
   vii. Medically Monitored Lead Placement and Rate Monitoring
      1) Standard lead selection shall be leads II and V1
      2) The monitor technician (MT) shall record and analyze a six (6) second strip on:
         a) Admission, At the beginning of the shift

b) As needed with rate changes or new ectopic beats

3) The MT shall communicate the analyzed strip to the primary RN or designee

4) The Unit Secretary or designee identified by the Assistant Nurse Manager (ANM) or relief charge RN will post the strips in the appropriate patient chart.

d. Invasive Pressure Monitoring Lines (Arterial, Pulmonary Artery, and Central Venous Pressure (CVP).)

i. Alarms

1) All invasive pressure lines must be monitored with alarms on.

2) All arterial line alarms shall be set according to the parameters and limits specified in the physician orders. If the physician orders do not address limits, alarms shall be set based on systolic pressure.

3) Pulmonary artery lines shall be set according to the diastolic parameter and shall be set 10 mm/Hg above and below the diastolic pressure.

4) CVP/RA alarms shall be set at "Mean" with limit set per physician order or 50% above and below baseline when port is not being used for infusions.

ii. Invasive Pressure Line Maintenance

1) Transducers shall be leveled to and maintained at the phlebostatic axis (supine or prone position), 4th intercostal space, ½ anterior-posterior diameter of the chest for all pressure measurements.

2) All pressurized transduced indwelling catheters shall be maintained with a 2 unit per mL concentration heparin flush bag pressurized at 300 mm/Hg or normal saline based on the patient condition or physician **preference**~~heparin~~.

3) The flush bag shall be **assessed**~~elevated~~ for adequate volume every shift and PRN. Change bag every 4 days and when empty.

4) Needleless system shall be used for drawing blood from all invasive lines.

5) A safety transfer device shall be used when filling blood tubes.

6) All arterial and pulmonary artery catheters shall be attached to a transducer.

7) All transduced lines shall have pressure waveforms continuously displayed on the bedside monitor.

8) All transduced lines shall have accuracy of the system checked by performing a square waveform test at the beginning of each shift and any time the system is disturbed (e.g. blood draw).

9) Patient shall be positioned supine, head of bed (HOB) between 0-60 degrees, lateral position 20, 30 or 90 degrees or supine for all pulmonary artery pressure (PAP), pulmonary artery occlusion pressure (PAOP) and central venous pressure (CVP) measurements. Patient shall be stabilized 5-15 minutes after a position change before readings are obtained.

10) Obtain PAP/PAOP/CVP measurements from a graphic tracing at end-expiration Q shift and PRN using a simultaneous ECG tracing to assist with proper waveform identification.

e. Pulmonary Artery Catheter Monitoring

i. Cardiac Output (CO) shall be measured **at least** every 4 hours and PRN

E. Standards of Care I.3: Assessment Pulmonary System Review

1. Pulmonary: System Review

a. Assess the following:

i. oxygen delivery devices

ii. oxygen flow/FiO2
iii. Respiratory Symptoms
iv. Respirations
v. Respiratory Pattern
vi. Chest Motion

b. Auscultate breath sounds, all lobes
c. Assess the following if present:
i. sputum amount, color, and consistency
ii. cough
iii. artificial airway, tubes, and drains

2. Pulmonary: Detailed System Review
a. Pulmonary: Chest Tubes
i. Assess the following:
1) Insertion location
a) Palpate insertion site for crepitus, document if present
2) Dressing condition
3) Color and consistency of drainage
4) Amount of suction or gravity drain i.e., water seal
5) Suction chamber fluid level
6) Water seal chamber fluid level, presence of air leak, tidling
7) Complications i.e., air leaks, indications of bleeding etc.

b. Pulmonary: Chest Tube Nursing Interventions as outlined in the following:
i. Chest Tube Management Procedure
ii. ~~Mosby's~~ **Online Skills** Chest Tube: Closed Drainage Systems

c. Pulmonary: Bi-Level Positive Airway Pressure (BiPAP) Assessment
i. Patients receiving BIPAP shall have skin assessed as follows:
ii. Area under headgear
iii. Bridge of nose, around perimeter of mask and along course of headgear straps
1) Ensure mask has a tight seal
iv. Place patient in a room near the nurse's station when possible
v. Elevate head of bed 30 degrees unless contraindicated
vi. Remove BIPAP mask when patient is eating or drinking to prevent aspiration as tolerated
vii. Readjust mask as appropriate to maintain oxygenation parameters as ordered and for patient comfort
viii. Provide communication equipment, i.e. picture boards
ix. Monitor continuous pulse oximetry and respiratory rate per physician's order
1) Ensure continuous pulse oximetry is ordered for patients on Telemetry

d. Pulmonary: Artificial Airway
i. The RN is primarily responsible for ensuring the tracheostomy tube is secured.
ii. Patients with tracheostomy tubes shall have a tracheal change set and an extra tracheostomy tube of the same size readily available at their bedside.
iii. Manual self-inflating resuscitation bags shall be used in the adult patients with endotracheal tubes (ETT) or tracheostomy patients for temporary ventilation whenever patient cannot be effectively ventilated by his/her own efforts.
iv. Two licensed health care providers are required when taping, manipulating, or cutting an endotracheal tube.
v. Trach care shall be done every shift and PRN by a licensed nurse or Respiratory Care Practitioner (RCP).

1) Trach care shall include evaluation and cleaning of the site
   a) Trach holders shall be changed PRN by a licensed nurse or RCP with the assistance of a second healthcare provider
2) Disposable inner cannula shall be changed every shift and PRN by the RN or RCP

vi. The head of the bed will be elevated 30 degrees unless contraindicated
vii. Oral care will be provided every 2-4 hours

e. Artificial Airway Nursing/Mechanical Ventilation Interventions
i. Ensure ICU and Telemetry patients with mechanical ventilation have continuous pulse oximetry.
ii. Ensure continuous pulse oximetry is ordered and monitored on patients with tracheotomies on Telemetry.
iii. Verify mechanical ventilation settings every shift and PRN with changes
1) Assess tidal volume with routine ~~vitals~~ **assessments** in ICU and PRN **with changes in condition**
~~1)~~**iv. Ensure ICU patients with mechanical ventilation have continuous end tidal carbon dioxide (Et~~T~~CO2) monitoring.**
~~2) Assess spontaneous tidal volume with routine vitals in ICU and PRN~~
~~iv.~~**v.** Collaborate with respiratory therapy to assess patient's readiness for extubation daily except for patients receiving paralytic agents, ICP monitoring, pressure control inverse ratio ventilation, and/or immediate post-op open heart surgery
1) Stop all sedation prior to 0800 between 0800 and 1000
2) Assess readiness to extubate
   a) Patient is awake and calm with a Richmond Agitation Sedation Scale (RASS) of 3 to 4
   b) Obtain rapid shallow breathing index (RSBI) as appropriate for RCP
   c) Initiate spontaneous breathing trials as appropriate
      i) Monitor patient for signs of fatigue
      ii) Continue for up to 2 hours or as ordered

~~v.~~**vi.** Collaborate with physician regarding patient's readiness to extubate
~~vi.~~**vii.** Monitor patient for signs of weaning failure during all weaning trials
1) Notify the physician if patient is unable to reach or maintain physician set goals.

~~vii.~~**viii.** Ensure ETT placement is confirmed with a chest x-ray.
~~viii.~~**ix.** Documentation of oral endotracheal tube placement shall be in cm at the lip line. Make every adjustment to an ETT with the aid of an RCP or additional RN.
~~ix.~~**x.** Perform oropharyngeal suctioning prior to making adjustments to the ETT.
~~x.~~**xi.** Standard oral endotracheal tube position shall be changed (from side to side) every 24 hours.
~~xi.~~**xii.** Auscultate and document after any ETT repositioning or manipulation.
1) Never re-tape, move, or adjust an ETT without assistance.

~~xii. Perform oropharyngeal suctioning prior to making adjustments to the ETT.~~

xiii. Suction patient only when necessary and do NOT instill normal saline while suctioning unless necessary.

f. Pulmonary: Passy Muir Speaking Valve
i. Requires a physician order for application
ii. Initial application and evaluation shall be completed by Speech Therapy

iii. Tracheostomy cuff must be deflated prior to the application of the Passy Muir

g. Pulmonary: Respiratory Procedures
   i. Nasotracheal/Orotracheal suctioning requires a physician order except in the ICU
   ii. Nasal airway (trumpet) may be used per RN/RCP discretion for patient comfort or airway protection

F. Standards of Care1.4: Assessment Gastrointestinal (Gi) System Review
1. GI: System Review
   a. Assess contour of abdomen
   b. Assess for nausea and/or vomiting
   c. Auscultate for presence of bowel sounds in all four quadrants
   d. Assess bowel function including passing flatus or last stool
   e. Assess for the presence of tubes and drains. If present, assess type and location
      i. Confirmation of placement, and drainage description
      ii. Check tube placement for drainage and insertion site integrity
      iii. Assess type of formula, rate, residual amounts
      iv. Assess condition of nares and mucosa (check for inflammation and excoriation)
   f. Assess for the presence of ostomies. If present, assess condition of stoma and surrounding skin.
      i. Document nursing ostomy interventions in the medical record

G. Standards of Care 1.5: Assessment Genitourinary (GU) System Review
1. GU: System Review
   a. Assess urine color and clarity, frequency, and voiding difficulties
   b. Assess for bladder distension
   c. Assess external anatomy/perineum as applicable
   d. Dialysis vascular access, if present
      i. Type
      ii. Location
      iii. Patency i.e., presence of thrill and bruit
      iv. Site
      v. Dressing
   e. Assess for presence of tubes/drains/ostomies, if present
      i. Document nursing ostomy interventions in the medical record
2. GU: Nursing Interventions
   a. Use bladder scanner to assess for urinary retention
   b. Urinary ~~C~~catheter, **indwelling** ~~(foley)~~
      i. Insertion
         1) Pericare shall be performed prior to urinary catheter insertion
         2) Urinary catheters should be inserted only when necessary and left in place only for as long as necessary.
         3) If urine analysis or urine culture is ordered, obtain the urine specimen at the time of catheter insertion
      ii. Preexisting urinary catheters
         1) If patient is admitted with a preexisting urinary catheter it should be removed and a new urinary catheter should be inserted.
      iii. Maintenance
         1) Assess and consult with a physician for the need, indwelling catheter daily.
            a) Other methods of urinary drainage such as condom catheter drainage, suprapublic catheterization, and intermittent urethral catheterization should be considered as alternatives to indwelling urethral catheterization.

2) **Urinary catheter**~~Foley~~ care should be performed every shift and PRN (i.e., after bowel movement)
   a) Document care provided in the EHR
3) Ensure drainage tube is secured with hospital approved securement device, i.e. Statlock
4) Ensure the tamper evident seal is intact
5) Ensure the drainage system does not touch the floor and is without dependent loops
6) Ensure the drainage bag is not overfilled
7) Urinary catheters should be changed every 28 days.

c. Discontinuation
   i. Review the patient's medical record for an order to discontinue the urinary catheter.
      1) If a patient has discharge orders and there is no order to discontinue the **urinary** ~~Foley~~ catheter, contact the discharging physician.
   ii. Discontinue the urinary catheter per the Urinary Catheter: Indwelling Catheter Removal Procedure
   iii. If patient is unable to void 2 hours after the urinary catheter is removed:
      1) Verify the bladder volume using a bladder scanner, document the volume in the medical record
      2) If patient has discharge orders, notify the discharging physician (do not discharge the patient)
         a) Time urinary catheter removed
         b) Bladder volume
   iv. Document the following in the medical record after removing the urinary catheter:
      1) Amount of urine in urinary drainage bag
      2) Time catheter removed
      3) Condition of the catheter
      4) Patient's response to the procedure
      5) Unexpected outcomes related to the removal of the urinary catheter
   v. Document the time the patient voids after the removal of the urinary catheter, color and amount of urine and unexpected outcomes in the medical record.

3. Dialysis In-Patients Nursing interventions
   a. Weigh all patients receiving peritoneal or hemodialysis daily prior to 0600
   b. Only dialysis staff shall access dialysis catheters except with a physician order, See TCMC Central Venous Access Devices Procedures.
   c. Do not use the extremity in which a fistula or graft is placed for peripheral IV, blood pressure measurements, invasive monitoring or blood draws without a physician order.
      i. Place an information sign above the head of the patient's bed to communicate the extremity with the dialysis access and the information listed in number 4 to other members of the health care team.
      ii. Maintain bed rest for all patients with femoral dialysis access catheters. The head of the bed may be elevated per the patient's request or comfort.

H. Standards of Care 1.6: Assessment Musculoskeletal System Review
   1. Musculoskeletal System Review
      a. Assess the following:
         i. Extremity movement
         ii. Extremity strength
         iii. Gait/ mobility appropriate for age
         iv. Presence of joint or musculoskeletal abnormalities, if applicable

v. Full range of motion against gravity, some to full resistance of all extremities, if applicable

b. Musculoskeletal System Abnormality Review

i. Presence of assistive devices

I. Standards of Care 1.7: Assessment Integumentary System Review

1. Integumentary System Review shall be performed as outlined in the Skin and Wound Care Policy

J. Standards of Care 1.8: Assessment Psychological/Social

1. Psychosocial assessment shall consist of the following:
   a. Coping
   b. Affect/Behavior
   c. Social Service (SS) Referral Reason
   d. Distress
   e. Stressors
   f. Support/Coping Interventions
2. Psychological/Social: Nursing Interventions
   a. In ordered to promote family centered care, the nurse shall:
      i. Introduce bedside health care providers to the patient/family.
      ii. Review visitation and unit policies with patient/family on admission and as needed.
      iii. Assess and then verify with patient/family age appropriate needs.
      iv. Assess and then verify patient/family ability to understand and participate in the plan of care.
   b. Promote patient/family centered care
      i. Discuss expectations and collaborate with patient/family
      ii. Encourage patient/family to ask questions
      iii. Encourage patient and/or their family to participate in their plan of care.
      iv. Request the assistance of Case Managers and Social Services
   c. Promote patient independence in Activities of Daily Living (ADL)
   d. Promote comfort measures by:
      e. Pharmacological and nonpharmacological
   f. Patients shall be informed of their responsibilities upon admission and as necessary thereafter. These responsibilities include: providing information, asking questions, following instructions, accepting consequences, following rules and regulations, showing respect and consideration, and meeting financial commitments.

K. Standards of Care: Infusion Therapy

1. Central venous lines shall be assessed as outlined in the PCS Central Venous Access Devices Procedure
2. Peripheral IV site shall be assessed:
   a. On admission
   b. Initial shift assessment
   c. Maintenance or continuous infusion shall be assessed every 2 hours and PRN
   d. prior to transfer, upon transfer to nursing unit PRN
   e. The following shall be assessed:
      i. IV insertion date and time
      ii. IV access type
      iii. IV site and condition
      iv. Patency
      v. Dressing type and condition
      vi. Document drainage if present
      vii. Infiltration score
      viii. Phlebitis score
3. Infusion Therapy: Nursing Interventions

a. Peripheral IV**'s are removed upon unresolved complications such as phlebitis, pain or malfunction.**~~sites shall be changed every 4 days unless otherwise ordered.~~

~~a.~~**b.** **Peripheral IV dressings are changed every 7 days and PRN.**

~~b.~~**c.** Document initials and date IV started directly on the dressing.

~~c.~~**d.** Pre-hospital IV starts shall be discontinued and restarted within 24 hours of admission.

e. Rotate IV insertion sites

~~d.~~**f.** IV site shall be discontinued immediately and restarted with patient's complaint of persistent discomfort or signs and symptoms of the following:
- i. Infiltration
  - 1) Skin at site blanched, cool to touch with or without pain
- ii. Inflammation
- iii. Pallor
- iv. Phlebitis
  - 1) Erythema at site with or without pain
  - 2) Pain at site with erythema and/or edema
  - 3) Streak formation, palpable, cord of any size
- v. Bleeding at insertion site
- vi. Leaking of IV solution at insertion site
- vii. Pain

~~e.~~**g.** IV solutions and tubing shall be changed as follows:
- i. Change every 4 days
  - 1) All IV tubing
  - 2) Add-on devices (neutral displacement connector (MicroClave), anti-reflux, extension set, etc) and with tubing change
  - ~~3) Rotate IV insertion sites~~
  - ~~4)~~**3)** Commercially prepared solutions, if the bag is spiked once with initial start
  - ~~5)~~**4)** Piggyback tubing (back flush with a minimum of 10 mL before and after each piggyback

~~f.~~**h.** Change every 24 hours
- i. All IV solutions mixed by pharmacy or nursing, unless manufacturer's
  - 1) Expiration recommends less than 24 hours (examples: Lipids or lipid containing products, neutral displacement connector, anti-reflux, extension set, etc. and with tubing change).

4. Label IV tubing change date sticker indicating date tubing is to be changed using numerical day and month.
5. Label IV solutions with date and time IV solution hung.
6. Dressings shall be changed when damp, loose, soiled, or whenever dressing prevents direct visualization of the site.
7. Infusion pumps shall be used per TCMC Infusion Pump-Infusion System with Guardrails.
8. A separate site shall be used for research study drugs per TCMC Investigational Drugs Policy.
9. Needleless components added to IV administration sets shall be changed every 4 days unless contaminated or a catheter-related infection is suspected or documented.
10. Port Protector
    a. Place a port protector on all unused central venous and peripheral line injection port(s) and at the lowest port of the IV tubing if used frequently for intravenous pushes (IVP) or intermittent infusions
    b. Port protector shall be used on IV tubing ports for patients with central and peripheral lines receiving mainline infusion.
    c. Apply a new port protector
       - i. Every time a port protector is removed
       - ii. Every 8 hours with routine IV flushing

iii. PRN IV flushing

VI. **NURSING PROCESS:**

A. Standard of Care: Assessment
   1. The RN shall ensure all adult patients have a general system review in all systems completed. Detailed system assessments shall be completed as indicated by the patient's condition.

B. Standard of Care: Diagnosis
   1. The RN shall review the data obtained from the patient's assessment, history, and information documented by the interdisciplinary team to identify outcomes to develop the patient's plan of care (POC) on admission, every shift, on transfer to another nursing unit, and PRN.
   2. RNs shall review the data collected by LVNs to develop the patient's POC.

C. Standard of Care: Outcome Identification
   1. The RN shall use the information obtained from Standard of Care: Assessment and Standard of Care: Diagnosis to identify appropriate patient outcomes every shift and PRN.

D. Standard of Care: Planning
   1. The RN shall use the outcomes identified in Standard of Care: Outcome Identification and the physician orders to develop an individualized patient POC. The POC shall prescribe interventions that which may be implemented to attain expected outcomes.

E. Standard of Care: Implementation
   1. A RN shall implement the interventions identified in the POC and ensure task delegated to unlicensed assistant personnel are assigned appropriately and completed.

F. Standard of Care: Evaluation
   1. A RN shall evaluate the patient's progress toward obtaining their outcomes in the POC every shift and PRN.
   2. Emergent and urgent changes in the patient's assessment shall be communicated to physicians as soon as possible per TCMC policy.
   3. Non-emergent and/or not urgent changes in patient's assessment shall be communicated during physician rounds or as soon as possible within the shift the changes were identified.

G. Standard of Care: Documentation
   1. All shift assessments, focus reassessments, PRN assessments and/or care provided will be documented after completion of the care in a timely manner.
   2. When it is not possible to document shift assessments, focus reassessments, PRN assessments and/or care provided due to unforeseen circumstances such as urgent or emergent situations, changes in assignment or increased patient acuity, document the nursing care and assessment as soon as reasonably able to do so.
   3. Reasonable and a timely manner may be defined as within 4 hours after completion of assessments or care provided.

VII. ADDENDUM:

A. Women~~'s~~ and Newborn~~Children's~~ Services

~~VII.~~**VIII. REFERENCE(S):**

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WOMEN'~~S~~ AND NEWBORN~~CHILDREN'S~~ SERVICES Addendum
For Obstetric Patients Receiving Care on Non-Obstetric Nursing Units

I. **GENERAL NURSING ASSESSMENT**

A. Standards of Care: Vital Signs

1. Vital signs shall be obtained upon admission, upon transfer to a unit, upon discharge, per provider's orders, or per unit standards of care :
   a. Notify provider for the following for any antepartum or postpartum patient:
      i. Temperature greater than or equal to 100.4° F or 38° C
      ii. Blood Pressure:
         1) Systolic Blood Pressure (SBP) greater than or equal to 140 and/or Diastolic Blood Pressure (DBP) greater than or equal to 90
         2) For known Preeclampsia with severe features: SBP greater than or equal to 160 and/or DBP 110
      iii. Heart Rate greater than or equal to 120 beats per minute (bpm)
      iv. Respirations greater than 28 or less than 12 breaths per minute
   b. Antepartum:
      i. As ordered by provider, or as clinically indicated per protocol, i.e., PCS procedure: Magnesium Sulfate Administration for Obstetric Patient
      ii. Subjective assessment-ask patient if having any of the following: leaking of fluid, bleeding, contractions, fetal movement, headache or visual disturbances q shift
      iii. Coordinate fetal assessment by Obstetric provider
         1) For ordered fetal monitoring contact Labor and Delivery
   c. Postpartum: Vaginal Delivery:
      i. Vital signs including temperature shall be obtained upon admission, then every 6 hours for the first 24 hours post-delivery, then every shift until discharge, prior to discharge per Patient Care Services (PCS) procedure Discharge of Patients, and prn clinically indicated or per provider order.
   d. Post-Operative: Cesarean Delivery: Post Anesthesia Care Unit (PACU)
      i. Vital signs as ordered by anesthesiologist/provider
         1) See Anesthesia PowerPlan for vital signs in the first 24 hours after cesarean section (generally includes respiratory rate every 1 hour times 12 hours then every 2 hours times 12 hours).
2. Vital sign shall include temperature, upon admission then every 6 hours for first 48 hours post-delivery, then every shift until discharge, prn as clinically indicated or ordered by provider and prior to discharge per PCS procedure Discharge of Patients

B. Standards of Care: Intake And Output

1. As outlined in this document and as follows:
2. Assess for vaginal bleeding as part of the shift reassessment throughout antepartum and postpartum period.
   a. Assess and document:
      i. quantity (number) of pads/chux
      ii. degree of saturation
      iii. color
      iv. frequency of bleeding
   b. For concerns of hemorrhage weigh all blood saturated pads, chux, other soft/cloth materials for accurate assessment of blood loss
      i. Notify physician for active bleeding and report above findings
         1) Obtain order to start IV infusion with Normal Saline or Lactated Ringers
3. Postpartum Hemorrhage is defined as a cumulative blood loss greater than:
   a. 500 mL for Vaginal Delivery
   b. 1000 mL for Cesarean Section

c. 1500 mL for massive hemorrhage for any birth mode
d. Assess and review risk factors for obstetrical hemorrhage and monitor patient's blood loss for baseline blood loss output
e. Monitor lochia for color, odor, amount, consistency, clots, steady stream or trickle
    i. Assess number of pads and degree of saturation
    ii. Weigh all blood saturated pads, chux, other soft/cloth materials for accurate assessment of blood loss
f. When there is a cumulative blood loss considered to be a postpartum hemorrhage:
    i. Start IV infusion with Normal Saline or Lactated Ringers per provider order
    ii. Call RRT and/or Code Maternity
    iii. Notify OB and primary unit ANM/Relief Charge Nurse
    iv. Assist with patient care as directed by RRT and/or Code Maternity team
    v. Consider uterotonic medications per provider order
g. Documentation should include:
    i. Blood loss in medical record,
    ii. Provider notification
    iii. Interventions
    iv. Blood replacement products
    v. Medications given during the Code Maternity shall be documented by a RN on the Code OB Report form
h. Refer to Obstetrical Hemorrhage procedure

C. Standards of Care: Aspiration Assessment
1. Maintain aspiration precautions for maternal patients identified at risk.
    a. Maintain head of bead (HOB) at 30 degrees at all times.
        i. If eclamptic seizure occurs: lower head of bed, open airway, roll patient to side and suction secretions as necessary
        ii. Avoid attempts to insert suctioning device when patient's teeth are clenched.
    b. Maintain suction equipment at bedside at all times.

D. Standards of Care: Patient Safety
1. Maternal: Same as Adult SOC and as indicated below
2. Patient safety shall be assessed per the following:
    a. The RN shall observe the patient's physical condition on admission and/or transfer to their unit, prior to and after epidural placement, and/or other procedures and as needed.
    b. Patients shall be identified per Patient Care Services (PCS): Identification, Patient Policy.
3. System Specific Assessment (Focus assessment/postpartum assessment) shall be completed as follows:
    a. Change in patient's condition from the initial shift assessment or reassessment
    b. Response to treatment provided to a patient
    c. Postpartum assessment:
        i. Uterine assessment (to include lochia assessment):
            1) Fundal height/relationship to umbilicus (-3, -2, -1, 0, +1, +2, +3)
            2) Location (midline (ML) is the normal location, right or left of ML may means a displaced bladder that needs to be emptied)
            3) Consistency (firm, boggy-firms with massage, boggy)
        ii. Time intervals, beginning post-delivery:
            1) 2 hrs.-6 hrs. upon admission then at 6 hrs. post-delivery
            2) Vaginal Delivery: 6 hrs. – 24 hrs.: every 6 hrs or sooner if clinically indicated, then q shift until discharge
            3) Cesarean Section: 6-48 hours every 6 hours or sooner if clinically indicated times 48 hours, then q shift until discharge

4) Evaluation of blood loss/lochia: include at the same time intervals for uterine assessment
a) Slight, Scant, Moderate, Heavy (with or without clots)
b) Rubra, serosa, alba or other
c) Note presence of foul odor

d. Breast Assessment
i. Assess breasts per the postpartum documentation section
1) Assess for softness of the breast
2) Assess nipples
3) Document treatment to nipples

4. Maternal
a. Assess the following:
i. Level of consciousness
ii. Orientation
iii. Presence of:
1) Headache
2) Visual disturbances, e.g. blurred vision or scotoma
iv. Deep Tendon Reflexes-usually done in the presence of hypertension
1) Patellar or brachial (0, 1+, 2+, 3+)
v. Clonus (absent or present)-usually done in the presence of hypertension
1) Effects of epidural/regional anesthesia on lower extremities
vi. Progressive return to pre-anesthesia response, accompanied by increased voluntary movement of legs
vii. Assessment of epidural site, removal of catheter post-delivery per procedure (Reference: WCS procedure: "Epidural Medication Administration")

E. Standards of Care I.3: Assessment Pulmonary System Review
1. Pulmonary: System Review
a. Maternal: (in addition to the Adult SOC Patient Care Pulmonary System review)
b. Assess pulse oximetry
i. Continuous monitoring post-epidural placement
ii. Continuous monitoring for Magnesium Sulfate administration for preeclampsia/preterm labor. Reference: PCS procedure: "Magnesium Sulfate Administration in Obstetric Patients

F. Standards of Care 1.5: Assessment Genitoutinary System Review
1. Genitourinary (GU) System Review
a. Assess urine color and clarity, frequency and voiding difficulties
b. Assess for bladder distension
c. Assess external anatomy/perineum as applicable
d. Assess bladder every 4-6 hours or as ordered by provider
e. Notify provider if patient is not voiding and/or measured output is less than or equal to 30 mL per hour or less than or equal to 120 mL in 4 hours
f. Postpartum patient
i. Check patient for voiding without difficulty every 2 hours x 2 voids post-delivery. After delivery or catheter removal goal is for patient to void spontaneously within 6 hours.
ii. Assess and document patency of a **urinary**~~Foley~~ catheter as well as collection bag for amount, color and clarity of urine

G. Standards of Care 1.8: Assessment Psycho/Social
1. Request social services as appropriate.
2. Initiate social services referrals for the following including, but not limited to:
a. Adoptions
b. Infants going to foster care
c. Patients with no prenatal care
d. Teen moms (less than 17 years old)

e. Positive toxicology results
f. Mothers of infants in Neonatal Intensive Care or in facility
g. All mothers and families experiencing Perinatal loss

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	~~STOOL MANAGEMENT (RECTAL TUBE) DIGNICARE STOOL MANAGEMENT SYSTEM~~
Purpose:	~~To define the appropriate use, initiation and man~~ Management System (SMS). The DigniCare® "is ~~diverting and collecting liquid or semi-liquid stool~~ patients. This may help to reduce patient's risk of skin breakdown, minimize exposure to infectious microorganisms and save nursing time and hospital costs associated with bed linen changes and cleanup" (Bard), 2009)
Equipment:	~~1. Gloves~~ ~~2. 45 mL tap water~~ ~~3. Cavilon Skin Barrier~~ ~~4. Cavilon Skin Sealant~~ ~~5. Collection Bag~~ ~~6. DigniCare®SMS Insertion Tray~~ ~~a. Rectal tube assembly (closed system), self locking collection bag with drainage plug~~ ~~b. 60 mL syringe~~ ~~c. Underpad~~ ~~d. 10 mL water soluble lubricating jelly syringe~~ ~~e. 1 oz MEDI AIRE® biological odor eliminator~~ ~~f. Instructions for use~~

DELETE: Material is covered in ~~Elsevier~~ Online Skills.

~~A.~~ ~~**CONTRAINDICATIONS:**~~

~~1.~~ ~~Do not use for more than 29 consecutive days.~~
~~2.~~ ~~Do not use on patients known to be sensitive to or allergic to any components within the system.~~
~~3.~~ ~~Do not use on patients who have large bowel or rectal surgery within the last year.~~
~~4.~~ ~~Do not use on patients with any rectal or anal injury, severe rectal or anal stricture or stenosis (or on any patient if the distal rectum cannot accommodate the inflated cuff), confirmed rectal or anal tumor, severe hemorrhoids, or fecal impaction.~~
~~5.~~ ~~Not for use in patients with suspected or confirmed rectal mucosa impairment (i.e. severe proctitis, ischemic proctitis, mucosal ulcerations).~~
~~6.~~ ~~Not for use in patients with indwelling rectal or anal devices (i.e. thermometer) or delivery mechanism (i.e. suppositories) or enemas in place.~~
~~7.~~ ~~Not for use in neutropenic patients with absolute neutrophil count (ANC) less than 500~~
~~8.~~ ~~Do not use for patients with solid or soft formed stool.~~

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

~~1.~~ ~~A physician's order is required for initiation of the DigniCare® SMS.~~
~~2.~~ ~~A Registered Nurse (RN) shall be responsible for initiation and managing the DigniCare SMS.~~
~~3.~~ ~~Product is for single use only.~~
~~4.~~ ~~Indications for use include the following:~~
~~a.~~ ~~Critically ill patient~~
~~b.~~ ~~Functional rectal sphincter~~
~~c.~~ ~~Frequent episodes of liquid to semi liquid stool~~
~~d.~~ ~~Protection of medical devices or wound dressing which will become compromised by fecal contact~~
~~e.~~ ~~Management of infectious or potentially infectious stool~~
~~f.~~ ~~Collection of liquid to semi solid stool in the medical/surgical patient who requires stool containment for:~~

Department Review	Clinical Policies & Procedures	Nurse Executive Council	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
10/11, 04/16, 04/19	11/11, 05/16, 05/19	11/11, 05/16, 05/19	1/12, 6/16, 06/19	07/19	2/12, n/a	2/12, 7/16

i. Protection of skin and prevention of pressure ulcers in the incontinent patient.
ii. Stool control and diversion.

5. Discontinue SMS when the patient's bowel control, consistency and frequency of stool begin to return to normal.
6. Care should be used in patients with the following diseases or conditions:
   a. Inflammatory Bowel Disease
      i. The physician shall determine the degree and location of the acute inflammation prior to use of the device.
   b. Anti-coagulant/anti-platelet therapy
   c. Colon or rectal surgery of anastomosis prior to initiation
      i. Consider site of anastomosis prior to initiation
   d. Hemorrhoids
7. Do not insert devices such as thermometers or suppositories into the anal canal while the device is in place.
8. Do not connect mechanical pumping devices to catheter irrigation port.
9. Rectal bleeding should be investigated to ensure no evidence of pressure necrosis from the device, discontinuation of the device is recommended if evident.
10. Abdominal distention that occurs while using the device should be investigated.
11. Excessive prolonged traction on the catheter may result in the retention cuff migrating into the anal canal which may result in temporary or permanent clinical sphincter dysfunction, or catheter expulsion.
12. Notify a physician if any of the following occur:
    a. Rectal pain
    b. Rectal bleeding
    c. Abdominal symptoms such as distension or pain

C. **PROCEDURE:**

1. The DIGNICARE® SMS has three drainage tube ports which are labeled as outlined below:

Label	Port Color	Label Definition
INF (45mL)	Green (matches the cuff color)	Inflation port for retention cuff specifies recommended inflation volume and inflation medium. • The green inflation port is used for cuff inflation to ensure proper cuff seating in the rectal vault.
FLUSH	Purple	Flush port for clearance of drain tube only • The purple flush port is designed to flush the rectal tubing via the 8 outlet tubes (located throughout the main tubing) for irrigation (as needed) throughout the stool management system's use.
IRRG	Clear	Irrigation port infuses water into rectum • The clear irrigation port is used to irrigate the patient's bowel to break up stool (as needed) • To verify proper cuff placement during initial insertion, as well as throughout the stool management system's use.

2. Insertion of the DigniCare® SMS
   a. Perform hand hygiene and don gloves.
   b. Explain the procedure to patient.
   c. Open DIGNICARE® SMS Insertion Tray. Identify cuff end. Identify ball valve end.

d. Ensure green "door" on ball valve is in closed position with the green latch pointed back towards the hanger. Connect collection bag to catheter as follows:
   i. Holding collar on collection bag upright with non-dominant hand, align the valve latch with the groove on bag collar and insert.
   ii. Turn ball valve clockwise until fully (snaps into place) engaged.
e. Locate green inflation port and align with the tubing to ensure patency. Connect syringe (included) to port and pull back slowly on plunger to remove all air from DIGNICARE® SMS inflation cuff. Remove syringe.
   i. Ensure cuff is fully deflated.
f. Draw 45 mL of tap water into 60 mL syringe and connect to inflation port. DO NOT INSTILL!
g. Unfold and Position tubing of catheter lengthwise on bed, extending collection bag towards the foot of the bed, and assure tubing is not coiled or kinked.
h. Attach 60 mL syringe with 45 mL tap water to the inflation port but do not inflate.
i. Position patient (left side lying) and place absorbent pad under patient.
   i. The preferred patient position for catheter insertion is the left lateral knee-chest position, to maximize sphincter relaxation to ease catheter insertion.
   ii. Position patient based on their clinical situation.
j. Perform a digital rectal exam to assess for fecal impaction.
   i. If fecal impaction is present, patient should be disimpacted before insertion of the DigniCare® SMS.
k. Lubricate patient's anus (lubricant included in tray).
l. Insert the inflation cuff as follows:
   i. Squeeze the inflation cuff to ensure all air has been removed and hold the cuff flat in order to fold for insertion.
   ii. Holding the left point of the cuff between the thumb and index finger, fold the top right point of the cuff down and to the left in a 45 degree angle (this creates a conical shape with a leading edge for easy insertion).
   iii. Generously coat the cuff end on the catheter with the lubricating jelly.
   iv. Gently insert the cuff end through the anal sphincter until the cuff is beyond the external orifice and well inside the rectal vault.
m. Slowly instill 45 mL of tap water (previously drawn up) into cuff and disconnect syringe.
   i. Do not over inflate.
   ii. Use the external pilot balloon as a guide to determine proper inflation.
      1) The pilot balloon indicates over or under inflation.
      2) Use the syringe to withdraw the fluid from the cuff, reposition the cuff in rectal vault and re-inflate.
      3) Ensure the inflation port remains parallel to the catheter in order to prevent kinking of the inflation lumen and blockage of injected fluid.
n. Gently tug on the tubing to "seat" cuff completely in rectal vault.
o. Note where black position indicator line is in relation to the rectum.
p. Locate irrigation port. Irrigate with tap water to determine patency.
q. Locate purple flush port. This port is designed to flush and clear tubing only. Flush tubing at least twice per shift and as needed.
r. Hang the collection bag by the hanger and secure to bed (lower than patient) and position rectal tubing alongside patient. Do not place collection bag on the floor.

3. Care and Maintenance of the DigniCare® SMS
   a. Assess patient every shift and PRN for indications to continue DigniCare® SMS.
   b. Verify proper cuff placement every shift and PRN.
   c. Assess cuff volume every shift and PRN to ensure proper inflation.
   d. Assess the position indicator band after repositioning the patient and PRN to ensure the device is positioned properly against the rectal floor every shift and PRN.
   e. Assess the catheter tubing and collection bag ensure the tubing is not twisted or kinked and collection bag is in properly position.
   f. Irrigation of patient's bowel (through the clear port) may be performed to break up stool.

g. Flush tubing at least twice per shift and as needed.
h. Monitor output per the Standards of Patient Care.
i. The collection bag should be changed and disposed of as needed, and/or when full.
   i. Grab ball valve connector, gently push in catheter, and twist counterclockwise.
   ii. Remove bag, insert bag plug into socket connector, and dispose of bag.
j. Remove/replace when clinically indicated, at least every twenty nine days per manufacturer's recommendation.

4. Obtaining a Fecal Sample
   a. Disconnect the ball valve connector from the bag by turning counterclockwise.
   b. Obtain a sample from the drainage bag by pouring specimen into a specimen container.
   c. Re-attach current bag or new bag to ball valve by turning clockwise.
5. Troubleshooting the DigniCare® SMS
   a. If the retention cuff area becomes obstructed with fecal matter and the catheter may require irrigation of flushing with tap water and/or the patient may be lying on catheter drain tube.
   b. Use only gravity or slow manual irrigation.
   c. Do not irrigate patient with compromised intestinal wall integrity.
   d. Ensure the appropriate port irrigation or flush port remains parallel to the catheter in order to prevent kinking in the tubing and blockage of the injected liquid.
   e. Irrigate the catheter as follows and repeat the procedure as often as necessary to maintain proper functioning of the device.
      i. Fill syringe with tap water
      ii. Attach to irrigation port
      iii. Depress plunger
   f. Flush the catheter if the drainage tube becomes obstructed with fecal matter and repeat the process as needed. If repeated flushing with water does not return the flow of stool through the catheter, the device should be inspected to determine if there is an external obstruction i.e. pressure from a body part or piece of equipment) if no source of obstruction of the device is detected, use of the device should be discontinues.
      i. Fill syringe with tap water
      ii. Attach to flush port
      iii. Depress plunger
6. Replacement/Removal of the Collection Bag
   a. Grab the collection bag
   b. Grab the ball valve connector
   c. Gently push the catheter in and twist the catheter in a counter-clockwise direction.
      i. Rotate the ball valve connector 90 degrees to ensure the ball valve is closed prior to removal of the collection bag.
   d. Once the bag is remove, insert bag plug into the socket connector and dispose.
   e. Replace the collection bag by securely snapping a new bag to the connector.
7. Removal of DigniCare® SMS
   a. Explain procedure to patient.
   b. Deflate cuff by attaching syringe to inflation port and slowly withdraw all water.
      1) If less than 45 mL is removed, reposition patient and repeat as needed.
      ii. Disconnect the syringe and discard.
      iii. Grasp the rectal tubing as close to the patient as possible, have patient bear down, and slowly pull cuff out of the anus.
      iv. Dispose of the device
8. Documentation
   a. The RN inserting the DigniCare® SMS is responsible for entering the following in the patient's medical record:
      i. Date and time of insertion.
      ii. Patient's response to insertion.
      iii. Volume of stool every shift and PRN.
      iv. Education provided and follow-up education.

v. Flushing and irrigation, if performed.

b. Document presences of the DigniCare ® SMS every shift and PRN in the medical record.

c. Document discontinuation of the DigniCare® SMS in the medical record.

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

A. **POLICY:**

1. A Stroke Code shall be initiated if a patient presents to the Emergency Department (ED) experiencing "stroke-like" symptoms of less than **twenty-four (24)**~~eight (8)~~ hours duration.

B. **PROCEDURE:**

1. Stroke Code Activation:
   a. Patient with "stroke-like" symptoms who are in route to Tri-City Medical Center (TCMC) by Emergency Medical Service (EMS) providers will have a Stroke Code activated by the Mobile Intensive Care Nurse (MICN) prior to arrival by dialing 66 and notifying the operator.
      i. The MICN will notify the ANM/Charge RN as well as the ED Physician.
   b. Patients with "stroke-like" symptoms who present through triage should be immediately placed in an emergency department bed and notify the ED ANM/Charge RN and ED physician.
      i. The Registered Nurse or Unit Secretary will activate a Stroke Code at the direction of the ED Physician by dialing 66 and notifying the operator.
   c. The operator will page the Stroke Team consisting of:
      i. Computed Tomography (CT) Technologist
      ii. Lab Phlebotomist
      iii. Stroke Coordinator
      iv. Radiology Technologist
      v. Lab Technologist
2. Notification of Neurologist:
   a. The Neurologist on call will be notified by the ED physician.
3. Initial Care of the Stroke Patient per physician orders:
   a. Initial care of the stroke patient should include immediate stabilization of the airway, breathing, and circulation (ABC's). This is quickly followed by an assessment using the National Institute Health Stroke Scale (NIHSS).
   b. The ED Physician serves as the Stroke Team Leader and is responsible for initial evaluation and stabilizing treatment, as well as determining eligibility for thrombolytics in collaboration with the Neurologist.
   c. Determine time of symptom onset.
      i. This is defined as when the patient was at his or her previous baseline or symptom-free state. For patients unable to provide this information or who awaken with stroke symptoms, the time of onset is defined as when the patient was last awake and symptom-free or known to be "normal".
   d. Obtain finger stick blood glucose.
      i. Notify ED physician of result.
   e. Initiate continuous cardiac monitoring
   f. Monitor blood pressure every 15 minutes until thrombolytic eligibility is determined.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Committee	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
04/09, 11/11, 01/17, 09/18	12/11, 4/15, 02/17, 10/18, 03/19	12/11, 4/15, 02/17, 11/18, 03/19	n/a	02/17, 11/18, 05/19	01/12, 02/17, 11/18, 06/19	01/19, 07/19	02/12, 03/17, n/a	02/12, 03/17, 01/19

g. Obtain vital signs including: heart rate, blood pressure, respiratory rate, oxygen saturation, and estimated weight.
h. Obtain 12 lead Electrocardiogram (ECG).
i. Obtain Intravenous (IV) access.
   i. Place 18 or 20 gauge IV in antecubital (AC) or forearm.
j. Initiate supplemental oxygen as ordered.
k. Perform NIHSS assessment and Swallow Screen prior to any oral intake.
   i. Notify ED physician of results.

4. Time Parameter goal is to maintain the best practice times listed below per physician orders:
   a. Draw STAT labs to include prothrombin time (PT)/international normalized ratio (INR), partial thromboplastin time (PTT), Glucose, and Creatinine –complete within 45 minutes of arrival but not to delay ~~rtPA~~**tPA** administration.
      i. Draw labs prior to CT scan.
   b. Obtain STAT CT scan – completed within 25 minutes of arrival.
      i. The Emergency Department RN accompanies all Stroke Code patients to CT scan.
      ii. CT Technologist will notify Radiologist of the Stroke Code CT for STAT read.
      iii. Radiologist will notify the Emergency Department Physician of CT results within 20 minutes of completion.
   c. Obtain portable chest x-ray and ECG – complete within 45 minutes of arrival but not to delay ~~r~~-Patients tPA administration.
5. Care of the patients eligible for thrombolytics per physician orders:
   a. Continuous cardiac monitoring
   b. Place second peripheral IV.
   c. Place Foley Catheter prior to ~~rtPA~~**tPA** administration if ordered by the ED Physician.
   d. Monitor blood pressure Q 15 minutes.
      i. Acceptable blood pressure obtained prior to administration of ~~rtPA~~**tPA** is a systolic blood pressure less than (<) 185 and diastolic blood pressure of less than (<) 110.
   e. If patient is eligible for ~~rtPA~~**tPA** treatment informed consent will be obtained by ED Physician and/or Neurologist.
      i. Signed consent is not required for administration of ~~rtPA~~**tPA**.
6. Administer ~~rtPA~~**tPA** per physician order:
   a. Recommended TOTAL dose of ~~rtPA~~**tPA** is 0.9 mg/kg, not to exceed 90 mg.
   b. Reconstitute and administer ~~rtPA~~**tPA** as follows:
      i. Reconstitute ~~rtPA~~**tPA** with 100 mL of sterile water for injection utilizing the transfer device to create a solution with a concentration of 1 mg/mL.
      ii. With a second Registered Nurse, calculate the weight based dose of ~~rtPA~~**tPA**.
      iii. Remove from the vial any quantity drug in excess of that specified for patient treatment, calculate the excess dose and discard 10 mL less than that dose. This will allow for the complete dose of ~~rtPA~~**tPA** to be infused.
      iv. Withdraw the bolus amount (bolus dose is 10% of total dose) and administer IVP over 1 minute.
      v. Program the infusion pump to deliver the remaining dose over 60 minutes.
      vi. ~~rtPA~~**tPA** must be double checked by two Registered Nurses and documented in the Medication Administration Record.
7. Monitoring During and Post Thrombolytic Administration:
   a. Continuous cardiac monitoring.
   b. Monitor blood pressure:
      i. ~~every~~ **Every** 15 minutes for 2 hours
      ii. Then every 30 minutes for 6 hours
      iii. Then every 1 hour for 16 hours.
      iv. Notify ED Physician immediately for systolic blood pressure greater than (>) 185 and/or diastolic blood pressure greater than (>) 110.

c. Monitor neurological status every:
   i. 15 minutes for 2 hours
   ii. Then every 30 minutes for 6 hours
   iii. ŧTŧhen every 1 hour for 16 hours.
   iv. Neurological assessment should include: level of consciousness, orientation, response to commands, motor scoring of upper and lower extremities, language, dysarthria, and pupillary response.
   v. If the patient develops a severe headache, acute hypertension, nausea, vomiting or has worsening neurological examination notify ED Physician immediately.
   vi. Monitor temperature and maintain normothermia.
   vii. Monitor blood sugar and maintain euglycemia.

d. Continue monitoring patient upon transport and during diagnostic tests. If unable to perform assessment/vital signs during test, document reason and resume assessment/vital signs as soon as test is completed.
   i. Note: most diagnostic areas have vital sign monitoring capability but staff may not be able to perform assessment during test

8. Care of the patients eligible for thrombectomy
   a. Neurology and/ or ED Physician will discuss case with on call Interventional Radiologist
   b. The Registered Nurse (RN), Unit Secretary, or designee will activate a Code Thrombectomy at the direction of the Interventional Radiologist and/or ED Physician by dialing 66 and notifying the operator.
   c. The operator will page the Code Thrombectomy Team consisting of:
      i. Administrative Supervisor
      ii. Intensive Care Unit (ICU) Charge Nurse
      iii. Stroke Coordinator
   d. The operator will also call 5400 and notify Operating Room (OR) desk to gather their team (Anesthesiologist, Anesthesia Tech and OR RN). The OR desk will return a call to the private branch exchange (PBX) with OR team names and call response.
   e. The operator will call the Interventional Radiology Team (RN, scrub tech, rad tech) as per the on-call schedule
9. Disposition of Stroke Patient:
   a. Monitoring Post Thrombectomy without thrombolytics (tPA):
      i. Continuous cardiac monitoring, vitals and groin checks:
         1) Every fifteen (15) minutes for one (1) hour
         2) Then every half (½) hour for (1) hour
         3) Then every one (1) hour for four (4) hours
         4) Then routine.
      ii. NIHSS every one (1) hour for six (6) hours
   b. Monitoring Post Thrombectomy with thrombolytics (tPA)
      i. Continuous cardiac monitoring
      ii. Monitor blood pressure, VS and NIHSS:
         1) Every fifteen (15) minutes for two (2) hours
         2) Then every thirty (30) minutes for six (6) hours
         3) Then every one (1) hour times sixteen (16) hours
   c. Stroke patients who have received thrombolytics and/or Thrombectomy are admitted to the Intensive Care Unit
   d. Stroke patients who do not meet the criteria for admission to the Intensive Care Unit should be admitted to 4 Pavilion or Telemetry.

C. **FORM(S):**
1. 24 hour ~~#PA~~**tPA** Flow Sheet. Form # 6010-1010 - Sample

D. **REFERENCE(S):**

~~1. Guidelines for the Early Management of Adults with Ischemic Stroke. Stroke, Journal of the American Heart Association, 2007: 1655-1708~~
~~2. Guidelines for the early management of patients with acute ischemic stroke: a guideline for healthcare professionals from the American Heart Association/American Stroke Association. Stroke. Volume 44 pages 870-947 (2013)~~
~~3.~~1. **Guidelines for the early management of patients with acute ischemic stroke: a guideline for healthcare professionals from the American Heart Association/American Stroke Association. Stroke. Volume 49 (2018)**
~~4.~~2. **Thrombectomy 6 to 24 Hours after Stroke with a Mismatch between Deficit and Infarct. engl j med 378;1 nejm.org January 4, 2018**

24 hour ~~rt~~PAtPA Flow Sheet. Form # 6010-1010 - SAMPLE

Score Table

Level of Consciousness
0=Alert 2=Obtunded
1=Drowsy 3=Coma/Unresponsive

Orientation Questions "What month"/"How old"
0=Answers both correctly
1=Answers one correctly
2=Answers neither correctly

Response to Commands
Open/Close eyes/makes fist
0=Performs both tasks correctly
1=Performs one tasks correctly
2=Performs neither task correctly

Language
0=Normal, no aphasia
1=Mild to moderate aphasia
2=Severe aphasia 3=Coma, mute

Motor Score-10 sec-arms, 5 sec-legs
0=No Drift 1=Drift
2=Some effort against gravity
3=No effort against gravity
4=No movement

Pupil Reaction
N-Non Reactive S-Sluggish
B-Brisk

Dysarthria
0=Normal articulation
1=Mild to moderate dysarthria
2=Severe dysarthria, coma

Pupil Assessment
Reaction to light: B=Brisk
F=Fixed S=Sluggish

Pupil size:

Abbreviated NIHSS	t-PA Start	15 min	30 min	45 min	1 hr	1 1/4 hr	1 1/2 hr	1 3/4 hr	2 hr	2 1/2 hr	3 hr	3 1/2 hr	4 hr	4 1/2 hr	5 hr	5 1/2 hr	6 hr	6 1/2 hr	7 hr	7 1/2 hr	8 hr	9 hr	10 hr	11 hr	12 hr	13 hr	14 hr	15 hr	16 hr	17 hr	18 hr	19 hr	20 hr	21 hr	22 hr	23 hr	24 hr
Time																																						
Systolic Blood Pressure																																					
Diastolic Blood Pressure																																					
Heart Rate																																					
Pupil Size: Right																																					
Pupil Size: Left																																					
Pupil Reaction: Right																																					
Pupil Reaction: Left																																					
Level of Consciousness																																					
Orientation Questions																																					
Response to Commands																																					
Motor Score Right Arm																																					
Left Arm																																					
Motor Score Right Leg																																					
Left Leg																																					
Language																																					
Dysarthria																																					
TOTAL SCORE																																					
*Groin site ✓ R/L/NA																																					
Initials																																					

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

6010-1010
(Rev. 08/14)

Neuro checks and Vital Signs to be completed.
- 15 Minutes X 2 Hours
- 30 Minutes X 6 Hours
- 1 Hour X 16 Hours

24 Hour t-PA Flow Sheet

Permanent part of the record

Affix Patient Label

Signature Date/Time

Signature Date/Time

Signature Date/Time

Signature Date/Time

Document any site abnormalities in the EHR

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 09/08

SUBJECT: Therapeutic Anticoagulation Management

REVISION DATE(S): 12/09, 03/12, 05/12

~~**POLICY NUMBER: IV.B**~~

~~Department~~ Patient Care Services Content Expert Approval:	~~03/17~~04/19
Clinical Policies ~~and~~& Procedures Committee Approval:	~~03/17~~05/19
Nurse Executive Committee Approval:	~~03/17~~05/19
Pharmacy ~~and~~& Therapeutics Committee Approval:	~~05/17~~05/19
Medical Executive Committee Approval:	~~06/17~~06/19
Administration Approval:	07/19
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

A. **PURPOSE:**

1. Joint Commission has identified therapeutic anticoagulation (unfractionated heparin infusion, low molecular weight heparins and warfarin) as a high risk therapy that "often leads to adverse drug events due to complex dosing [and] requisite follow-up monitoring".
2. This Therapeutic Anticoagulation Program includes comprehensive anticoagulation policies, ~~pre-printed~~ order sets, guidelines and general tools to assist all health care providers in providing the optimal anticoagulant therapy for Tri-City Hospital ~~Disctrict~~ **District** (TCHD) patients. This document describes the overall Therapeutic Anticoagulation Program developed for TCHD intended to ensure regulatory compliance and improve the care of patients.
3. Given the broad, multi-disciplinary scope of the anticoagulation NPSG, this document will also be broad in scope but will emphasize the inpatient management of therapeutic anticoagulation. The TCHD Therapeutic Anticoagulation Program addresses the activities of the following department and groups:
   a. Physician/Allied Healthcare Professional (AHP)
   b. Pharmacy
   c. Nursing
   d. Dietary
   e. Laboratory
   f. Education Department
   g. Patients
   h. Patients' Families

B. **OVERVIEW OF THE TCHD INPATIENT THERAPEUTIC ANTICOAGULATION PROGRAM**

1. Prescribing:
   a. Overview:
      i. Prescribing of therapeutic anticoagulation therapy is expected to be standardized. Accordingly, all prescribers will be expected to utilize a master TCHD **Pharmacy Procedure:** Anticoagulation Dosing **Protocol** Policy for adults and pediatrics. This dosing policy has been developed to assist the Physician/AHP in appropriate medication selection (based on patient's co-morbidities), medication dosing as well as mandated baseline and follow-up medication monitoring. See ~~appendix 1~~**Pharmacy Procedure: Anticoagulation Dosing Protocol.**

ii. The prescribing of anticoagulants in specialized patient care settings where it is reasonably expected for a Physician/AHP to be present during the entire course of therapy (such as in or en route to the cardiac catheterization laboratory or operating rooms) does not require the use of the **Pharmacy Procedure:** ~~a~~Anticoagulation ~~d~~Dosing **Protocol**~~policy~~.

iii. Short term heparin usage (e.g., 4 hours or less) during the course of hemodialysis is deemed "prophylactic" anticoagulation that is not expected to produce prolonged alterations in the coagulation studies. Accordingly, heparin usage in this manner is also considered exempt from the mandatory use of the **Pharmacy Procedure:** Anticoagulation Dosing **Protocol**~~Policy~~.

b. Unfractionated Heparin Infusion:

i. The Physician/AHP has the option of consulting pharmacy services to manage the heparin therapy or retaining the heparin management responsibilities. The pharmacy heparin dosing/monitoring service is guided by the Pharmacy **Procedure:** Anticoagulation Dosing Protocol that is consistent with the elements of the NPSG and approved by the organization.

ii. For adults, if the Physician/AHP elects to retain the heparin management responsibilities, the **Pharmacy Procedure:** ~~a~~Anticoagulation ~~d~~Dosing **Protocol**~~policy~~ will allow the Physician/AHP to select one of the 2 heparin nomograms
(-venous thromboembolism/deep vein thrombosis/pulmonary embolism or Cardiac). The selection of an appropriate nomogram will depend on the patient's indication for anticoagulation and the risk for severe bleeding complications

iii. Upon receipt of the order, the inpatient clinical pharmacist will review the order for accuracy and completeness (patient weight and indication), and ensure that the completed nomogram is entered as an order comment prior to order verification. The nomogram will be visible to the nurse within the electronic MAR

c. Low Molecular Weight Heparin:

i. All orders for therapeutically-dosed low molecular weight heparin must be initiated on a **weight based** ~~per~~**(mg/kg)** dosing ~~policy basis~~**regimen**.

ii. Guidelines to assist the Physician/AHP in the safe use of low molecular weight heparins based on patient's renal function or other co-morbidities are incorporated into **Pharmacy Procedure:** Anticoagulation Dosing Protocol.

d. Warfarin:

i. The Physician/AHP has the option of consulting pharmacy services to manage the warfarin therapy or retaining the warfarin management responsibilities. The pharmacy warfarin dosing/monitoring service is guided by the Pharmacy **Procedure:** Anticoagulation Dosing Protocol that is consistent with the elements of the NPSG and approved by the organization.

ii. Pharmacy services shall monitor warfarin patients to ensure compliance with required NPSG monitoring expectations before warfarin daily administration and to provide recommendations to prescribers as needed.

2. Dispensing:

a. Overview:

i. Only oral unit dose products, pre-filled syringes, or pre-mixed infusion bags will be dispensed whenever possible. If these products are not commercially available, patient-specific doses will compounded to be dispensed.

b. Unfractionated Heparin Infusion:

i. **When possible,** ~~O~~only standardized, pre-mixed heparin infusion bags (25,000 units/500 mL D5W) will be dispensed **for therapeutic anticoagulation.** ~~No alternative strengths will be admixed nor dispensed from pharmacy services.~~**Shortages may require other diluents/concentrations, which will be communicated to nursing and Medical Staff prior to use.**

~~i.~~**1) For Impella use, multiple concentrations may be needed, which will be admixed by pharmacy and labeled accordingly**

c. Low Molecular Weight Heparin:
   i. For adults, pre-filled enoxaparin syringes (doses rounded to nearest 10 mg) will be dispensed whenever possible. If an appropriate enoxaparin does is not commercially available as a pre-filled syringe, pharmacy will compound the doses for the patient, so to eliminate the need for nursing to administer a partial syringe.
   ii. For pediatrics, enoxaparin doses will be rounded to the nearest 5 mg. Pre-filled enoxaparin syringes will be dispensed whenever possible. If an appropriate dose is not commercially available as a pre-filled syringe, pharmacy will compound the syringe, using a 100 mg/mL diluted vial.
   iii. Exact warfarin doses will be dispensed for patient administration. The nursing staff will not be expected to split any warfarin tablets to obtain the prescribed dose.

3. Baseline Monitoring:
   a. Overview:
      i. Baseline laboratory monitoring within 24 hours prior to initiation of therapeutic anticoagulation will be mandated by the use of the **Pharmacy Procedure:** Anticoagulation Dosing Protocol. The specific baseline laboratory tests that will be assessed are listed below.
   b. Unfractionated Heparin Infusion:
      i. Complete Blood Count (CBC)
      ii. Activated Partial Thromboplastin Time (PTT)
   c. Low Molecular Weight Heparin
      i. **Complete blood count (CBC),** Blood Urea Nitrogen (BUN), and serum creatinine
      ii. Baseline Activated, Prothrombin Time (PT) and International Normalized Ratio (INR) are optional but recommended
   d. Warfarin
      i. Complete Blood Count (CBC), PT, and INR
   e. Direct Oral Anticoagulants (DOAC's)
      ~~ii.~~i. CBC, BUN, SCr, as needed

4. Administration:
   a. Unfractionated Heparin Infusions
      i. All heparin infusions will be administered by a programmable infusion pump with "smart pump" technology.
      ii. All heparin bolus doses will be administered in units using the 1,000 unit per mL ~~vial~~ **concentration**.
      iii. All heparin infusions will be programmed as units/kg/hour.
      iv. Independent double checking and documentation is to be performed as per Patient Care Services (PCS) **Policy:** Medication Administration ~~Policy, IV.I.~~
   b. Low Molecular Weight Heparin:
      i. **Administer per manufacturer's instructions for use**~~The air bubble is NOT to be ejected from the syringe prior to injection~~.
      ii. ~~The needle shield is to be removed by pulling it straight off the syringe. For subcutaneous (SC) injections, the patient should be lying down and t~~The injection should be administered by deep SC injection. ~~Remove the syringe from the injection site, keeping a finger depressing the plunger rod. Activate the safety system by firmly pushing the plunger rod. A protective sleeve will automatically cover the needle. Dispose of needle in appropriate sharps container.~~
      iii. Rotate SC injection sites. Do not rub the injection site after completion of the injection.
      ~~iv. Document administration of enoxaparin dose per hospital policy.~~

c. Warfarin:
~~i. Nursing staff will document administration of warfarin doses on the patient's medication administration record (MAR).~~
~~ii.~~i. Pharmacy will track all warfarin dosing and monitoring via ~~the Warfarin monitoring sheet.~~**electronic health record (EHR).**

5. Follow-up Monitoring:
a. Overview
i. Patients receiving therapeutic anticoagulation are expected to receive follow-up safety and efficacy monitoring.
ii. All patients receiving therapeutic anticoagulation are expected to be monitored for any evidence of major oozing, bleeding or internal bleeding, changes in neurologic status, as well as indications of an allergic reaction. The nursing staff is to notify the prescriber if any of these adverse effects are noted.
iii. According to the Critical Result and Critical Tests/Diagnostic Procedures policy all critical laboratory values are to be reported to the prescriber within 60 minutes of notification from the laboratory except in cases whereby ~~physician/~~Physician/AHP orders/policies for treatment of the critical results were previously available. Relevant critical laboratory results that will require ~~physician/~~Physician/AHP orders/policies for treatment of the critical results were previously available. Relevant critical laboratory results that will require ~~physician/~~Physician/AHP notification include: INR greater than 5, hemoglobin less than 7gm/dL, platelet count less than 50 K/miroliter, and PTT>200 seconds.
iv. Medication specific monitoring parameters are listed below.
b. Unfractionated Heparin Infusion:
i. PTT 6 hours after each heparin dose change and every 6 hours while stable unless otherwise dictated per policies.
ii. Nursing staff to report any fall in platelet count to less than 100K/microliter to the Physician/AHP.
iii. CBC every 1-3 days (default is daily).
c. Low Molecular Weight Heparin:
i. CBC every 1-3 days (default is daily).
ii. Nursing staff to report any fall in platelet count to less than 100K/microliter to the Physician/AHP.
iii. BUN and serum creatinine every 1-3 days (default is daily).
d. Warfarin:
i. CBC every 1-3 days (default is daily).
ii. For acute care patients, PT/INR every morning. This may be reduced to once weekly after 7 consecutive INR's within the therapeutic without requiring warfarin dose adjustments are obtained.
iii. Nutrition Services will identify all new inpatient warfarin patients on a daily basis and make necessary menu adjustments as needed.
e. DOAC's
i. CBC every 1-3 days (default is daily)
~~iii.~~ii. BUN and SCr every 1-3 days (default is daily)

6. Patient Education:
a. Overview:
i. TCHD staff will provide "patient/family education that includes the importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse drug reactions and interactions".
ii. For all therapeutic anticoagulation, the patient and their family members will be educated about the name, indication, dosage, administration procedure, side effects, and monitoring of all anticoagulant therapies. The patient and family will be instructed to alert nursing staff of any bleeding or bruising during anticoagulation therapy.

iii. Additional discharge education will be provided as per TCHD policy.

C. **INPATIENT PROGRAM MONITORING:**

1. Overview:
   a. Results of anticoagulation monitoring ~~and~~ **in** adults will be reviewed by Pharmacy and Therapeutics annually, in order to reassess the safety and effectiveness of the **Pharmacy Procedure:** Anticoagulation Dosing **Protocol**~~Policy~~ and allow for re-assessment and modification, as needed.
2. Specific Monitoring Parameters
   a. Safety:
      i. Percentage of PTT values that fall into critical range (greater than 100 seconds) in patients receiving heparin infusions.
      ii. Percentage of INR values that fall into critical range (greater than ~~5.0~~) in patients receiving warfarin therapy.
      iii. Review of vitamin K and protamine usage as trigger tools for potential bleeding complications.
      iv. Percentage of patients initiated on anticoagulation therapy with appropriate baseline laboratory measures (as described above).
      ~~iv.~~**v. Analyze medication errors and adverse drug events associated with the use of anticoagulation therapy**
   b. Efficacy:
      i. Frequency of goal PTT measures (~~65-100~~**73-110** seconds, encompassing both heparin nomograms) in patients receiving heparin infusions.
      ii. Frequency of goal INR measures (2 – 3.5) in patients receiving warfarin therapy.
   c. Education Compliance:
      i. Percentage of staff pharmacists and staff nurses that have completed anticoagulation competency training.

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

1. Pharmacy Procedure: Anticoagulant Dosing Protocol
~~3.~~2. PCS Policy: Medication Administration

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: NEW **SUBJECT:** Secure Environment

REVISION DATE(S): **POLICY NUMBER:** 8610-204

Administrative District Operations Content Expert Approval:	**03/19**
Administrative Policies & Procedures Committee Approval:	**~~03/19~~05/19**
Environmental Health & Safety Committee Approval:	**06/19**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**06/19**
Administration Approval:	**07/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To clearly define the procedures and process by which patients, visitors and workforce members are provided with a secure environment and how that outcome is achieved.

B. **DEFINITION(S):**

1. Workforce Member: Employees, Medical Staff and Allied Health Professionals **(AHP)**, volunteers, trainees~~,~~ and other persons whose conduct, in the performance of work for **Tri-City Healthcare District** (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.

~~1.~~2. **Contingent Worker: freelancer, independent contractor, consultant, or other outsourced and non-permanent worker hired on a per-project basis whose job or project is structured to last a limited length of time.**

C. **POLICY:**

1. ~~Tri-City Healthcare District (~~TCHD~~)~~ requires workforce members, visitors to patient areas, guests, and patients to have appropriate identification to establish a safe and secure environment~~. TCHD provides a safe and secure environment~~ for all ~~of its~~ patients and ~~staff~~ **Workforce** Members.
2. All identification badges are to be worn/adhered on the outside of their clothing, chest high and clearly visible.
3. Employees, Travelers, Physicians/AHPs~~, and~~ Volunteers**, and Contingent Workers**:
   a. Will have a TCHD issued ~~picture and~~ name **and picture** identification badge, which is to be worn so ~~that~~ the photo, name and vocational classification is clearly visible to any patient, visitor or ~~other~~ Workforce Members.
   b. Employees**, travelers, physicians/AHPs, volunteers, and contractors** without the proper ~~Tri-City Medical Center~~**TCHD** identification will be given a visitor badge and their Director~~/~~Manager will be notified.
4. Registry~~ staff~~:
   a. Will have a TCHD issued badge to be worn in addition to ~~the~~ **a** registry badge with photo and name.
5. Guests~~/~~Visitors:
   a. Will have an authorized visitor badges indicating date and area they are visiting or rendering services from.
   b. The guests~~/~~visitors are to check in with the Main Lobby,~~/~~ Security or Information Desk to receive their badges, which are ~~then~~ to be adhered on the outside of their clothing, chest high and clearly visible.
6. Patients:

6. Patients:
   a. Will have the patient identification ~~badge~~**band to be worn around the wrist and clearly visible.**
7. Students:
   a. Will a TCHD issued ~~picture and~~ name **and picture** identification badge or **a** TCHD issued student badge to be worn **in** addition to **their** school badge with photo and name.
8. Independent Contractors and Vendors:
   a. Will have a badge issued via vendor management software (~~for example~~**i.e.** Reptrax) or through Purchasing.

D. **SECURITY / TRAFFIC CONTROL, ACCESS TO FACILITY:**

1. ~~Tri-City Medical Center~~**TCHD** Security Officers will be posted at the Main Lobby Security Desk from 0530-2000 hours and will ~~i~~ensure ~~that~~ all guests, visitors or Workforce Members ha**s**ve the required identification badge(s) visible prior to entering the facility. After 2000 hours, ~~the~~ only **the** following persons will be allowed access to the facility:
   a. Badged members of the medical staff
   b. TCMC staff and affiliates (Registry, Travelers, Students)
   c. Vendors/Contractors having confirmed business
   d. Visitors for patients currently receiving care at TCHD.
2. ~~Those g~~**G**uests / visitors requiring room numbers or additional information will be directed to the Information Desk.
3. ~~There will be c~~**C**learly defined visitations procedures, expectations and hours **will be** posted at entrances to facility.
4. All perimeter entrances to the facility except for the Main Lobby and Emergency Room Lobby are to be locked at all times to prevent unauthorized access to the facility. Staff members will be permitted to utilize controlled access areas ~~that their controlled access badges~~ allow**ed** ~~them to use~~**by their TCHD issued badge**.
5. **After visiting hours,** ~~there will~~ **the** only ~~be one~~ public access ~~allowed~~ to ~~the facility~~**Tri-City Medical Center** ~~after visiting hours that will be~~ **is** through the Emergency Department Lobby controlled entrance.
6. Traffic flow ~~through~~ or access to departments / patient care areas are managed and controlled at all times.
7. ~~Tri-City Medical Center~~**TCHD** Security Staff in collaboration with all facility ~~staff~~ **Workforce** Members are responsible for safeguarding patients, employees, visitors and the property ~~of the facility~~**TCHD**. Security Staff and ~~staff~~**Workforce** Members are required to contact any guest, visitor or vendor ~~they~~ observe**d** without proper identification and redirect them to Security, / Information Desk or notify security staff.
8. Security Staff has the right to refuse admittance to the facility to any visitor or guest not complying with ~~the identification badge request~~**TCHD Policy**.
9. All persons entering the ~~Hospital~~ **TCHD** shall be subject to a reasonable search as a condition of entry to the property. Persons refusing search will be denied services until a safe environment may be established.

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

~~Security Operations Policy - Weapons Prevention / Searches~~

1. **Administrative Policy: 436 Identification of Staff**

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: NEW

SUBJECT: Weapons Scanning in the Emergency Department

REVISION DATE(S):

POLICY NUMBER:

Administrative District Operations Content Expert Approval:	**05/19**
Administrative Policies & Procedures Committee Approval:	**05/19**
Environmental Health & Safety Committee Approval:	**06/19**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**06/19**
Administration Approval:	**07/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To provide Security staff with guidelines for conducting searches of individuals when entering the Emergency Department to prevent the entry of prohibited items into the hospital and to keep Tri-City Healthcare District ("TCHD") staff, patients and visitors safe from items that may harm or have the potential to harm.

B. **DEFINITIONS:**

1. Weapon - A weapon is defined as any firearm, knives, night sticks, brass knuckles and other items defined as weapons by California and federal law or device that could cause bodily harm or injury.
2. Contraband - Any item that is banned from TCHD property and/or is of harm to the patient or others. Items include, but are not limited to weapons, illegal drugs or drug paraphernalia and other items that pose safety or risk as determined by TCHD staff.
3. Search – a systematic inspection of a person, personal effects or room.

C. **POLICY:**

1. TCHD recognizes that patients, staff, and visitors have a right to privacy, dignity and to be free from unreasonable searches. Patients, staff, and visitors also have the right to a safe and therapeutic environment which under certain circumstances necessitates taking steps to ensure persons on TCHD property are not in possession of items that may present a hazard to personal safety or the therapeutic environment.
2. For the safety and protection of both patients and staff, Security may conduct searches of persons and their belongings when entering the Emergency Department in order to prevent weapons from entering TCHD. (See Administrative Policy: Weapons on Medical Center Campus 284).
3. All searches will be carried out in a professional and courteous manner recognizing the intrusion to personal privacy that occurs. The search may not be any more intrusive than necessary to ensure the person is not in possession of weapons.

D. **PROCEDURE FOR SEARCHES AT EMERGENCY DEPARTMENT ENTRANCE:**

1. All persons, including off duty TCHD staff, entering through the Emergency Department entrance will be subject to a search of their person via a metal detector by Security. It is

designed to be a non-intrusive search to prevent weapons from entering the facility and to maintain the safety of patients, visitors and staff.

a. On duty TCHD staff and public safety personnel are not subject to a search when entering through the Emergency Department entrance.

2. Patients entering the Emergency Department entrance with obvious life threatening emergencies will be allowed to pass through the metal detector unchallenged. If the metal detector alarms, notification will be given to the Emergency Department nurse. Unconscious, critically ill, or seriously injured patients need not pass through the metal detector provided that medical staff will be removing the patient's clothing.
3. The ambulance entrance is restricted to entry by public safety personnel along with private vehicles. Non-ambulatory patients in private vehicles will be allowed access to the ambulance entrance. However, occupants other than the patient, must enter via the metal detection area.
4. Persons are allowed to approach the metal detection area and depart without passing. However, once entry and activation of the metal detector occurs, Security will complete the screening process prior to allowing the person to depart.
5. All baggage, briefcases, purses, back-packs, sacks, baby carriers, etc., will be inspected for weapons by Security at the metal detection area. Attention should be given to belt buckles, pagers, metal canes, and other questionable items that may conceal weapons.
6. Persons declining searches of items will not be allowed to bring the items into the facility and may be allowed to return to their vehicle and store their possessions in a locked vehicle.
7. TCHD prohibits all persons, except those expressly authorized in Administrative Policy: Weapons on Medical Center Campus 284, from bringing firearms onto TCHD property. Any person with a valid carry permit will be asked to return the firearm to their vehicle.
8. In the event of discovery of weapons, drugs, drug paraphernalia, or other contraband, Security shall secure the items and take the necessary steps in accordance with Administrative Policy: Disposal of Drugs and Drug Paraphernalia 217 and Administrative Policy: Weapons on Medical Center Campus 284, including contacting the Oceanside Police Department.
9. Persons refusing to comply with the search may be denied entrance. Persons seeking emergency medical services will not be refused services.
10. All persons who leave the Emergency Department will be screened upon their return.

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

1. Administrative District Operations Policy: Disposal of Drugs and Drug Paraphernalia 8610-217
2. Administrative District Operations Policy: Weapons on Medical Center Campus 8610-284
3. Patient Care Services Policy: Visiting Guidelines
4. Security Operations Policy: Property Custody 232

F. **REFERENCE(S):**

1. Code of Federal Regulations, Title 42, Section 482.13(c)(2)
2. California Code of Regulations, Title 8, Section 3342
3. Angela T. Burnette, Searches of Hospital Patients, Their Rooms and Belongings, Health Care Law Monthly, Vol. 2012, Issue 10, at 2

Tri-City Medical Center
Oceanside, California

ENGINEERING
INFECTION CONTROL

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Decontamination Of Equipment~~ ~~Policy Number: 6001 Page 1 of 1~~
~~Department: Hospital Wide~~	~~EFFECTIVE: 11/1/87~~ ~~REVISED: 11/7/94; 2/97; 5/00; 5/03, 06/06; 5/09, 6/12~~

SUBJECT: Decontamination of Equipment

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 11/94; 02/97; 05/00; 05/03; 06/06; 05/09; 06/12

Department Approval ~~Date(s)~~:	**07/18**
Environmental Health ~~and~~& Safety Committee Approval ~~Date(s)~~:	**11/18**
Infection Control Committee Approval:	**04/19**
Medical Executive Committee Approval ~~Dates(s)~~:	**n/a**
Administration Approval:	**07/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval ~~Date(s)~~:	

A. **PURPOSE:**
1. To define under what circumstances and in what manner engineering tools should be decontaminated.

B. **POLICY:**
1. ~~1.~~ Tools which do not come into contact with contaminated material normally do not require decontamination.
2. ~~2.~~ Plumbing snakes, wrenches, plungers, etc, used to open drains or plugged toilets will be considered contaminate after use.
3. ~~3.~~ All tools used in a room posted with isolation precautions should be considered contaminated.

C. **PROCEDURE:**
1. ~~1.~~ Wear protective gloves of leather or plastic when working on sewer lines.
2. ~~2.~~ Place contaminated tools in a plastic bag for transport to an outside cleaning area.
3. ~~3.~~ Hose down tools and equipment thoroughly near a sewer drain and allow them to air dry before bringing them back into the building.
4. ~~4.~~ Use a 10% bleach solution to disinfect tools and equipment after washing.
5. ~~5.~~ Disinfect or dispose of contaminated clothing or gloves promptly.

Tri-City Medical Center
Oceanside, California

ENGINEERING
INFECTION CONTROL

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: INFECTION CONTROL~~ ~~Subject: Prevention Of Exposure To Blood Borne Diseases~~ ~~Policy Number: 6002 Page 1 of 4~~
~~Department: Hospital Wide~~	~~EFFECTIVE: 4/12/91~~ ~~REVISED: 11/7/94; 2/97; 5/00; 5/03, 06/06; 5/09; 6/12~~

SUBJECT: Prevention of Exposure to Blood Borne Diseases

ISSUE DATE: 04/91
REVIEW DATE(S):
REVISION DATE(S): 11/94; 02/97; 05/00; 05/03; 06/06; 05/09; 06/12

Department Approval ~~Date(s)~~:	**07/18**
Environmental Health ~~and~~& Safety Committee Approval ~~Date(s)~~:	**11/18**
Infection Control Committee Approval:	**04/19**
Medical Executive Committee Approval ~~Dates(s)~~:	**n/a**
Administration Approval:	**07/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval ~~Date(s)~~:	

A. **DEFINITIONS:**
1. Universal Blood/Blood Precaution (Universal Precautions): The ~~concept,~~**concept** now referred to simply as "universal precautions" stresses that all patients should assumed to be infectious for HIV and other blood-borne pathogens HBV.
2. In the hospital and other health-care settings, "universal precautions" should be followed when workers are exposed to blood, certain other body fluids (amniotic fluid, pericardial fluid, peritoneal fluid, pleural fluid, synovial fluid cerebrospinal fluid, semen and vaginal secretions), or any body fluids visibly contaminated with blood. Since HIV an HBV transmission has not been documented from exposure to other body fluids (feces, nasal secretions, sputum, sea tears, urine and vomitus), "universal precautions" do not apply to saliva, except in the dental setting, where saliva is likely to be contaminated with blood.

B. **AUTHORIZED TO PERFORM PROCEDURE:**
1. Any health care worker with potential risk for exposure to blood or certain other body fluids via non-intact skin, mucous membranes or other tissues.

C. **PURPOSE:**
1. Universal precautions should be followed to reduce risk of occupation exposure to blood-borne diseases, Hepatitis Virus (HBV) and Human Immunodeficiency Virus (HIV).

D. **POLICY:**

1. Protective equipment, including personal protective equipment for eyes, face, head and extremities, protective cloth respiratory devices, and protective shields and barriers will be provided for the health care worker's use to prevent potential exposure to blood, certain other body fluids, or any fluid visibly contaminated with blood.
2. It will be mandatory for employees who participate and/or who work in defined high risk areas to use appropriate barrier precautions to prevent skin and mucous membrane contact with blood and other body fluids from all patient defined high risk areas include,
   a. ~~1.~~ Laboratory - Employees who are at risk for mucous-membrane contact with blood or body fluids.
   b. ~~2.~~ Inpatient/Outpatient Surgery - team members working in the sterile field area.
   c. ~~3.~~ Labor and Delivery Rooms - Assisting with vaginal deliveries or with surgical procedures during which bleeding may occur.
   d. ~~4.~~ Emergency Room - Where there is risk for splash of blood or body fluid.
   e. ~~5.~~ Pulmonary Lab - Assisting with bronchoscopy and ABG procedures.
   f. ~~6.~~ Cardiac Catheterization Lab - Invasive procedures with splash factors.
   g. ~~7.~~ Dialysis Unit - During any exposure to blood and body fluids.
   h. ~~8.~~ Imaging Services - Invasive procedures with splash factors.
   i. ~~9.~~ Engineering - Waste clean out.

E. GENERAL GUIDELINES:

1. ~~1.~~ Gloves:
   a. Gloves should be worn for touching blood and body fluids, mucous membranes, or non-intact skin of all patient for handling items or surfaces soiled with blood or body fluids.
   b. Gloves should always be worn when the health care worker's hands are abraded or active dermatitis is present.
   ~~b.~~c. Gloves should be removed and replaced if a glove is torn or a needle stick injury occurs.
   d. Gloves should be changed after contact with each patient and in-between procedures on the same patient.
   e. Gloves must be used when handling bagged materials and obviously contaminated linen.
   f. ~~2.~~ Hands should be washed immediately after gloves are removed.
2. ~~3.~~ MASKS AND PROTECTIVE EYE WEAR or face shields should be worn during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure of mucous membranes of the mouth, nose and eyes. Masks and protective EYE WEAR or face shields must be worn for procedures that commonly result in the generation of droplets, splashing of blood or other body fluids, or the generation of bone chips.
3. ~~4.~~ GOWN OR APRONS should be worn during procedures that are likely to generate splashes of blood or other body fluids.
4. ~~5.~~ Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood or other body fluids.
5. ~~6.~~ Resuscitative bags are to be used to provide respiratory support and to minimize the necessity of mouth-to mouth resuscitation ventilation devices should be available for use in areas in which the need for resuscitation is predictable.
6. ~~7.~~ All specimens of blood and body fluids should be put into a well constructed container with a secure lid to prevent leaking during transport. Care should be taken when collecting each specimen to avoid contaminating the outside of the container and the laboratory form accompanying the specimen. Collected specimens are to be placed into plastic bag for transport to the laboratory. Laboratory form is attached to the outside of the plastic bag.
7. ~~8.~~ "Blood and Body Fluid Precautions" will continue to be used, as well as universal precautions for patients know to be infected with blood-borne pathogens (HIV, HBV).
8. ~~9.~~ All places of employment, passageways, storerooms and service rooms will be kept clean and orderly and in a sanitary condition. The floor of every workroom will be maintained in a clean condition and be as dry as possible Blood spills will be cleaned immediately with a

chemical germicide or a solution of sodium hypochlorite (a 1: 1 dilution of household bleach).

9. ~~10.~~ All sweepings, solid or liquid wastes, refuse, and garbage will be removed in such a manner as to avoid creating a menace to health, and as often as necessary or appropriate to maintain the place of employment in a sanitary condition.

F. CORRECTIVE ACTION:

1. ~~1.~~ Failure to follow recommended practices of wearing protective EYE WEAR and dress apparel in high risk areas and/ assisting with invasive procedures may result in corrective action up to and including an intent to terminate action
2. ~~2.~~ Purpose for corrective action:
   - a. ~~a.~~ To assure protection for those employees who work in high risk areas.
   - b. ~~b.~~ To minimize workman's compensation claims that- arise from noncompliance with protective EYE WEAR and dress apparel.
3. Corrective action steps:
   - a. First occurrence - will result in verbal counseling. Counseling should be non-punitive and safety oriented in nature
   - b. Second occurrence - will result in written counseling.
   - c. Third occurrence - will result in suspension action.
   - d. Fourth occurrence - will result in an intent to terminate action.

G. REFERENCE(S):

1. ~~1.~~ CDC. Recommendations for Prevention of HIV Transmission in Health-Care Settings. MMWR, August 21, 1987.
   - a. 36:2S.
2. ~~2.~~ Department of Labor. Federal Register: Occupational Exposure to Hepatitis B Virus and Human Immunodefi ciency Virus, November 27, 1987; 58:228.
3. ~~3.~~ Hospital Infection Control. OSHA Enforcement Document E=hasizes Protection, Education, March 1988; 350-
4. ~~4.~~ CDC. Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Blood-borne Pathogens in the Health Care Settings, MMWR, June 24, 1988; 37:24.

Tri-City Medical Center
Oceanside, California

FOOD AND NUTRITION SERVICES

ISSUE DATE: 09/07	**SUBJECT:** Nutritional Care & Assessment for Infants Admitted to NICU

REVISION DATE(S): 11/07, 07/08, 11/08, 10/10, 10/11

Food and Nutrition Services Department Approval ~~Date(s)~~:	**~~02/17~~03/18**
~~Medical Staff Department/Division Approval Date(s)~~:	**~~n/a~~**
Perinatal Collaborative Practice Approval:	**03/19**
Pharmacy & Therapeutics Committee Approval ~~Date(s)~~:	**n/a**
Medical Executive Committee Approval ~~Date(s)~~:	**~~01/12~~06/19**
Administration Approval:	**07/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval ~~Date(s)~~:	**02/12**

A. **DEFINITIONS:**

1. Malnourished or Nutritionally at Risk:
   a. Acute weight loss of greater than 10% of body weight
   b. Weight below 3rd percentile on growth chart
   c. Decreased percentile scores of height and/or weight
   d. Low birth weight or prematurity
   e. Inadequate provision or tolerance of nutrients
   f. Chronic lung disease/bronchopulmonary dysplasia
   g. Congenital heart disease
   h. Necrotizinig enterocolitis (NEC)
   i. Short bowel syndrome
   j. Small for gestational age (SGA)
   k. Intrauterine growth retardation (IUGR)
   l. Rickets of prematurity
   m. Cholestasis
   n. Failure to thrive
   o. Inadequate weight gain (</= 20 gm) after day of life 14
   p. Inappropriate or inadequate weight gain x 4 days after day of life 14

B. **POLICY:**

1. Function: A systematic method for the **CCS-paneled Clinical** 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:
3. Setting: All patients admitted to or being treated at Tri City Medical Center's Neonatal Intensive Care Unit
4. Supervision: None required
5. Referrals for a nutrition assessment are generated if certain criteria are met via the neonatal admission assessment in Compass Power Chart.
6. **The CCS-paneled Clinical** Registered **D**~~d~~ietitians (RD) will **screen for nutritional risk within 48-72 hours of hospital admission, and will complete a comprehensive nutritional assessment** ~~assess nutritional status of~~ **of** triggered patients within 48-**72** hours of referral~~,~~.

~~Complettion~~**Completion and within 72 hours of admission, per CCS guidelines. This assessment to include** ~~considering~~ age of patient, disease states, nutrition history, medical history, medical therapies/treatments, ~~and~~ laboratory values~~.~~**,**

~~7. 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, and education of patients/families regarding appropriate nutrition intervention for a particular disease state

C. **PROCEDURE:**

~~1. The Registered Dietitian shall provide nutrition assessment, consultation, and/or medical nutrition therapy for patients, families, and for medical professionals providing care in the Neonatal Intensive Care Unit (NICU). Referrals for nutrition assessment are generated if certain criteria are met via the admission database, requested by physician, and/or identified during multidisciplinary rounds.~~

~~2.~~**1.** Referrals for nutrition assessment are generated if the following criteria are met upon completion of the NICU admission data base and patient history, as requested by physician, and/or as identified during multidisciplinary rounds, or at any point during the NICU stay:

a. Extremely Low Birth Weight (ELBW) less than 1000gm
b. Very Low Birth Weight (VLBW) less than 1500gm
c. Chronic lung disease/bronchopulmonary dysplasia
d. Congenital heart disease
    i. Necrotizing enterocolitis (NEC)
    ii. Short bowel syndrome
    iii. Small for gestational age
    iv. Intrauterine growth retardation
    v. Rickets of prematurity
    vi. Cholestasis
    vii. Patients on TPN for more than ~~three~~ **five** days
    viii. Intolerance to enteral feeds
    ix. Failure to thrive
    x. Inadequate weight gain (less than or equal to 20 grams) after day of life 14
    xi. Inappropriate or inadequate weight gain for 4 days after day of life 14

~~3.~~**2.** The **Clinical Registered** ~~d~~**D**ietitian will complete the assessment with consideration of:

a. Nutrition order (TPN versus gavage feedings versus nipple feedings versus breastfeeding)
b. Diagnosis
c. Chronological age and/or gestational age
d. Weight
e. Length
f. Head circumference as appropriate
g. Food allergies
h. Birth weight - if available
i. History of weight changes
j. Potential drug nutrient interactions
k. Laboratory and biochemical values
l. Psychosocial, physiological, social and or environmental issues
m. Clinical assessment changes
n. Any other general nutrition concerns

~~4.~~**3.** **The** Clinical **Registered** ~~d~~**D**ietitian will document **in the Neonatal** nutrition assessment **form** ~~in the progress notes~~ of the medical record. Assessments will be based on information provided by admission assessment, review of history and physical, physician notes, other disciplines' notes, and interview with parents, nursing, or other members of health care team:

a. Nutrition order
b. Diagnosis
c. Age (gestational age and adjusted age)
d. Weight, length, **head circumference**

e. Macronutrient and micronutrient requirements
f. Food allergies
g. Laboratory and biochemical values: pertinent to assessment
h. History of weight changes
i. Feeding problems
j. Psychosocial, physiological, social, and or environmental issues

~~5.~~4. **The** Clinical **Registered** Dietitian will further document **in the Neonatal Nutrition Assessment form** ~~assessment in the progress notes of~~ in the medical record. The Dietitian will also calculate the following:
a. Weight for height percentile or weight for age/weight for height percentile.
b. Head circumference percentile
c. Weight change percentile (postnatal growth for the premature infant should mimic in utero fetal growth rates - ~1.5% (15g/kg) increase per day.
d. Estimation of calories is based on the neonate's age, weight, disease state, and nutrition status
e. Grams of protein per day
f. Fluid requirements

~~6.~~5. A nutrition care plan will be developed and individualized based on assessment and will meet specific needs of patient. Goals will be individually determined with delineation of methods of achievement of goals and time frames. Goals will be documented in the **electronic** ~~paper~~ medical record.

Energy, Protein, Fluid Requirements of the Pre-term Infant			
	Protein g/kg/d	Kcal/Kg/d	Water ml/kg/d
Preterm fed Enterally	2.5 - 4	105-130	120-200*
Preterm fed parenterally	3-4	90-120	140-160*

*Dependent upon clinical condition (i.e. less with PDA or BPD)

~~7.~~6. **The** Clinical **Registered** Dietitian will confer with physician, RN, and/or Pharmacist regarding pertinent factors affecting nutrition status (i.e. medication, I&O, intake, etc.).

~~8.~~7. Clinical Dietitian will provide follow-up for patients assessed at risk daily and will:
a. ~~document~~**Document** at least every seven (7) days depending on medical status and nutritional status and revise therapy as indicated.
b. Follow-up assessment is documented **in the Neonatal Nutrition Assessment form** ~~on the progress notes~~ of the medical record, to include nutrient intake, tolerance to feedings, weight changes, laboratory parameters, and I&O.
c. Follow-up assessments may be triggered sooner as warranted by change in nutritional status and/or medical condition.

~~9.~~8. **The** Clinical **Registered** Dietitian will provide nutrition counseling and education explaining rationale to parent(s) as ordered by physician, as requested by nursing, or family, or as deemed appropriate by RD.
a. Documentation of education is completed in the physician progress notes.
b. Education may include, but is not limited to, formula preparation, appropriate recommendations related to infant feedings and formulas. Referrals for outpatient medical nutrition therapy will be generated as appropriate, i.e. specialty formulas, feeding issues, growth concerns.

D. **REFERENCE(S):**

~~1. "Nutritional Needs of the Preterm Infant," ed Tsang, RC, 1993. "The A.S.P.E.N. Nutrition Support Practice Manual," 2nd ed., ed. Merritt, R, 2005.~~

1. "The Science and Practice of Nutrition Support: A Case based Core Curriculum," ed. Gottschlich, MM, 2001.
2. **Tsang, RC. "Nutrition of the Preterm Infant: Scientific Basis and Practical Guidelines" Cinicinnati, OH: 2005.**
~~2.~~3. **Koletzko, B., R. Vavay. "Nutritional Care of Preterm Infant". Frieburg Im Breisagua: Kerger. S, 2014.**

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES - NICU

SUBJECT: NUTRITIONAL CARE AND ASSESSMENT FOR INFANTS ADMITTED TO NICU

ISSUE DATE: 09/07
REVISION DATE: 11/07; 7/08; 11/08, 4/09, 06/11, 8/12, 05/15

DELETE: Policy incorporated into Food and Nutrition Services Policy: Nutritional Care and Assessment for Infants Admitted to NICU

Women and Newborn Services Department Approval:	**12/18**
Perinatal Collaborative Practice Approval:	**~~03/15~~01/19**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**~~04/15~~06/19**
Administration Approval:	**07/19**
Professional Affairs Committee Approval Date(s):	**~~05/15~~ n/a**
Board of Directors Approval Date(s):	**05/15**

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

~~1. Function~~

~~a. A systematic method for the registered dietician 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 patients admitted to or being treated at Tri-City Medical Center's neonatal intensive care unit.~~

~~b. Supervision – none required.~~

~~3. Referrals for a nutrition assessment are generated if certain criteria are met via the neonatal admission assessment in Compass Power Chart.~~

~~4. Registered dieticians (RD) will assess nutritional status of triggered patients within 48 hours of referral, considering age of patient, disease status, nutrition history, medical history, medical therapies/treatments and laboratory values.~~

~~5. Registered dieticians (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, and education of patients/families regarding appropriate nutrition intervention for a particular disease state.~~

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

~~1. Malnourished or nutritionally at risk:~~

~~a. Acute weight loss of greater than 10% of body weight~~
~~b. Weight below 3rd percentile on the growth chart~~
~~c. Decreased percentile scores of height and/or weight~~
~~d. Low birth weight (less than 2500 grams) or prematurity (less than 37 weeks)~~
~~e. Inadequate provision or tolerance of nutrients~~
~~f. Chronic lung disease/bronchopulmonary dysplasia~~
~~g. Congenital heart disease~~
~~h. Necrotizing enterocolitis (NEC)~~
~~i. Short bowel syndrome~~
~~j. Small for gestational age (SGA)~~
~~k. Intrauterine growth restriction (IUGR)~~
~~l. Rickets of prematurity~~
~~m. Cholestasis~~
~~n. Failure to thrive~~
~~o. Inadequate weight gain (< 20 gm) after day of life 14~~

p. Inappropriate or inadequate weight gain x 4 days after day of life 14

C. **PROCEDURE:**

1. The registered dietician shall provide nutrition assessment, consultation, and/or medical nutrition therapy for patients, families, and for medical professionals providing care in the Neonatal Intensive Care Unit (NICU). Referrals for nutrition assessment are generated if certain criteria are met via the admission database, requested by physician and/or identified during multidisciplinary rounds.
2. Referrals for nutrition assessment are generated if the following criteria are met upon completion of the NICU admission database and patient history, as requested by physician and/or as identified during multidisciplinary rounds, or at any point during the NICU stay.
   a. Extremely Low Birth Weight (ELBW) less than 1000gm
   b. Very Low birth Weight (VLBW) less than 1500gm
   c. Chronic lung disease/bronchopulmonary dysplasia
   d. Congenital heart disease
   e. Necrotizing enterocolitis (NEC)
   f. Short bowel syndrome
   g. Small for gestational age
   h. Intrauterine growth retardation
   i. Rickets of prematurity
   j. Cholestasis
   k. Patients on TPN for more than five days
   l. Intolerance to enteral feeds
   m. Failure to thrive
   n. Inadequate weight gain (less than or equal to 20 grams) after day of life 14
   o. Inappropriate or inadequate weight gain for 4 days after day of life 14
3. The dietician will complete the assessment with consideration of:
   a. Nutrition order (TPN versus gavage feedings versus nipple feedings versus breastfeeding)
   b. Diagnosis
   c. Chronological age and/or gestational age
   d. Weight
   e. Length
   f. Head circumference as appropriate
   g. Food allergies
   h. Birth weight, if available
   i. History of weight changes
   j. Potential drug nutrient interactions
   k. Laboratory and biochemical values
   l. Psychosocial, physiological, social and/or environmental issues
   m. Clinical assessment changes
   n. Any other general nutrition concerns
4. Clinical dietician will document nutrition assessment in the progress notes of the medical record. Assessments will be based on information provided by admission assessment, review of history and physical, physician notes, other disciplines' notes, and interview with parents, nursing, or other members of health care team.
   a. Nutrition order
   b. Diagnosis
   c. Age (gestational age and adjusted age)
   d. Weight, length
   e. Macronutrient and micronutrient requirements
   f. Food allergies
   g. Laboratory and biochemical values: pertinent to assessment
   h. History of weight changes
   i. Feeding problems
   j. Psychosocial, physiological, social and/or environmental issues
5. Clinical dietician will also calculate the following:
   a. Weight for height percentile or weight for age/weight for height percentile

b. Head circumference percentile
c. Weight change percentile (postnatal growth for the premature infant should mimic inutero fetal growth rates ~1.5% (18g/kg) increase per day
d. Estimation of calories is based upon the neonate's age, weight, disease state, and nutrition status
e. Grams of protein per day
f. Fluid requirements

6. A nutrition care plan will be developed and individualized based on assessment and will meet the specific needs of the patient. Goals will be individually determined with delineation of methods of achievement of goals and time frames. Goals will be documented in the infant's medical record.

Energy, Protein, Fluid Requirements of the Preterm Infant			
	Protein g/kg/d	Kcal/Kg/d	Water ml/kg/d
Preterm fed enterally	2.5 – 4	105 – 130	120 – 200*
Preterm fed parentally	3 – 4	90 – 120	140 – 160*

*Dependent upon clinical condition (i.e. less with PDA or BPD)

7. Clinical dietician will confer with physician, RN, and/or pharmacist regarding pertinent factors affecting nutrition status (i.e. medication, I&O, intake, etc.).
8. Clinical dietician will provide follow up for patients assessed at risk daily and will:
   a. Document at least every seven (7) days depending on medical status and nutritional status and revise therapy as indicated.
   b. Follow up assessment is documented on the progress notes of the medical record, to include nutrient intake, tolerance to feedings, weight changes, laboratory parameters, and I&O.
   c. Follow up assessments may be triggered sooner as warranted by change in nutritional status and/or medical condition.
9. Clinical dietician will provide nutrition counseling and education, explaining rationale to parent(s) as ordered by physician, as requested by nursing, family, or as deemed appropriate by RD.
   a. Documentation of education is completed in the physician progress notes.
   b. Education may include, but is not limited to, formula preparation, appropriate recommendations related to infant feedings and formulas. Referrals for outpatient medical nutrition therapy will be generated as appropriate, i.e. specialty formulas, feeding issues, and growth concerns.

D. **REFERENCES:**

1. Nutritional Needs of the Preterm Infant: 2nd Ed. Tsang, RC, 2005.
2. The A.S.P.E.N. Nutrition Support Practice Manual, 2nd ed., ed. Merritt, R. 2005.
3. The Science and Practice of Nutrition Support: A Case Based Core Curriculum, " ed. Gottschlich, MM, 2001.

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL ~~MANUAL~~

ISSUE DATE:	**SUBJECT: Influx of Infectious Patients: Epidemic Influenza or Other Respiratory Transmitted Disease**
REVIEW DATE(S): 11/12	**POLICY NUMBER: IC15.0**
REVISION DATE(S): 10/09	

Department Approval ~~Date(s)~~:	**~~04/16~~04/18**	
Infection Control Committee Approval ~~Date(s)~~:	**~~04/16~~04/19**	
Pharmacy ~~and~~ & Therapeutics Committee Approval ~~Date(s)~~:		**~~n/a~~05/19**
Medical Executive Committee Approval ~~Date(s)~~:	**~~09/16~~06/19**	
Administration Approval:		**07/19**
Professional Affairs Committee Approval:	**n/a**	
Board of Directors Approval ~~Date(s)~~:	**11/16**	

A. **PURPOSE:**

1. Provide a plan to manage patients requiring Droplet or Airborne Precautions when the availability of rooms, staff, supplies or other recourses are limited. This plan is intended to provide a decision pathway for initiating Code Triage and Code Orange status.

B. **SUPPORTIVE DATA:**

1. Influenza epidemic or pandemic are different from many threats for which public health and the health-care system are currently planning[1,2,3]:
   a. A pandemic will last much longer than most other emergency events and may include "waves" of influenza activity separated by months (in 20th century pandemics, a second wave of influenza activity occurred 3 to 12 months after the first wave).
   b. The numbers of health-care workers and first responders available to work can be expected to be reduced; they will be at high risk of illness through exposure in the community and in health-care settings, and some may have to miss work to care for ill family members.
   c. Because of how widespread an influenza pandemic may turn out, resources in many locations could be limited.

C. **POLICY:**

1. Most likely scenarios that would result in an influx of infectious patients include, but are not limited to:
   a. Epidemic influenza
   b. Epidemic gastroenteritis
   c. Epidemic exposure to suspected biological agent
   d. Epidemic biological agent (such as smallpox)

D. **PROCEDURE**:

1. Influx is localized to the Emergency Department (ED) due to:

[1] ~~Preparing for an Influx of Infectious Patients, Joint Commission: The Source, June 2009, Volume 7, Issue 6~~
[2] ~~Influenza Pandemic Response Plan. California Department of Health Services, September 2001~~
[3] ~~California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies, 2008~~

a. Worried well seeking information or prophylaxis.
b. Necessity for treatment of influenza symptoms which will result in discharge from ED:
   i. Initiate Code Triage - during code triage implement limited command center during business hours.
   ii. Notify Shift Supervisor, Administrator On Call, ED Clinical Manager, Safety Officer, Director of Engineering, and Infection Preventionist as directed - Administrative Supervisor
   iii. Refer to Disaster Lockdown policy in the event of uncontrolled access.
c. The Emergency Operations Plan will be initiated as needed.

2. **Level 1: 1-5** patients waiting for bed placement requiring isolation precautions
   a. Notify Administrative Supervisor - ED Charge Nurse.
   b. Notify Shift Supervisor, Administrator On Call, ED Clinical Manager, Safety Officer, Director of Engineering, and Infection Preventionist as directed - Administrative Supervisor.
   c. Notify Pulmonary lead (760) 802-1974 perform ventilator inventory.
   d. Assess all current inpatients for discharge or transfer potential - Bed Supervisor.
   e. Contact local skilled nursing facilities for bed availability - Case manager.
   f. Contact Public Health Department for coordination of patient placement - Infection Control.
   g. Exceed the state mandated nurse-patient ratio, if needed - Chief Nurse Executive.
   h. Post security at ED entrances.
   i. Refer to Disaster Lockdown policy in the event of uncontrolled access.
3. **Level 2: 6-10** patients waiting for bed placement requiring isolation precautions
   a. Implement Patient Care Procedure, Code Triage Alert - Emergency Department.
   b. Assess all current inpatients for discharge or transfer potential - Bed Coordinator.
   c. Consider contacting local skilled nursing facilities for bed availability - Case manager.
   d. Consider contacting the Public Health Department for coordination of patient placement - Infection Preventionist/Safety Officer.
   e. Refer to Disaster Lockdown policy in the event of uncontrolled access.
4. **Level 3: More than 11 patients** waiting for bed placement requiring isolation precautions
   a. Activate Code Orange - Chief Executive Officer (See Emergency Operations Plan).
      i. An internal disaster is declared when surge progresses beyond the ability of an initial localized response to contain or suppress the event.
      ii. In the event of an incident occurring outside of the Hospital, the need for mass casualty support will be identified by the County Office of Emergency Services and an **"Annex D"** notification will be transmitted by County Communications System to the Emergency Department (ED). An "Annex D" indicates an event has occurred somewhere and that patients with epidemic influenza or respiratory transmissible disease may be sent to the hospital. The ED will notify the Administrator-on-Call or Operations Supervisor of the Annex D notification, who will in turn advise the other members of the Emergency Command Staff. See Appendix A for Pandemic Alert Phases.
         1) Contact the County of San Diego Public Health: at 858-565-5255. ~~Ask for Station M~~. This is available 24/7 and to be utilized for emergencies only.
         2) Activate Code Orange (if not already activated).
      iii. Consider isolating a section of ED (Contact Engineering to facilitate).
   b. For Novel viruses - Patients with oral temperatures >101°F on two successive readings will require Standard and Droplet Precautions. If the suspect pathogen is found to be transmitted via airborne route, then Standard and Airborne Precautions will be initiated, if available. If the suspect pathogen is found to be transmitted via direct/indirect (fomite) routes, then Contact Precautions will be added.

c. Use Airborne Illness Isolation Rooms for admissions: 143, 243, 443, 287, 387, 487 and MCH rooms 200, 201
d. When AIIR's are fully utilized, use a private room with portable HEPA filter (call Engineering).
e. Expedite discharge of inpatients who are able – Case Management.
f. Consider available options for designating an inpatient isolation precautions unit or clinical area.
g. Consult with Staffing Department for staff resource management.
h. In the event of Epidemic gastroenteritis
    i. Assess need for:
        1) Contact Precautions
        2) Inventory private rooms available.
        3) When necessary cohort with like condition.
        4) Create a cohort patient care area using available facilities and considering all options (e.g., in the Assembly Rooms 1-3 move Child Care off site).
        5) Create patient care areas in the parking lot.
i. Supplies
    i. MDC to perform daily inventory of medical supplies and isolation supplies and report.
    ii. Supplies maintained on a three tier level.
    iii. Local inventor of stock (floor stock) will be maintained at higher levels.
    iv. When depleted, utilize central storage (in-house) of critical supplies including PPE, and strategic medical supplies will be maintained.
    v. When central storage is depleted, distributer will maintain supply of inventory readily available for distribution when needed.
j. Quarantine - Tri City Medical Center would most likely be a Type C Quarantine facility. Type C facilities care for actual and suspect cases. This would include individuals with:
    i. Compatible symptoms and laboratory confirmation of the specific pandemic strain of influenza (**confirmed case**).
    ii. Compatible symptoms following suspected/known exposure with pending laboratory confirmation (**probable case**).
    iii. Atypical clinical symptoms following suspected or known exposure (**suspect case**).
    iv. Contacts under surveillance that become febrile with oral temperatures > 101° F (38°C) on two successive readings.
    v. Individuals with other associated symptoms such as coughing and fever.
    vi. Ill persons requiring specialized health care may be isolated in a hospital; but, depending on their medical needs, persons may also be isolated at home or in a designated health care facility or community-based facility.
    vii. For non-hospital isolation, home/personal residence isolation is preferred and will be utilized first unless a contraindication exists such as homelessness, non-compliance with isolation, or at-risk persons in the home with inability to maintain separation.
    viii. Transportation to an isolation facility will be coordinated with the EMS DOC.
k. Bed availability
    i. If there are no hospital beds available, contact the County of San Diego Public Health ~~Station M~~ for guidance 858-565-5255.
l. Prophylaxis Immunization requirements:
    i. Implement mass prophylaxis protocols.

ii. Required for entry to facility if vaccine is available. NOTE: Prophylaxis may not be available.
iii. If no prophylaxis is available, individuals working with confirmed and suspect cases must use Standard, and Airborne Precautions.
iv. Strict respiratory hygiene to include frequent hand hygiene and masks must also be enforced.
v. The **Safety and Security Officer** or designee will ensure that all personnel who enter the facility have been recently prophylaxed with vaccine or antivirals if available and are on the list of individuals who may enter the facility

m. Staffing:
i. Maintain pre-epidemic staffing levels, if possible.
ii. If the number and types of staff are insufficient to meet the needs of the number of people being contained, additional staff may be requested through the County Emergency Operations Center (EOC).
iii. **Planning Chief** will compile a list of individuals who can enter the facility. This should be established in collaboration with the Public Health Officer and/or the authorized designee.
iv. The list will include the smallest possible number of people required for patient care, disease investigation, and facility maintenance (physicians, nurses or aides, laboratory personnel, housekeeping, dietary, and maintenance personnel, etc.).
v. This list will be kept by the **Personnel Pool Unit Leader** or designee.
vi. Consider cross training of staff to facilitate work flow.
vii. If isolation unit is established, consider ancillary staffing including on-unit Radiology, Lab and Respiratory Care staffing.
viii. If child care is provided, screening for signs of illness including temperature reading and recording may be indicated.

n. The **Employee Health Director** or designee will:
i. Ensure that employees monitor and report their temperature and any symptoms every 12 hours until -
1) 14 days after they are vaccinated or
2) 14 days after they completed their antiviral prophylaxis or
3) 5 days after the date of last patient contact.
ii. Those personnel on the list to enter the facility that are not vaccinated or on prophylaxis drugs will also monitor and report their temperature and any symptoms every 12 hours and use personal protective equipment (PPE) while in the facility until 14 days after they have been vaccinated, placed on antiviral therapy when it becomes available, or 5 days from date of last contact.
iii. This access monitoring system will include a confidential log of all persons who enter and leave, including staff, and will include each person's vaccination, antiviral treatment status, temperature, and any symptoms reported.
iv. Until 14 days after immunization, once vaccine is available, or completion of antiviral therapy, all personnel will check their temperature every 12 hours. At the beginning of each shift, they are to report their temperatures or any illness to the person assigned to monitor employees' health. On off days, they are required to be in telephone contact each morning to report their temperatures. Once the waiting period is over, personnel are not required to routinely check their temperatures. They are still required to report any illness.
v. Staff with febrile oral temperatures >101°F on two successive readings will not be able to work.

o. **Medical Staff Office**

i. Refer to Medical Staff Disaster Plan (See Medical Staff -Policy #8710-553).

p. Extended Epidemic- PRIORITIES
   i. Sustained staffing
   ii. Vaccine acquisition and distribution
   iii. Antiviral medication acquisition and distribution
   iv. Mask supply and reuse
   v. Bed availability
   vi. Security

	2 weeks	4 weeks	2 months	6 months
Staffing and possible quarantine	Consider housing staff at hospital	Request staff from outside effected areas	Train additional staff to perform non-critical functions	
Medication supply	Request additional vaccine and antiviral medications	Reprioritize vaccination and antiviral distribution strategies		
Supplies	Request additional masks tissues, disposal bags and hand sanitizer	Consider changes to infection control practice related to reuse of supplies	Consider making gauze masks, if supply of disposables is nearly exhausted	
Bed availability	Use available private rooms; cohort with like illness	Consider transfer to another facility		
Security	24 hour restricted access to essential staff only			

E. ATTACHMENT(S):

1. World Health Organization (WHO) Stages of Alert Phases of a Pandemic

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

1. Emergency Operations **Procedure Manual General Information Policy: Emergency Operations** Plan

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

1. **Healthcare Surge-Emergency Preparedness https://www.calhospitalprepare.org/healthcare-surge**
2. **California Department of Public Health: Infectious Disease & Pandemic Influenzahttp://cdphready.org/category/infectious-diseases-pandemic-influenza/**
3. **CDPH: AFL 18-09 Requesting Increased Patient Accommodations including Medical Surge Tent Use January 12, 2018 https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-18-09.aspx**

Appendix A -

World Health Organization (WHO) Stages of Alert Phases of a Pandemic
Pandemic Stage Definition

Novel (new) Virus Alert
- Novel virus detected in one or more humans
- Little or no immunity in the general population
- Potential, but not inevitable precursor to a pandemic

Pandemic Alert
- Novel virus demonstrates sustained person-to-person transmission and causes multiple cases in the same geographic area

Pandemic Imminent
- Novel virus causing unusually high rates of morbidity and mortality in widespread geographic areas

Pandemic
- Further spread with involvement of multiple continents

Second Wave
- After the number of cases falls and the pandemic appears to be ending, typically a second wave of cases occurs within several months

Pandemic Over
- Cessation of successive pandemic "waves", accompanied by the return (in the U.S.) of the more typical wintertime "epidemic" cycle

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE:	**02/01**	**SUBJECT:**	**Credentialing Standards for Catheter-Based Peripheral Vascular* Interventional Procedures**
REVISION DATE(S):	**09/07, 10/09**	**POLICY NUMBER:**	**8710-504**

Medical Staff Department Approval ~~Dates(s)~~:	**03/17**
~~Medical Staff~~ Division of Radiology Approval ~~Date(s)~~:	**~~03/17~~05/19**
Pharmacy ~~and~~ & Therapeutics Committee Approval ~~Date(s)~~:	**n/a**
Medical Executive Committee Approval ~~Date(s)~~:	**~~03/17~~06/19**
Administration Approval:	**07/19**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~04/17~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**04/17**

A. **PURPOSE:**

1. The following criteria shall be used in credentialing physicians who request privileges in catheter-based peripheral vascular interventional procedures.
   a. Catheter-based peripheral vascular interventional procedures include diagnostic angiography, balloon angioplasty, atherectomy, stent placement, and/or thrombolysis of the non-coronary native vasculature or grafts, either arterial or venous. (Refer to Appendix 1)
   b. Criteria for privileging and maintenance of privileges encompass four general areas:
      i. Didactic education in the diagnosis and treatment of patients with peripheral vascular disease;
      ii. Training in the technical aspects of the performance of peripheral vascular interventional procedures;
      iii. Proctoring;
      iv. Compliance with reappointment criteria.

B. **CREDENTIALING CRITERIA:**

1. Body of Knowledge:
   a. The applicant must have completed an accredited residency program and possess board certification or board eligibility in general internal medicine, diagnostic radiology or general surgery.

   *Non-Cardiac

   b. The applicant must have additional fellowship training, board/CAQ eligibility or certification in interventional radiology, neuroradiology, peripheral vascular surgery or interventional cardiology. Individuals who completed their training prior to the establishment of fellowship programs in the above mentioned disciplines but who are engaged in the active practice of peripheral vascular interventions may be granted privileges established on the basis of guidelines described below with acceptable documentation of success and complication rates ~~as defined in Appendix II and Appendix III~~.
   c. The applicant must be trained and licensed in fluoroscopy.
2. Basic Training
   a. Applicants for this privilege should have extensive training in the diagnosis and treatment of patients with peripheral vascular diseases to include anatomy, natural history, clinical manifestations, non-invasive assessment, indications and contraindications to catheter-based intervention, risks and benefits of catheter-based

intervention, alternative therapies and recognition and management of complications including catheter directed thrombolysis.

i. For individuals who have completed fellowship training in interventional radiology neuroradiology, or peripheral vascular surgery, ACGME accreditation of their fellowship and documentation of satisfactory completion of the fellowship will provide adequate documentation of this training.

ii. For individuals completing fellowship training in interventional cardiology, there must be both ACGME accreditation of the fellowship training, documentation of satisfactory completion of the fellowship and evidence that the fellowship includes formal didactic education in all aspects of peripheral vascular disease.

iii. For individuals who are practicing peripheral vascular surgery, interventional radiology or interventional cardiology but completed their training prior to the establishment of fellowship training program or inclusion of material on peripheral vascular in those fellowship training programs, documentation of 100 hours of CME approved credit directly pertaining to peripheral vascular disease or the equivalent of 20 days of such course instruction must be provided.

3. Specific Procedural Training and Experience:
   a. Applicants must be knowledgeable regarding appropriate use and options of x-ray imaging techniques for peripheral vascular applications.
   b. Individuals applying for this privilege must be able to document the performance and interpretation of the following:
      i. 100 Diagnostic peripheral arteriograms
      ii. 50 Peripheral arterial angioplasties
      iii. 10 Cases of peripheral stent placement
      iv. 10 Cases of catheter-directed peripheral thrombolysis
   c. The individual must be able to document that he/she was the primary operator (defined as the physician who physically performed the procedure and dictated the operative report) in the above listed procedures. For an individual trained in an approved fellowship, a standard procedural log indicating procedure, the individual's role in the procedure, outcome and complications, will be adequate documentation. For individuals whose training occurred outside of a fellowship setting, the above procedural log must be provided as well as copies of the dictated procedural reports.
4. Proctoring Criteria:
   a. Ten cases performed during the first six months after granting of the privilege(s) will be proctored. These cases should include two cases of peripheral arterial stent placement and two cases of catheter-directed peripheral thrombolysis. The proctor must be privileged for the specific procedure that he/she is proctoring.
5. Reappointment Criteria:
   a. Maintenance of peripheral vascular credentialing requires ongoing experience in performing these procedures with acceptable success and complication rates. In order to qualify for reappointment, the minimum number of cases to be performed in a two-year period for each procedure is:
      1) Peripheral transluminal angioplasty 25 cases
      2) Intravascular stent placement 10 cases
      3) Catheter-Directed Peripheral thrombolysis 10 cases
   b. Reappointment of privileges is also dependent on the active participation in the hospital's Quality Improvement program. The QI program will monitor indications, success rates and complications. ~~The acceptable complication rates are outlined in Appendix II and Appendix III.~~ Each physician QI data will be reviewed using the same criteria. ~~If a physician's indications, success, and complication rates deviate from Appendix II or Appendix III, then these privileges may be revoked or not reappointed.~~ It is recommended that any practitioner with this privilege maintain a database to record accurate information regarding numbers of procedures, indications and outcomes for quality assessment purposes.

[1]

C. **REFERENCE(S):**

1. White R.A. Training and Credentialing Requirements for Endovascular Procedures. Stanford Vascular Symposium: Frontiers in Vascular Disease 1999. (Abstract)
2. Levin DC, Becker GJ, Dorros G, et al. Training Standards for Physicians Performing Peripheral Angioplasty and other Percutaneous Peripheral Vascular Interventions – American Heart Association Medical/Scientific Statement Position Statement. Circulation. 1992;86(4):1348-1350.

[1] The criteria above are minimum criteria. Departments or Divisions performing these procedures may elect to require more stringent criteria.

APPENDIX I

For the purposes of these standards, a diagnostic angiogram is defined as the percutaneous passage of a catheter into an artery under fluoroscopic guidance with subsequent injection of contrast material and imaging of the entire vascular distribution in question using conventional serial film changers or large field digital imaging systems. For example, peripheral angiography of lower-extremity vessels must image the vessels of both lower extremities from the distal aorta to at least the ankles. Conventional cineradiography or video fluoroscopy alone is not sufficient for the routine recording of peripheral angiographic studies. Measurements of intra-arterial pressure gradients are a useful adjunct and may be necessary to fully assess the significance of vascular occlusive disease as well as the outcome of an interventional procedure.

Angioplasty is defined here as a percutaneous transluminal balloon dilation procedure or similar procedure using an atherectomy, stent or other interventional device. Such a procedure would generally involve percutaneous vascular access, transluminal passage of a balloon catheter or other interventional device and treatment at the appropriate sites. The angioplasty process includes angiographic and hemodynamic documentation of the result and appropriate clinical follow-up during the patient's hospitalization.

APPENDIX II

The following complications are the indicators of the safety of catheter-based diagnostic peripheral vascular procedures. If these threshold levels are exceeded, a QI review may be possible.

Puncture site complications:

Hematoma (requiring transfusion, surgery or delayed discharge)	<3.0%
Occlusions	<0.5%
Psuedoaneurysm	<0.5%
Asteriovenous fistula	<0.1%
Contrast extravasation	<1.0%

Non-puncture site complications

Distal emboli	<0.5%
Unintended dissection/occlusion of selected vessels	<2.0%

Neurologic complications (during carotid or cerebral angiography)

All neurologic deficits	<4.0%
Permanent neurologic deficits	<1.0%

Contrast Reactions

All idiosyncratic reactions	<3.0%
Major reactions (respiratory symptoms)	<0.5%
Contrast-related death	<0.01%

Non-idiosyncratic reactions

(hypertension, nausea, vomiting, bradycardia)	<10.0%

Contrast-induced renal failure (increase in serum creatmine by 50% or by 1 mg/dl within 48 hours of the procedure resulting in an abnormal serum creatimine level)

Transient	<10.0%
Permanent	<2.0%

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1. Hessel SH, Adams DF, Abrams HL. Complications of angiography, Radiology 1981;138:273-281.
2. Abrams HL. The opague media: Psychologic effects and systematic reactions. In Abrams's Angiography: Vascular and interventional Radiology 3rd ed, Boston, Little & Brown 1983,15-39.
3. Sigstedt B, Lunderquist A. Complications of angiographic examinations. AJR 1978;130;455-460.
4. Shehadi WH, Tamolo G. Adverse reactions to contrast media. Radiology 1980;137:299-302.
5. Shehadi WH. Contrast media adverse reactions: occurrence, recurrence and distribution patterns. Radiology 1982;143:11-17.
6. Byrd L, Sherman RL. Radiocontrast-induced acute renal failure: a clinical and pathophysiologic review. Medicine 1979;58:270-279.
7. Earnest F, Forges G, Sandek BA, et al. Complications of cerebral angiography: Prospective assessment of risk. AJNR 1983;4:247-253.
8. Gomes AS, Baker JD, Martin-Paredero VWM, et al. Acute renal dysfunction after major anteriography AJR 1985;45:1249-1256.

APPENDIX III

The following complications are the indicators of the safety of percutaneous transluminal angioplasty procedures. If these threshold levels are exceeded, a QI review may be possible.

Threshold

Emergency surgery	<3.0%
Severe bleeding or hematoma (requiring transfusion, surgery, or delayed discharge)	<4.0%
Puncture site occlusion	<0.5%
Angioplasty site occlusion	<3.0%
Distal Embolization causing tissue damage	<0.5%
Vessel perforation requiring surgery	<0.5%
Vessels perforation, no surgery required (Laser angioplasty)	<15.0%

For contrast reactions and contrast-induced nephropathy, refer to Appendix II

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1. Johnson KW, Rao M, Hogg-Johnston S.A, et al. 5 year result of a prospective study of percutaneous study of percutaneous transluminal angioplasty. *Ann Surg* 1987; 206:403-413.
2. Spence RR< Freiman DB, Gatenby R. Long-term results of transluminal angioplasty of the iliac and femoral arteries. *Arch of Surg* 1980; 116:1377-1386.
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Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 04/94 **SUBJECT:** Scheduling Surgical Procedures

REVISION DATE(S): 09/99, 04/01, 01/02, 06/03, 02/05, 02/08, 06/09, 11/10, 10/12, 12/12, 01/13, 03/14, 02/17

Surgical Services Department Approval:	02/19
Department of Anesthesiology Approval:	n/a
Operating Room Committee Approval:	~~08/16~~04/19
Pharmacy &Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~01/17~~05/19~~06~~/19
Administration Approval:	07/19
Professional Affairs Committee Approval:	~~02/17~~ n/a
Board of Directors Approval:	02/17

A. **PURPOSE:**
1. To provide scheduling guidelines for surgery, endoscopy, ~~and~~ elective cesarean sections (in OB-OR) **and procedures requiring an anesthesia provider**.

B. **DEFINITIONS:**
1. Add-On Cases: Additions to the surgery schedule after the "final schedule" has been published. The "final schedule" is published by 4 PM for the next day.
2. Elective Case: Surgery can be scheduled at the time best suited for the surgeon and the patient.
3. Urgent Case: Surgical intervention is needed within 4-6 hours of presentation. Urgent procedures are placed in an available time on the OR schedule.
4. Emergent Case: Surgical intervention is needed within one hour of presentation and may require that another scheduled or add-on case is bumped.
5. Emergency: Surgical intervention is needed immediately upon presentation to preserve life or limb. Emergency procedures are performed in the first available operating room and may require that another scheduled or add-on case is bumped.

C. **SCHEDULING ELECTIVE CASES:**
1. All elective surgical and endoscopic procedures and elective cesarean sections in OB-OR will be scheduled through the Surgery scheduling office.
2. There are 12 rooms in the Tri-City Medical Center (TCMC) OR suite which are utilized as follows:
   a. Ten (10) operating rooms (OR 1-10) can accommodate any type of case.
   b. OR ~~5 and 6 are set up and primarily are used~~**is reserved** for cardiac cases.
      i. ~~OR 5 is released for non-cardiac cases at 24 hours~~
      ii. ~~OR 6 is held for cardiac cases~~
   c. OR 11 is the Cystoscopy Room and is considered a wound class II room. Only certain procedures may be performed in this room due to the open drain:
      i. Circumcision
      ii. Endourology procedures
      iii. Percutaneous Suprapubic Cystotomy
      iv. Vasectomy

v. Orchiectomy

d. OR 12 is the GI Endoscopy Room

3. Expected available surgery rooms Monday-Thursday (may fluctuate based on staffing, surgical volume and surgical acuity):
   a. 0730-1500 hours: 8 rooms
   b. 1500-1900 hours: 5 rooms
   c. 1900-2100 hours: 3 rooms
   d. 2100-2300 hours: 2 rooms
4. Expected available surgery rooms on Friday (may fluctuate based on staffing, surgical volume and surgical acuity):
   a. 0730-1500 hours: 7 rooms
   b. 1500-1900 hours: 4 rooms
   c. 1900-2100 hours: 3 rooms
   d. 2100-2300 hours: 2 rooms
5. Elective cases shall be scheduled by the surgery scheduling office between the hours of ~~0835~~ **0800** and 1630, Monday through Friday, at 760-940-7382. **After 1400, cases scheduled for the following day are scheduled by staff at the Surgery desk (760-940-5400).**
   a. Elective cases are performed Monday through Friday from 0715 (0815 on Thursday) to 2300 hours. Elective cases should not extend beyond 2300.
6. Start Times:
   a. The Start time of a procedure (time on the OR schedule) is the time the patient is expected to be in the OR. Start time of first cases are tracked and report to the OR committee monthly.
   b. The start time of elective or add-on case requested for 1600 or later cannot be guaranteed. In those instances, the surgeon's preferred start time will be noted, and the surgeon will be given one hour's notice of expected start time. If the surgeon cannot start at the expected time, the next surgeon to start will be offered the time.
7. Delays:
   a. Surgeons who notify the OR they will be late for their scheduled start time must provide an expected time of arrival. Delays of more than 30 minutes, or delays that will impact another surgeon's schedule will cause the first surgeon to be bumped back to the next available start time.
   b. Surgeons who are not in house 30 minutes past the scheduled time of surgery and are unable to be contacted will be bumped back to the next available start time once they either arrive at the hospital or contact the OR.
8. Cases are scheduled on a consecutive, first-come first-served basis, or in a surgeon's block time.
9. Procedures may be scheduled by the surgeon or the surgeon's office staff only.
10. The process for scheduling an elective case is as follows:
    a. The surgeon's office calls the TCMC Surgery Scheduling department to reserve a case time.
    b. The surgeon's office completes a written "TCMC Surgery Scheduling Patient Information" booking form and faxes to the TCMC Surgery department fax server (Fax # 760-940-7138) within 48 hours of the telephone reservation.
       i. Upon receiving the written booking form, the TCMC Surgery Scheduler will schedule the case, obtain a financial account number (FIN#) and book a Pre-Operative Education appointment.
       ii. The TCMC Surgery Scheduler will write the FIN# and the date and time of the Pre-Operative Education appointment on the "TCMC Surgery Scheduling Patient Information" booking form, and will fax the form back to the surgeon's office as confirmation.
    c. The surgeon's office enters electronic orders or faxes written orders to the TCMC Surgery Scheduling department fax server at least one week prior to surgery date. Electronic orders will also be accepted.

i. If the case is scheduled less than one week prior to the date of surgery, written or electronic orders are required by the next business day.

11. Age/Weight/ASA Requirements:
    a. Surgery patients must be at least 14 years of age at the time of surgery
    b. Adolescent patients (ages 14-18) must be:
        i. At least 80 pounds
        ii. ASA class I or II
    ~~c. Adult Patients (over age 18) must be at least 80 lbs.~~
    ~~d.~~**c.** Any requested Adolescent or Adult patient who does not meet criteria must be reviewed/approved prior to scheduling by the Chief of Anesthesia or designee.
12. The surgeon must have the appropriate privileges granted to be allowed to schedule a procedure.
    a. Current privilege lists are maintained through the E-PRIV system, accessible through TCMC Intranet.
    b. If the physician's privilege status is still not clear, the Medical Staff Office is contacted for clarification. **The Administrative Supervisor may be contacted for assistance outside of Medical Staff Office hours.**
    ~~b.~~**c.** **It is the responsibility of the surgeon to acquire an assistant or proctor as necessary for designated procedures.**

D. **PRE-OPERATIVE EDUCATION APPOINTMENT SCHEDULING GUIDELINES:**
1. Patients may be scheduled for a telephone vs. in-person Pre-Operative Education appointment.
2. Those patients who ~~do not need to be scheduled for regular teaching include~~**qualify for a telephone Pre-Operative Education appointment include**:
    a. Debilitated patients
    b. Nursing home patients
    c. Requests from physician's office if HMO is doing blood work and the patient has a transportation problem
    d. Patients who are rescheduled for surgery and have already attended a Pre-Operative Education appointment

E. **SCHEDULING ADD-ON URGENT, EMERGENT, OR EMERGENCY PROCEDURES:**
1. Urgent, Emergent, and Emergency cases may be performed at any time.
2. Urgent, Emergent, and Emergency cases shall be scheduled through the Main OR desk in person or via telephone (760-940-5400).
3. Required information when scheduling an add-on case includes:
    a. Patient name, date of birth, age, and medical record number
    b. Patient phone number, Social Security number, and insurance information (excludes in-house patients)
    c. Patient current location in the hospital
    d. NPO status
    e. Pre-Op diagnosis and Procedure to be performed
    ~~e.~~**f.** **Physical needs/mobility limitations**
    ~~f.~~**g.** Surgeon and assistant (if applicable)
    ~~g.~~**h.** **Instrumentation**/Equipment/X-ray needed
    ~~h.~~**i.** Relevant cardiac/medical history
    ~~i.~~**j.** Time of surgeon availability

F. **WEEKEND/HOLIDAY CASES:**
1. Saturday, Sunday and three recognized Monday Holidays (President's Day, Memorial Day and Labor Day) have two rooms available for Add-on and Urgent cases 0730-1530. After 4 PM only one room is available. In addition, one room is available for emergency cases only.
    a. The heart room counts as one of the available rooms.

2. The remaining holidays (July 4, Thanksgiving, Christmas, New Year's Day) have one urgent room and one emergent room only. No elective surgeries are scheduled on these holidays.
3. Weekend/holiday cases are scheduled no more than 24 hours prior to the day of surgery.
4. Add-on cases are started in order of scheduling, providing the surgeon is available and the patient is ready for surgery.
5. If the first scheduled add-on case cannot be performed in the first available time, the next case's surgeon will be contacted and offered to start at the available time. Upon availability of the next time to start an add-on case, the surgeon for the first case will again be contacted and offered the time.
   a. The first available time is ~~0715~~**0730**. If a physician requests a specific time, eg, 0900 to start a case, then another physician is available to start at ~~0715~~**0730**, the physician requesting the 0900 start time will be contacted to move up to ~~0715~~**0730**, or will start after the preceding case is finished.
6. For ~~0715~~ **0730** cases, the patient must be ready for transfer to the Operating Suite by 0645, otherwise, the next scheduled case may replace the delayed case
7. When the first Saturday/Sunday room is booked for three hours or more, the second room is opened. The surgeon following the ~~0715~~ **0730** slot in the first room will be offered the ~~0715~~ **0730** slot in the newly available room.
8. Surgeons are allowed to schedule no more than ONE elective procedure, no greater than three hours, per weekend. Scheduling questions for weekend electives are decided by the 1st call Anesthesiologist.
9. Robotic Cases (Mazor or daVinci) are not scheduled **on** ~~for weekends or~~ holidays. **Robotic cases may be scheduled on weekends if appropriately trained staff are scheduled and necessary vendor representatives are available.**

G. **ENDOSCOPY:**
1. Endoscopy services are available 24/7.
2. Endoscopy procedures are scheduled in the same manner as surgical procedures.
3. ~~Endoscopic~~ **Endoscopy** procedures requiring ~~general~~ **an** anesthesia **provider** are scheduled in an open time on the OR schedule.

Tri-City Medical Center	Women and Newborn Services
PROCEDURE:	**NEWBORN SEPSIS CARE GUIDELINES**
Purpose:	To provide guidelines ~~fo~~ ~~T~~to outline the nursing management of newborns demonstrating signs and symptoms of sepsis that may require further evaluation and management.
Supportive Data:	Any newborn with signs of sepsis should receive an initial ~~–~~diagnostic evaluation, ~~–~~a review of maternal and newborn risk factors, and receive antibiotic therapy pending the results of the evaluation. The evaluation should include a blood culture, a Complete Blood Count (CBC) including manual count differential and platelet count, a chest radiograph (X-ray) if any abnormal respiratory signs are present. Therapy should include antimicrobial agents active against Group B Streptococcus (GBS) as well as other organisms that might cause newborn sepsis such as E. coli.

A. **PURPOSE:**

1. To identify newborns with risk factors and who develop signs and symptoms that may indicate neonatal sepsis.
2. Newborns at risk for sepsis can include but are not limited to these indications:
   a. Positive maternal GBS status without receipt of Intrapartum Antibiotic Prophylaxis (IAP) within 4 hours of delivery
   b. Prolonged maternal rupture of membranes (ROM) greater than 18 hours
   c. Premature delivery, less than 37 weeks estimated gestational age (EGA)
   d. Unknown GBS status with ROM history greater than 18 hours
   ~~e. Maternal Chorioamnionitis~~ **Intrauterine Inflammation, Infection or Both (Triple I) may consist of an Isolated Maternal Fever, Suspected Triple I or Confirmed Triple I.**
      i. **Isolated Maternal Fever: Maternal oral temperature greater than or equal to 39°C (102.2°F) on any occasion or if the oral temperature is greater than 38°C (100.4°F) but less than 39°C (102.2°F) and the repeat measurement value is greater or equal to 38°C (100.4)**
      ii. **Suspected Triple I: Fever without a clear source plus any of the following:**
         1) **Baseline fetal tachycardia (greater than 160bpm for 10 minutes or longer, excluding accelerations, decelerations and periods of marked variability)**
         2) **Maternal White Blood Cell Count (WBC) greater than 15,000 per MM^3 in the absence of corticosteroids**
         3) **Definite purulent fluid from the cervical os**
      iii. **Confirmed Triple I: All of the findings for Suspected Triple I plus:**
         1) **Amniocentesis proven infection through a positive gram stain**
         2) **Low glucose or positive amniotic fluid culture**
         3) **Placental pathology revealing diagnostic features of infection**
   ~~f.~~**e.** -Maternal history of genital herpes
   ~~g.~~**f.** Newborn with traumatic delivery history
3. Signs and Symptoms of Newborn sepsis can include but are not limited to:
   a. Respiratory Distress
      i. Tachypnea
      ii. Grunting
      iii. Retractions
      iv. Nasal flaring

~~Department Review~~ Women and Newborn Services	Department of OB/GYN	~~Division of Neonatology~~ Perinatal Collaborative Practice	Department of Pediatrics	Pharmacy & Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
NEW, **04/19**	n/a	**n/a**	2/16, **05/19**	09/16, **05/19**	09/16, **06/19**	07/19	10/16, n/a	11/16

v. Decreased breath sounds or adventitious breath sounds i.e.(wheezing, rhonchi, rales)
vi. Apnea
vii. Cyanosis

b. Temperature instability
c. Lethargy
d. Hypertonia (poor tone)
e. Irritability
f. Poor feeding
g. Hypoglycemia
h. Poor perfusion (mottled skin pattern)

B. **SPECIFIC SCENARIOS:**

1. Positive or Unknown Maternal GBS Status and/or Prematurity:
   a. Please refer to Unit Specific Procedure: GBS Prevention and Treatment in Labor and Newborn follow-up
2. ~~Maternal~~ **Confirmed Triple I** ~~Chorioamnionitis~~:
   a. The Diagnosis of ~~maternal chorioamnionitis~~ **Confirmed Triple I** is the responsibility of the Obstetrical (OB) provider and is defined by:
      i. Maternal **oral** temperature greater than or equal to **39°C (102.2°F) on any occasion or** ~~(~~**38°C** (100.4° F)~~ or 38 C)~~ **two times, plus any of the**~~AND (2) other~~ signs/-symptoms listed below:
         1) Fetal tachycardia
         ~~2) Maternal tachycardia~~
         2) Maternal White Blood Cell (WBC) Count greater than or equal to 15,000 **per MM^3 in absence of corticosteroids**
         3) Definite purulent fluid from the cervical os
      ii. **All of the above plus:**
         1) Amniocentesis-proven infection through a positive gram stain
         2) Low glucose or positive amniotic fluid culture
         3) **Placental pathology revealing diagnostic features of infection**
         ~~4) Uterine tenderness~~
         ~~5) Foul smelling amniotic fluid~~
   b. A diagnosis of **Triple I** ~~Maternal Chorioamnionitis~~ requires immediate newborn evaluation and admission to the Neonatal Intensive Care Unit (NICU).
3. Maternal Fever:
   a. If a maternal fever ~~of 100.5 or higher~~ is obtained **according to the Isolated Maternal Fever definition above**~~,~~ the newborn's provider should be called to determine if any further evaluation, monitoring or treatment is needed based on the condition of the newborn and any maternal or intrapartum risk factors.
   b. A newborn that is asymptomatic may remain in couplet care to facilitate the opportunity for exclusive breastfeeding until symptoms and/or laboratory results indicate a reason for NICU admission.
4. Newborn with signs and symptoms of sepsis:
   a. The nurse shall contact the newborn's provider immediately to determine further evaluation, monitoring and treatment plans.

C. **PROCEDURE:**

1. If a newborn presents with signs and symptoms of sepsis or has known maternal risk factors, the nurse should obtain an initial set of vital signs and consider a point of care glucose screening.
   a. Newborns with temperature instability shall be placed on a radiant warmer and warmer placed on servo mode for temperature regulation.
   b. Newborns with hypoglycemia shall be managed per the Blood Glucose Newborn Monitoring Standardized Procedure.

2. A pulse oximeter shall be placed on the newborn to obtain a baseline oxygen saturation value with an oxygen source nearby for use as indicated.
   a. For newborns with respiratory distress and/or cyanosis, apply supplemental oxygen for pulse oximetry readings of less than 95% and per provider order
3. Placement of cardiac leads for ongoing monitoring can be considered.
4. If lab work is requested, the provider orders may include:
   a. Neonatal Complete Blood Count (CBC with manual differential)
   b. **C-Reactive Protein** (CRP)
   c. Blood Culture
   d. Chest X-ray
5. The newborn, who has unresolved clinical symptoms and/or abnormal laboratory results, shall be prepared for transport to the NICU.
6. Document clinical findings, nursing interventions and provider notification.

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

1. Women and Newborn Services Procedure: Group B Strep Prevention and Treatment in Labor and Newborn follow-up.
2. Patient Care Services Standardized Procedure: Blood Glucose Newborn Monitoring

E. **REFERENCES:**

1. American College of Obstetricians and Gynecologists. August 2017. Committee Opinion Number 712: Intrapartum Management of Intraamniotic Infection.
2. American Academy of Pediatrics and American College of Obstetricians and Gynecologists (2017~~2~~).*Guidelines to Perinatal Nursing* (~~8~~7th ed.). Washington DC~~,~~
~~1.~~**3. American Academy of Pediatrics Management of Neonates With Suspected or Proven Early-Onset Bacterial Sepsis. May, 2012; Volume 129 Number 5**
4. American Medical Association JAMA Pediatrics. A Quantitive, Risk-Based Approach to the Management of Neonatal Early-Onset Sepsis. 2017;171(4): 365-371.
5. Journal of Pediatrics. Reappraisal of Guidelines for Management of Neonates with Suspected Early-Onset Sepsis. April, 2015; 166(4): 1070-1074
6. Peng, C., Change, J., Lin,H. Cheng, P, Su, B. Intrauterine inflammation, infection or both (Triple I): A new concept for chorioamnionitis. Science Direct Pediatrics and Neonatology (2018) 59, 231-237
~~2.~~**7.** Simpson, K.& Creehan, P.(2014) *Perinatal Nursing (4th ed)*. Philadelphia, PA: Wolters/Kluwer/Lippincott Williams & Wilkins

Rapivab (peramivir)

Drug Class: Antiviral, neuraminidase inhibitor with activity against influenza A and B viruses

FDA Approval: 2014

FDA Labeled Indications:

Treatment of acute uncomplicated influenza in patients 2 years and older who have been symptomatic for no more than two days.

Please note the prescribing information states the following limitations of use:

- Efficacy based on clinical trials in which the predominant influenza virus type was influenza A; a limited number of subjects infected with influenza B virus were enrolled.
- Consider available information on influenza drug susceptibility patterns and treatment effects when deciding whether to use.
- Efficacy could not be established in patients with serious influenza requiring hospitalization.

Potential Off-Label Use:
Administration of multiple daily doses for the treatment of severe influenza in hospitalized patients

Manufacturer: BioCryst Pharmaceuticals, Inc

Available Dosage Forms:

Injection: 200 mg in 20 mL (10 mg/mL) in a single-use vial

Dosing Recommendations:

Recommended Usual Dose (Single Intravenous Infusion)
Adults and adolescents (13 years and older): 600 mg
Pediatric patients (2 to 12 years of age): 12 mg/kg (up to 600 mg)

Recommended Dose Adjustments in Adult Patients with Altered Creatinine Clearance
Creatinine Clearance (mL/min):
≥ 50 = 600 mg
30-49 = 200 mg
10-29 = 100 mg

Administration/Preparation:

- Administer as a single dose within 2 days of onset of influenza symptoms
- Administer by intravenous infusion for a minimum of 15 minutes

Clinical Pharmacology/Pharmacokinetics:

The pharmacokinetics of peramivir was evaluated in Phase 1 trials in adults. The pharmacokinetic parameters following intravenous administration of peramivir (0.17 to 2 times the recommended dose) showed a linear relationship between dose and exposure parameters (Cmax and AUC). Following intravenous administration of a single dose of peramivir 600 mg over 30 minutes, a maximum serum concentration (Cmax) of 46,800 ng/mL (46.8 µg/mL) was reached at the end of infusion. Distribution In vitro binding of peramivir to human plasma proteins is less than 30%. Based on a population pharmacokinetic analysis, the central volume of distribution was 12.56 L.

Metabolism and Elimination:

Peramivir is not a substrate for CYP enzymes, does not affect glucuronidation, and is not a substrate or inhibitor of P-glycoprotein mediated transport. Peramivir is not significantly metabolized in humans. The elimination half-life of peramivir following IV administration to healthy subjects of 600 mg as a single dose is approximately 20 hours. The major route of elimination of peramivir is via the kidney. Renal clearance of unchanged peramivir accounts for approximately 90% of total clearance. Negligible accumulation was observed following multiple doses, either once or twice daily, for up to 10 days.

Breast Feeding/Pregnancy:

Limited available data with peramivir use in pregnant women are insufficient to determine a drug-associated risk of adverse developmental outcomes. Pregnancy category C.

There are no data on the presence of peramivir in human milk, the effects on the breastfed infant, or the effects on milk production. Infant risk cannot be ruled out.

Efficacy:

Approval of peramivir was based upon a single pivotal Phase 2 trial, two supporting Phase 2 trials, and one supporting Phase 3 trial (refer to Table 1) evaluating adult patients with acute, uncomplicated influenza who presented within 48 hours of symptom onset; all trials were randomized, multicentered, double-blind, and placebo-controlled. The primary efficacy endpoint used in these trials was the time-to-alleviation of symptoms, as self-monitored by patients, and was assessed in the intent-to-treat-infected population (i.e., all patients who received the study drug and had laboratory confirmed influenza). Analysis of pooled data from these trials showed that peramivir reduced the duration of influenza symptoms by ~20 hours compared to placebo.

Peramivir has also been studied in patients (both adult and pediatric) hospitalized with severe influenza, though additional benefit beyond standard of care therapy has not been demonstrated. In a population of patients primarily from India and Eastern Europe hospitalized with influenza, treatment with peramivir 600mg daily for 5 days in addition to standard of care was not shown to significantly improve the time to clinical resolution. A small reduction in time to resolution was found for patients receiving therapy within the first 48 hours of symptoms or directly admitted to the ICU, but it was not significant in either case

Contraindications:

Serious hypersensitivity or anaphylaxis to peramivir or any component of the product

Precautions:

- Dermatologic: Serious skin reactions (eg, erythema multiforme, Stevens-Johnson syndrome) have been reported; discontinue if occurs or suspected
- Immunologic: Anaphylaxis has been reported; discontinue if occurs or suspected
- Immunologic: Secondary bacterial infections may occur
- Psychiatric: Neuropsychiatric events, including hallucinations, delirium, and abnormal behavior leading to injury, have been reported; monitoring recommended
- Renal: Renal impairment (CrCl less than 50 mL/min); dosage adjustment recommended based on degree of impairment
- Special populations: Use not recommended in patients with serious influenza requiring hospitalization

Drug Interactions:

The use of neuraminidase inhibitors, including peramivir, may decrease the efficacy of the live attenuated influenza vaccine (LAIV), due to inhibition of viral replication. The concurrent use of peramivir and LAIV has not been studied but it is recommended to avoid administering LAIV within two weeks prior to or 48 hours following use of peramivir if possible. This does not apply to inactivated influenza vaccine

Monitoring:

- Improvement in respiratory function and alleviation of influenza symptoms is indicative of efficacy
- Signs of abnormal behavior

Adverse Drug Reactions:

- Most common adverse reaction (incidence >2%) is diarrhea
- Serious (rare): Stevens-Johnson syndrome, anaphylaxis, abnormal behavior, hallucinations.

Cost Impact (TCMC Acquisition Cost):

Each 10mg/ml 20ml vial cost is $297.92

Requestor Proposed Criteria For Use:

Peramivir would be restricted for use or approval by infectious disease specialist in patients unable to tolerate oral or enteric administration of oseltamivir in influenza infection

Conclusion:

Permivir is an antiviral neuraminidase inhibitor with activity against influenza A and B viruses. It is FDA approved for treatment of acute uncomplicated influenza in patients 2 years and older who have been symptomatic for no more than two days. Potential off label uses include administration of multiple daily doses for the treatment of severe influenza in hospitalized patients.

The infectious disease consult service and the antimicrobial stewardship committee have reviewed this formulary request and agree with the addition of peramivir to the Tri-City Medical Center formulary with the following proposed criteria for use:

Peramivir would be restricted for use or approval by infectious disease specialist in patients unable to tolerate oral or enteric administration of oseltamivir in influenza infection

References:

1. Rapivab [package insert]. BioCryst Pharmaceuticals, Inc., Durham, April 2018
2. Peramivir. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, Il. Available at: http://online.lexi.com. Accessed May 23, 2019.
3. De jong MD, Ison MG, Monto AS, et al. Evaluation of intravenous peramivir for treatment of influenza in hospitalized patients. Clin Infect Dis. 2014;59(12):e172–85.

ADMINISTRATION REVIEW CONSENT AGENDA
August 7th, 2019

CONTACT: Barbara Vogelsang, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Administration of Pediatric Hepatitis B Vaccine and Hepatitis B Immunoglobulin (HBIG) (HyperHEP B S/DÂ®) to Newborns Standardized Procedure	2 Year Review, Practice Change	Forward to BOD for Approval
2. Blood Glucose Newborn Monitoring Standardized Procedure	2 Year Review, Practice Change	Forward to BOD for Approval
3. Discharge from Outpatient Post-Anesthesia Service Standardized Procedure	2 Year Review, Practice Change	Forward to BOD for Approval
4. Emergency Department Standardized Procedure	Practice Change	Forward to BOD for Approval
5. Gastric Intubation Procedure	3 Year Review, Practice Change	Forward to BOD for Approval
6. Local Anesthetic Prior to Intravenous Insertion Standardized Procedure	DELETE	Forward to BOD for Approval
7. Organ Donation, Including Tissue and Eyes Policy	3 Year Review, Practice Change	Forward to BOD for Approval
8. Restraints Used for Non-Violent Non-Self Destructive Behavior Policy	3 Year Review	Forward to BOD for Approval
9. Universal Blood Saturation Screening for Critical Congenital Heart Disease (CCHD) Standardized Procedure	3 Year Review, Practice Change	Forward to BOD for Approval
10. Witnessing a Patient Signature on Patient's Personal Documents	3 Year Review	Forward to BOD for Approval
Administrative Policies & Procedures		
1. Absences and Tardies 408	3 Year Review, Practice Change	Forward to BOD for Approval
Infection Control		
1. Aerosol Transmissible Diseases and Tuberculosis Control Plan	1 Year Review	Forward to BOD for Approval
2. Scabies and Lice	3 Year Review	Forward to BOD for Approval
3. Standard and Transmission-Based Precautions	Practice Change	Forward to BOD for Approval
Intensive Care Unit		
1. Scope of Services for Intensive Care Unit	NEW	Forward to BOD for Approval
NICU		
1. Cardio-Respiratory Monitoring in the NICU	2 Year Review, Practice Change	Forward to BOD for Approval
2. Intrafacility Transport of the NICU patient	2 Year Review, Practice Change	Forward to BOD for Approval
3. Measuring Infant Length in the NICU	2 Year Review, Practice Change	Forward to BOD for Approval
Rehabilitation		
1. Outpatient Medical Records 1001	3 Year Review, Practice Change	Forward to BOD for Approval
Pre-Printed Orders		
1. Intraoperative Endoscopy Physician Orders 8711-4018	DELETE	Forward to BOD for Approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: ADMINISTRATION OF PEDIATRIC HEPATITIS B VACCINE AND HEPATITIS B IMMUNOGLOBULIN (HBIG) ~~(Hyper-B-SD®)~~ TO NEWBORNS

I. **POLICY:**

A. Function: To provide guidelines for the Women and Newborn Services (WNS) Registered Nurse administering Pediatric Hepatitis B vaccine and Hepatitis B Immunoglobulin (HBIG) ~~(Hyper-B-SD®)~~ to newborns.

B. Circumstances:

1. Setting: **WNS**~~Labor & Delivery, Newborn Nursery, Mother-Baby, Neonatal Intensive Care Unit (NICU)~~
2. Supervision: None required.
3. Requires that an RN complete administration Pediatric Hepatitis B vaccine and Hepatitis B Immunoglobulin (HBIG) ~~(Hyper-B-SD®)~~ to newborns.

C. Consent:

1. The RN shall obtain verbal parental consent prior to administration of the Pediatric Hepatitis B vaccine and/or Hepatitis B Immunoglobulin (HBIG) ~~(Hyper-B-SD®)~~ to the newborn.
   a. Prior to giving consent, the parent or patient's legal guardian shall receive written information about Hepatitis B according to Tri City Medical Center (TCMC) Patient Care Services Policy: Vaccination Administration. This will be documented in the electronic health record (EHR) in the education form.
   b. If the parent or legal guardian declines the Pediatric Hepatitis B vaccination and or HBIG ~~(Hyper-B-SD®)~~ injection, the RN shall contact the Pediatrician immediately for those infants of mothers with positive or unknown Hepatitis B results. ~~Refer to notification and documentation guidelines.~~ Document refusal in the Medication Administration Record (MAR)~~.~~ **and have parent sign the Refusal Hepatitis B Vaccine form. Refer to notification and documentation guidelines.**

II. **PROCEDURE:**

A. When the mother is Hepatitis B Surface Antigen (HBsAg) (positive):

1. The RN will administer Pediatric Hepatitis B vaccine and HBIG ~~(Hyper-B-SD®) after birth~~ ~~(~~within 12 hours of birth~~)~~, regardless of weight.

B. When the mother is Hepatitis B Surface Angtigen (HBsAg) (negative):

1. The RN will administer Pediatric Hepatitis B vaccine, within ~~12 hours of birth~~ **24 hours of birth** ~~regardless of weight~~ **for infants greater than or equal to 2000 grams**, for infants going to the mother-baby unit.
2. Infants going to the NICU should be given Pediatric Hepatitis B vaccine
   a. If full term or greater than or equal to 2000 grams
   ~~a.~~**b. If less than 2000 grams B**~~b~~**y** ~~30 days of chronological~~ **one month of** age if medically stable, or
   ~~b.~~**c.** At discharge if before ~~30 days of chronological age~~ **one month of age**, and/or

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Committee	Department of Pediatrics	Pharmacy & Therapeutics Committee	Inter disciplinary Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
12/05, 8/07, 4/09, 06/11, 07/13, 03/18	12/05, 8/07, 4/09, 06/11, 07/13, 4/15, 07/18	03/11;7/13; 4/15, 07/18	05/15, 11/18	06/11, 9/13, 05/15, 03/19	06/11, 09/13, 09/15, 04/19	06/11, 10/13, 09/15, 07/19	08/19	10/15, n/a	06/11, 10/1, 10/15

~~c.~~**d.** Transfer to the mother-baby unit prior to **24 hours of life** ~~maternal/infant discharge~~.

C. When the mother's Hepatitis B Surface Angtigen (HBsAg) status is unknown:
1. Give Pediatric Hepatitis B vaccine, soon after birth, **but** ~~(~~within 12 hours of birth~~)~~, regardless of weight.
2. Obtain STAT Hepatitis B screen.
   - **a.** If maternal Hepatitis B Surface Antigen (HBsAg) status is determined to be HBsAg positive, give HBIG ~~(Hyper-B-SD®)~~ as soon as possible.
   - ~~a.~~**b.** ~~-~~If the maternal status is still unknown by discharge **and infant greater than or equal to 2000 grams,** give HBIG ~~(Hyper-B-SD®)~~ prior to discharge **or at 7 days of birth (whichever is first) if status remains unknown.**.
     - i. NICU infants < 2000g: if the mother's HBsAg result is not available within 12 hrs of birth, give HBIG ~~(Hyper-B-S/D®)~~ as soon as possible.
     - ii. NICU infants ≥ 2000g: Administer HBIG ~~(Hyper-B-S/D®)~~ within 7 days if the mother's HBsAg result is positive, or if maternal status remains unknown by discharge give prior to discharge.

D. The RN will administer Pediatric Hepatitis B vaccine and Hepatitis B Immunoglobulin (HBIG) ~~(Hyper-B-SD®)~~ in accordance with the Tri-City Medical Center Patient Care Services Policies:
1. Medication Administration
2. Vaccination Administration

E. Pediatric Hepatitis B vaccine dose is 5–10 mcg*/0.5 mL, administered intramuscularly. (*Note: Hep B mcg dosage varies depending on manufacturer)

F. Hepatitis B Immunoglobulin (HBIG) ~~(Hyper-B-SD®)~~ dose is 0.5 mL, administered intramuscularly ~~at~~ **in** the opposite thigh from the **Hep B** vaccination site.

G. Documentation
1. The newborn's EHR
   - a. Refer to TCMC Patient Care Services Vaccinations Administration Policy.
2. Immunization Record
   - a. Document newborns receipt of immunization on the Immunization Record.
   - b. The Immunization Record shall be given to the newborn's parent(s) upon discharge of the newborn, **and the parent(s) need to be notified to bring the record to the Pediatrician's office appointment.**
   - c. If the parent declines the immunization after receiving the Vaccine Information Sheet, document in the newborn's EHR. In the Medication Administration Record (MAR) this will be documented as "refusal".
     - i. **Have parent sign the form titled "Refusal of Hepatitis B Vaccine" and keep the original copy for the newborn chart.**
     - ~~i.~~**ii.** Still give parent immunization record at discharge.
   - d. Document tests, treatments, and physician notification in the EHR.
   - e. When administering medications or implementing orders from a standardized procedure, the Registered Nurse shall enter the medication/order into the electronic health record as a standardized procedure.
     - i. Not required if a screening process triggers the order.

I. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. Current California **unencumbered** RN license working in Women~~'s~~ and **Newborn** ~~Children's~~ Services/NICU.
B. Education: Registered Nurse
C. Initial Evaluation: Orientation
D. Ongoing Evaluation: Annually

II. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.

B. Review: Every two (2) years.

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

A. All Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform Administration of Pediatric Hepatitis B Vaccine and Hepatitis B Immunoglobulin (HBIG) ~~(Hyper-B-SD®)~~ to Newborns Standardized Procedure.

IV. **FORM(S):**

A. **Refusal of Hepatitis B Vaccine form 6385-1023~~-in~~ – English – Sample**

~~A.~~B. **Refusal of Hepatitis B Vaccine form 6385-1025~~-in~~ – Spanish – Sample**

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

A. Patient Care Services Policy: Vaccination Administration

B. Patient Care Services Policy: Medication Administration

~~B.~~C. **Vaccine Information Sheet (VIS) Hepatitis B Vaccine: What You Need to Know – Sample (available via external link: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-b.pdf)**

~~V.~~VI. **REFERENCES:**

~~A. Tschudy, M. & Archara, K (2012). *The Harriet Lane Handbook (19th Ed.)* Philadelphia, PA~~

~~B. Simpson, K. & Creehan, P. (2014). AHWONN: Perinatal Nursing. Philadelphia, PA~~

A. Elimination of Perinatal Hepatitis B: Providing the First Vaccine Dose Within 24 Hours of Birth. *Pediatrics* (2017);140.

B. Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, United States, 2018, www.cdc.gov/vaccines/schedules

C. Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices, February 6, 2018 *MMWR*.

D. Drutz, J.E., (2018) Hepatitis B virus immunization in infants, children, and adolescents

~~C. Immunization Action Coalition (2012). Guidance for Developing Admission Orders in Labor & Delivery and Newborn Unit to Prevent Hepatitis B Virus Transmission. Retrieved July 30, 2013 from http://www.cdc.gov/mmwr~~

SAMPLE

I, _____, have been advised by my child's doctor/nurse that my child should receive the Hepatitis B Injection. I have been provided with and given the opportunity to read the Vaccine Information Statement from the Centers for Disease Control and Prevention explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the recommendation and my refusal with my child's doctor or nurse.

I understand the following:

- The purpose of and the need for the recommended vaccine
- The risks and benefits of the recommended vaccine
- If my child does not receive the vaccine according to the medically accepted schedule, the consequences may include the following:
  - Contracting the illness the vaccine is designed to prevent
  - Chronic disease or death as a result of the illness
- My child's doctor and the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention all strongly recommend that the vaccine be given at this time according to recommendations

I have decided at this time to decline the vaccine recommended for my child. I know that failure to follow the recommendations about vaccination may endanger the health or life of my child and others with whom my child might come into contact. I therefore agree to tell all health care professionals in all settings that my child did not receive the vaccination.

I acknowledge that I have read this document in its entirety and fully understand it, but still decline the vaccine for my child.

_____	_____	___/___/___	_____ AM/PM
Name: Patient/Representative	Signature: Patient/Representative	Date	Time

If signed by a person other than the patient, indicate relationship to patient _____
Examples: Spouse, Partner, Legal Guardian

If patient is unable to sign, state reason _____

_____	_____	___/___/___	_____ AM/PM
Witness – TCHD Representative (print name)	Signature	Date	Time

INTERPRETATION / INTERPRETER'S STATEMENT

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

_____	_____	___/___/___	_____ AM/PM
Interpreter ID number or Name	Interpreter Signature (if present)	Date	Time

☐ Patient refuses TCHD's interpretation services and selects as interpreter _____
Name and relationship to patient

Affix Patient Label

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

6385-1023

REFUSAL OF HEPATITIS B VACCINE

Authorization
White - Medical Record Canary - Patient

Board Approved (Date)

SAMPLE

A mi, _____ el doctor/la enfermera de mi niño(a) me han aconsejado que mi niño(a) debería recibir la inyección de Hepatitis B. Me han proporcionado y me han dado la oportunidad de leer la Declaración Informativa sobre la Vacuna de los Centros para el Control y Prevención de Enfermedades explicando la vacuna y las enfermedades que esta previene. He tenido la oportunidad de analizar la recomendación y mi rehúso (rechazo) con el doctor o la enfermera de mi niño(a)

Comprendo lo siguiente:

- El propósito y la necesidad de poner la vacuna recomendada
- Los riesgos y beneficios de la vacuna recomendada
- Si mi niño(a) no recibe la vacuna de acuerdo con el calendario médicamente aceptable, las consecuencias podrían incluir las siguientes:
  - Contraer la enfermedad que la vacuna está designada a prevenir
  - Enfermedad crónica o muerte como resultado de la enfermedad
- El médico de mi niño(a) y la Academia Americana de Pediatría, la Academia Americana de Médicos de Familia, y los Centros para el Control y la Prevención de Enfermedades enfáticamente recomiendan que la vacuna se ponga en este momento de acuerdo con las recomendaciones

Yo he decidido en estos momentos rechazar la vacuna recomendada para mi niño(a). Yo sé que no seguir las recomendaciones acerca de la vacunación podría arriesgar la salud o la vida de mi niño(a) y de otras personas con quien mi niño(a) pudiera entrar en contacto. Yo, por lo tanto, estoy de acuerdo en decirles a todos los profesionales que atienden la salud y en todas situaciones que mi niño(a) no recibió la vacunación.

Reconozco que he leído enteramente este documento y lo comprendo plenamente, pero aun así rechazo la vacuna para mi niño(a).

Name	Signature:	Date	Time
		/ /	AM/PM

Indicate relationship to patient: _____
Examples: Parent, Legal Guardian

Witness – TCHD Representative (print name)	Signature • *Firma*	Date • *Fecha*	Time • *Hora*
		/ /	AM/PM

INTERPRETATION (Complete if Interpretation provided)

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

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

❑ Patient refuses TCHD's interpretation services and selects as interpreter _____
Name and relationship to patient

Affix Patient Label

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

6385-1025

REFUSAL OF HEPATITIS B VACCINE
(RECHAZO DE VACUNA HEPATITIS B)

Authorization
White - Medical Record Canary - Patient

Board Approved (Date)

SAMPLE

VACCINE INFORMATION STATEMENT

Hepatitis B Vaccine

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Hepatitis B is a serious disease that affects the liver. It is caused by the hepatitis B virus. Hepatitis B can cause mild illness lasting a few weeks, or it can lead to a serious, lifelong illness.

Hepatitis B virus infection can be either acute or chronic.

Acute hepatitis B virus infection is a short-term illness that occurs within the first 6 months after someone is exposed to the hepatitis B virus. This can lead to:

- fever, fatigue, loss of appetite, nausea, and/or vomiting
- jaundice (yellow skin or eyes, dark urine, clay-colored bowel movements)
- pain in muscles, joints, and stomach

Chronic hepatitis B virus infection is a long-term illness that occurs when the hepatitis B virus remains in a person's body. Most people who go on to develop chronic hepatitis B do not have symptoms, but it is still very serious and can lead to:

- liver damage (cirrhosis)
- liver cancer
- death

Chronically-infected people can spread hepatitis B virus to others, even if they do not feel or look sick themselves. Up to 1.4 million people in the United States may have chronic hepatitis B infection. About 90% of infants who get hepatitis B become chronically infected and about 1 out of 4 of them dies.

Hepatitis B is spread when blood, semen, or other body fluid infected with the Hepatitis B virus enters the body of a person who is not infected. People can become infected with the virus through:

- Birth (a baby whose mother is infected can be infected at or after birth)
- Sharing items such as razors or toothbrushes with an infected person
- Contact with the blood or open sores of an infected person
- Sex with an infected partner
- Sharing needles, syringes, or other drug-injection equipment
- Exposure to blood from needlesticks or other sharp instruments

Each year about 2,000 people in the United States die from hepatitis B-related liver disease.

Hepatitis B vaccine can prevent hepatitis B and its consequences, including liver cancer and cirrhosis.

2 Hepatitis B vaccine

Hepatitis B vaccine is made from parts of the hepatitis B virus. It cannot cause hepatitis B infection. The vaccine is usually given as 3 or 4 shots over a 6-month period.

Infants should get their first dose of hepatitis B vaccine at birth and will usually complete the series at 6 months of age.

All **children and adolescents** younger than 19 years of age who have not yet gotten the vaccine should also be vaccinated.

Hepatitis B vaccine is recommended for unvaccinated **adults** who are at risk for hepatitis B virus infection, including:

- People whose sex partners have hepatitis B
- Sexually active persons who are not in a long-term monogamous relationship
- Persons seeking evaluation or treatment for a sexually transmitted disease
- Men who have sexual contact with other men
- People who share needles, syringes, or other drug-injection equipment
- People who have household contact with someone infected with the hepatitis B virus
- Health care and public safety workers at risk for exposure to blood or body fluids
- Residents and staff of facilities for developmentally disabled persons
- Persons in correctional facilities
- Victims of sexual assault or abuse
- Travelers to regions with increased rates of hepatitis B
- People with chronic liver disease, kidney disease, HIV infection, or diabetes
- Anyone who wants to be protected from hepatitis B

There are no known risks to getting hepatitis B vaccine at the same time as other vaccines.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

SAMPLE

3 Some people should not get this vaccine

Tell the person who is giving the vaccine:

- **If the person getting the vaccine has any severe, life-threatening allergies.**
  If you ever had a life-threatening allergic reaction after a dose of hepatitis B vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Ask your health care provider if you want information about vaccine components.
- **If the person getting the vaccine is not feeling well.**
  If you have a mild illness, such as a cold, you can probably get the vaccine today. If you are moderately or severely ill, you should probably wait until you recover. Your doctor can advise you.

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of side effects. These are usually mild and go away on their own, but serious reactions are also possible.

Most people who get hepatitis B vaccine do not have any problems with it.

Minor problems following hepatitis B vaccine include:

- soreness where the shot was given
- temperature of 99.9°F or higher

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

Your doctor can tell you more about these reactions.

Other problems that could happen after this vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting and injuries caused by a fall. Tell your provider if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get shoulder pain that can be more severe and longer-lasting than the more routine soreness that can follow injections. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

5 What if there is a serious problem?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

  Signs of a **severe allergic reaction** can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a **severe allergic reaction** or other emergency that can't wait, call 9-1-1 or get to the nearest hospital. Otherwise, call your clinic.

  Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC).
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at **www.cdc.gov/vaccines**

Vaccine Information Statement
Hepatitis B Vaccine

7/20/2016

42 U.S.C. § 300aa-26

Office Use Only

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: BLOOD GLUCOSE NEWBORN MONITORING

I. **POLICY:**

A. Function: To screen blood glucose (BG) levels in infants of diabetic mothers, late-preterm, small for gestational age, large for gestational age, and term symptomatic infants in order to correct or manage neonatal hypoglycemia.

B. Circumstances: Infants 36 0/7-36 6/7 weeks up to term, infants at risk, or symptomatic term infants with no risk factors.

1. Setting: **Women and Newborn Services (WNS)**~~Labor and Delivery (L&D), Transition Nursery and Mother Baby~~

C. Background: Neonatal glucose concentrations decrease after birth, to as low as 30-mg/dL during the first 1 to 2 hours after birth, and then increase to higher concentrations, generally above 45-mg/dL by 12 hours after birth.

D. See Patient Care Services (PCS) Glucose Point of Care (POC) Testing using the Nova Stat Strip Blood Glucose Meter Procedure for step by step instructions for blood glucose machine.

II. **PROCEDURE:**

A. Identify infants at risk and implement monitoring as appropriate.

1. POC BG is performed for the following infants classified as at risk:
   a. Infants of diabetic mothers (IDM)
   b. Large for gestational age (LGA) infants (greater than or equal to 4 **kilogram** [kg] or 8 **pounds** [lbs] 13 **ounces** [oz])
   c. Small for gestational age (SGA) infants (less than or equal to 2.5-kg or 5lbs 9oz)
   d. Late Preterm (LPT) infants – (36 0/7 to 36 6/7 weeks gestation)
   e. Post-term infants - (greater than 42 weeks gestation)
   f. Intrauterine Growth Restriction (IUGR) infants
   g. Infants with signs and symptoms of hypoglycemia: (irritability, tremors, jitteriness, exaggerated Moro reflex, a high-pitched cry, seizures, lethargy, floppiness, cyanosis, apnea and poor feeding)
2. Monitoring and treatment is based on hours of age, risk factors, and symptoms.

B. Feed at risk infants by 1 hour of age. If unable to feed in the first hour, notify provider immediately.

1. Utilize breastfeeding **or expressed breastmilk** first. Supplement with formula if **medically indicated per physician/Allied Health Professional (AHP) ordered**~~needed~~.

C. Perform initial POC BG screen 30 minutes after the first feed by performing a heel stick per PCS Collection of Blood Specimen by Skin Puncture procedure.

D. From birth to 4 hours of age

1. If infant is symptomatic with a POC BG less than 40**mg/dL**, call provider for assessment or NICU consult.
2. If infant is asymptomatic, but falls into one of the risk factor categories above:
   a. If POC BG is greater than or equal to 40**mg/dL** continue feeds every 2-3~~-to-three~~ hours screening the glucose prior to each feed
   b. If initial screen is less than or equal to 39**mg**/dL, re-feed immediately, and re-check POC BG 1 hour after feed ends.

Patient Care ices tent Expert	Clinical Policies & Procedures Comm.	Nurse Executive Comm.	Perinatal Collab.	Dept. of Pediatrics	Pharmacy & Therapeutics Comm.	Inter-disciplinary Comm.	Medical Executive Comm.	Admin.	Professional Affairs Comm.	Board of Directors
12/14, 09/16, 06/18	03/15, 10/16, 07/18	04/15, 10/16, 07/18	05/15, 01/17, 09/18	05/15, 02/17, 11/18	03/17, 03/19	09/15, 04/17, 04/19	09/15, 04/17, 07/19	08/19	10/15, 05/17, n/a	10/15, 05/17

i. If follow-up POC BG is less than 25mg/dL, call provider for assessment or NICU consult.
ii. If follow up POC BG is 25-39mg/dL~~l~~, re-feed immediately, and re-check POC BG 1 hour after feed ends.
iii. If at any time the POC BG falls below 40mg/dL~~l~~, re-feed immediately, and re-check POC BG 1 hour after feed ends and continue to follow the steps above based on the POC BG result.
iv. If follow up POC BG is greater than or equal to 40mg/dL~~l~~, continue feeds every 2-3 hours and screen POC BG prior to each feed until 3 consecutive values greater or equal to 45mg/dL~~l~~ are achieved not counting the initial POC BG.

E. From 4 hours to 24 hours of age:
1. If pre-prandial screen is greater than or equal to 45**mg/dL**, continue to check POC BG prior to each feed until 3 consecutive values greater than or equal to 45-mg/dL are achieved not counting the initial POC BG
2. If pre-prandial screen is less than or equal to 44-mg/dL, re-feed immediately, and re-check POC BG 1 hour after feed ends.
a. If follow-up POC BG is less than 35-mg/dL, 1 hour after feed ends, then call provider for assessment or NICU consult.
b. If pre-prandial screen is 35-~~44-to-~~mg/dL, re-feed immediately and re-check POC BG 1 hour after feed ends.
c. If follow up POC BS is greater than or equal to 45-mg/dL, continue to monitor POC BG prior to each feed until 3 consecutive values greater than or equal to 45mg/dL are achieved, not counting the initial POC BG.

III. DOCUMENTATION:

A. Blood glucose results in the electronic health record (EHR)
B. Patient assessment and response to feeding or interventions
C. Any complications or adverse side effects
D. Provider notification and follow-up orders for any critical lab value.
E. When ~~administering medications or~~ implementing orders from a standardized procedure the nurse shall enter the orders electronically~~ unless a screening process triggers the appropriate order(s)~~.

IV. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. Education: Current **unencumbered** California License
B. Initial Evaluation: New Hire Orientation
C. Ongoing Evaluation: ~~a~~Annually~~ with Skills Lab~~

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

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

VI. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All healthcare providers in Women~~'s~~ and Newborn Services who have successfully completed requirements as outlined above are authorized to direct and perform.

VII. RELATED DOCUMENT(S):

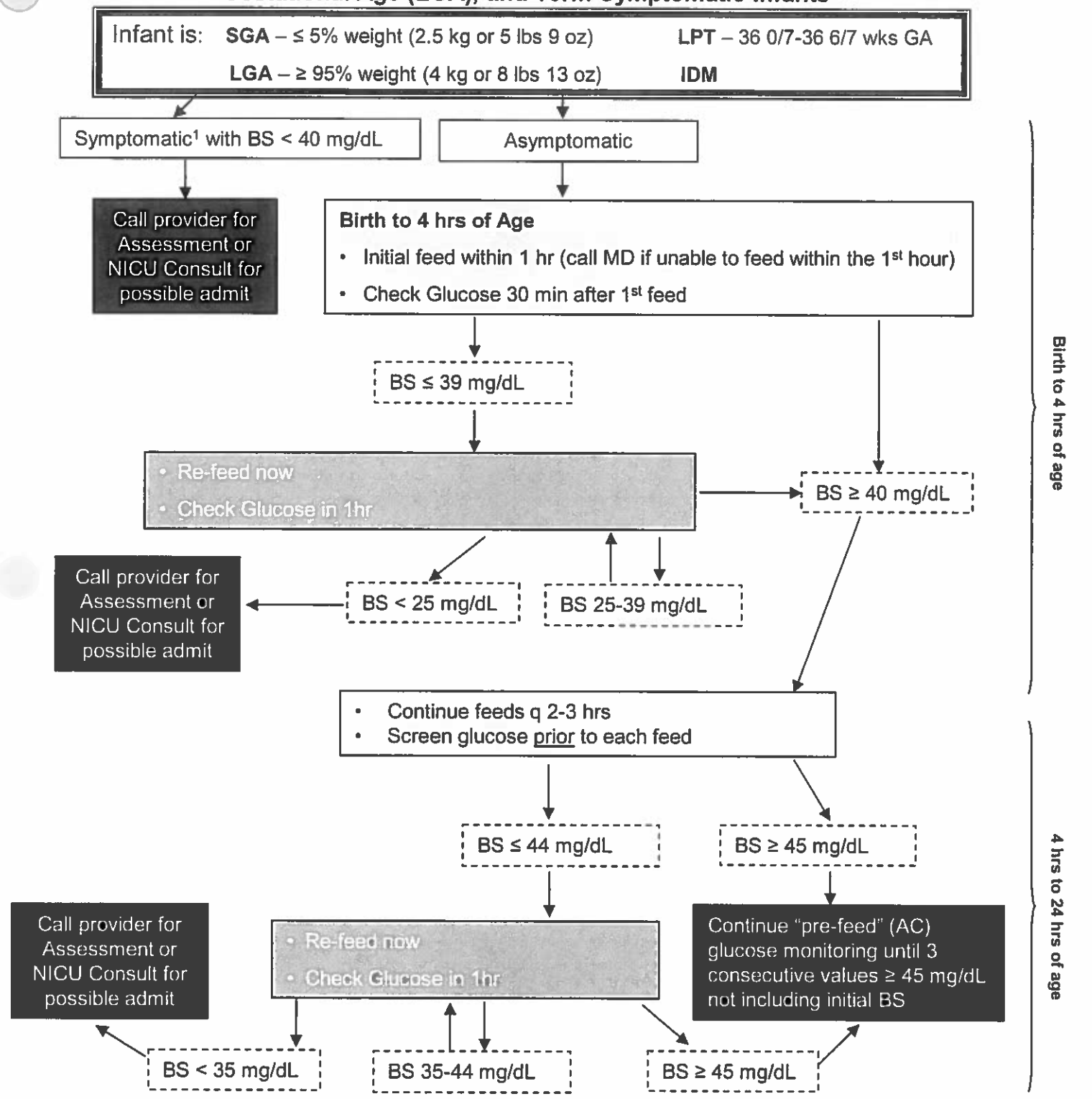
A. Patient Care Services **Procedure**: Collection of a Blood Specimen by Skin Puncture ~~Procedure~~
B. Patient Care Services **Procedure**: Glucose Point of Care Testing using the Nova Stat Strip Blood Glucose Meter ~~Procedure~~
C. ~~Patient Care Services:~~ Postnatal Glucose Homeostasis Flowchart

VIII. REFERENCE(S):

A. American Academy of Pediatrics. (2011). Postnatal Glucose Homeostasis in Late Preterm and Term Infants. Pediatrics. 127(3): 575-579. Retrieved online from pediatrics.aapublications.org.

~~A.~~**B. Guidelines for Perinatal Care 8th Ed., (2017). American Academy of Pediatrics and American College of Obstetricians and Gynecologists.**

Postnatal Glucose Homeostasis Flowchart
Screening and Management Guidelines of Glucose Homeostasis in Infants of Diabetic Mothers (IDM), Late-Preterm (LPT), Small for Gestational Age (SGA), Large for Gestational Age (LGA), and Term Symptomatic Infants



[1]Symptoms of hypoglycemia include: irritability, tremors, jitteriness, high pitched cry, seizures, lethargy, floppiness, cyanosis, apnea, and poor feeding (applicable to any infant showing symptoms of hypoglycemia).

Further management of symptomatic infants is **at the discretion of the provider** based on severity of symptoms and risk factors. May utilize the same management algorithm for asymptomatic patients as guidance or reference.

*This algorithm serves only as a screening and management guideline. At any time **the practitioner may deviate** from the guidelines noted above.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: DISCHARGE FROM OUTPATIENT POST–ANESTHESIA SERVICE

I. **POLICY:**

A. Function: To provide a timely and appropriate discharge of the stable patient from **the** Post Anesthesia Care Unit (PACU).

B. Circumstances:

1. Setting: PACU
2. Supervision: None required
3. Physicians Orders: The physician orders must clearly reflect a Registered Nurse (RN) may discharge a patient when discharge criteria have been met. **Anesthesia is required to complete a post anesthesia evaluation note of the patient within 48 hours, but prior to discharge.**
4. Patient Contraindications: The anesthesiologist is to be notified of any patient who does not meet discharge criteria within four hours of admission post procedure, **and/or of** any patient who has **airway complications,** hemodynamic instability, surgical complications, or fails to respond to treatment/interventions.

II. **PROCEDURE:**

A. A patient will be ready for discharge as determined by the following criteria:

1. Airway:
   a. **Patent airway and** ~~Intact airway~~ protective **airway** reflexes **are intact**
   b. ~~Patent airway (no sign of airway obstruction and no need for airway support)~~**Patient is able to cough and deep breathe**
2. Ventilation/Oxygenation:
   a. Respiratory rate greater than or equal to 10 per minute/adult
   ~~a.~~**b. SpO2 greater than (>) 94% (or return to baseline) on room air (or on baseline home oxygen)**
3. Cardiovascular:
   a. Blood pressure, heart rate, cardiac rhythm within patient's acceptable baseline parameters~~, and temperature greater than 36°C (96.8°F)~~
      ~~a.~~**i. Blood pressure within plus or minus (+) 20 mmHg of patient's baseline**
   b. Stable, no significant changes for at least 30 minutes
4. **Thermoregulation:**
   a. Temperature greater than or equal to (≥) 36°C (96.8°F)
   b. Patient describes feeling of acceptable warmth
4~~.~~**5.** General Condition:
   a. Awake, **alert and oriented** ~~and~~
   ~~a.~~**b.** F**f**ollows commands per baseline
   c. Adequate intake and output.
      i. Voiding ~~, able to take oral fluids~~**as indicated by procedure and patient condition**
      ~~b.~~**ii. Oral intake as indicated by procedure and patient condition**
   ~~c.~~**d.** ~~Comfort~~ **Pain** level meets target pain level **or is appropriate for procedure**

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Committee	Department of Anesthesiology	Pharmacy & Therapeutics Committee	Inter disciplinary Committee	Medical Executive Committee	Admin	Professional Affairs Committee	Board of Directors
2/99, 4/00, 02/09, 02/11, 07/13, 4/15, 03/18	02/11, 7/13, 08/15, 06/18, 12/18	03/11, 07/13, 09/15, 07/18, 12/18	01/16, 01/19	09/15, 03/19	04/11, 09/13, 07/16, 04/19	6/11,10/13, 09/16, 07/19	08/19	10/16, n/a	06/11, 10/13, 11/16

~~5.~~**e.** Vomiting controlled and/or ~~patient able to tolerate present state of nausea~~ **acceptable level of nausea.**

6. Ambulation
   a. Motor function/mobility ~~progressing toward optimal level~~ **baseline or consistent with procedure**
   b. Demonstrates understanding of assistive devices as appropriate
7. Post-procedural/operative bleeding controlled **or acceptable with procedure**
   a. Dressing/surgical site is clean, dry and intact or has mild to moderate drainage with no marked increase
   ~~7.~~**b. Patent tubes, catheters and drains**
8. **For spinal or epidural block, patient has complete resolution of block**
   a. No evidence of bleeding at puncture site
9. **For regional anesthesia, protection of patient's extremity**
10. Psychosocial issues identified and addressed
    a. Patient is calm
    ~~8.~~**b. Emotional status is under control**

~~9.~~**11.** Provision made for safe transport home **with responsible person present.**

~~10.~~**12.** Discharge from PACU with a ~~Modified~~ Aldrete score of ~~9~~—10 **(or baseline)** or per physician written orders

~~11.~~**13.** Last set of vital signs, ~~-~~**pain assessment and Aldrete Score** documented immediately before discharge.

III. **PROCESS:**

A. Discharge:
   1. When the patient meets the above criteria, initiate standardized procedure as appropriate.
   2. Prepare patient or responsible party by reviewing patient education.
      a. Patient care provider verbalizes understanding of all discharge instructions.
      b. Written discharge instructions will be signed by the accompanying responsible adult and a copy provided upon discharge.
      c. Questions by patient/responsible adult invited and answered.
   3. **New prescriptions will be scanned to pharmacy and a copy will be kept in the chart.**
   4. **Outpatients post sedation or anesthesia are required to be discharged in the company of a responsible person and have a pre-arranged ride home. See PCS Policy: Outpatient Post Anesthesia/ Procedure Discharge/ Transportation Guidelines.**

~~3.~~**5.** Follow-up
   a. A p~~P~~ost-o~~O~~p phone call **shall be** made ~~the following day~~**within 2 business days of surgery/procedure** by **a PACU** RN
      i. **Two attempts will be made to contact the patient**

~~4.~~**IV. DOCUMENTATION:** ~~Document in the patient's medical record~~

~~a. Goals/outcomes met~~
~~i. Deviations from expected outcomes to be documented on nursing record~~
~~b. Patient education~~
~~c. Follow up phone call including any unexpected effects along with RNs instructions to patient or support person.~~
~~d. RN signature completed on all physician orders and nursing documentation.~~
~~e. Completion of Patient Charge document~~
~~f. Discharge in Cerner~~

A. Document the following in the electronic health record (EHR):
   1. Vital signs
   2. Pain assessment

3. **Aldrete score**
4. **Intake and Output**
5. **Dermatome level (if applicable)**
6. **Surgical site assessment**
7. **Presence of nausea/vomiting**
8. **Additional elements of assessment as indicated by procedure and anesthesia/sedation type**
9. **PACU Expected Outcomes**
10. **For patients who have had moderate sedation without anesthesia care, document sedation outcomes.**
11. **PACU Departure**

B. Document patient education

C. Document all medications given in the eMAR

~~IV.~~V. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. ~~A c~~Current **unencumbered** California RN license

B. ~~A c~~Current Advanced Cardiac Life Support (ACLS) certification

C. Initial Evaluation: During orientation period to include a nursing competency check-off list on discharge criteria.

D. Ongoing Evaluation: Annually ~~through skills lab~~.

~~V.~~VI. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: This standardized procedure was developed through collaboration with nursing, medicine, and administration.

B. Review: Every two (2) years.

~~VI.~~VII. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All RNs who have successfully completed requirements as outlined above are authorized to direct and perform Discharge from Outpatient Post-Anesthesia Nursing Service Standardized Procedure.

VIII. REFERENCE(S):

A. American Society of Perianesthesia Nurses. (2016). *Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements 2017- 2018.* Cherry Hill, NJ: American Society of Perianesthesia Nurses.

B. Schick, L., & Windle, P. E. (Eds.). (2016). *PeriAnesthesia Nursing Core Curriculum: Preprocedure, Phase I and Phase II PACU Nursing* (3rd ed.). St. Louis, MO: Elsevier.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: EMERGENCY DEPARTMENT

I. **POLICY:**

A. Function: To define appropriate utilization of specific orders and order sets, otherwise referred to as standardized procedures.

B. Circumstances:

1. Setting: Tri-City Medical Center, Emergency Department (ED)
2. Supervision: An Emergency ~~Services~~ **Department** Physician will be available for consultation. Registered Nurses will immediately contact the physician for any patient who is critical in nature or unstable. Physician contact will not be delayed in order to initiate or complete Standardized Procedures.
3. Patient contraindications: None

C. Documentation:

1. The Registered Nurse (RN) will document all interventions performed into the electronic health record (EHR).
2. The RN will enter all orders performed per the standardized procedure in the EHR.

II. **PROCEDURE:**

A. Abdominal Pain between the ages of 10 – ~~29~~**30** :

1. In patients who present to the ED with abdominal pain, the RN shall order the following:
   a. Labs:
      i. CBCD
      ii. Metabolic Panel, Comprehensive
      iii. Jic Blue
      iv. Serum HCG in females
      ~~iv.~~**v. Lipase**
   b. Nurse Orders:
      i. Routine urinalysis with reflex culture
   c. Medications:
      i. For patients who are >=16 years old, the RN may order Ondansetron (Zofran) 8 mg oral disintegrating tablet (ODT) times one (1), prn for nausea ~~in patients 16 years of age and older.~~
      ~~i.~~**ii. For patients who are 10-15 years old, the RN may order Ondansetron (Zofran) 4 mg oral disintegrating tablet (ODT) x one (1) prn nausea**

B. Abdominal Pain, ages ~~26~~**30** and older :

1. In patients **who are >= ~~26~~30 years old** who present to the ED with abdominal pain, the RN shall order the following:
   a. Labs:
      i. CBCD
      ii. Metabolic Panel, Comprehensive
      iii. Jic Blue
      iv. Serum HCG in females aged ~~26~~**30** to 55
      ~~iv.~~**v. Lipase**
   b. Nurse Orders:
      i. Routine urinalysis with reflex culture

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Committee	Department of Emergency Medicine	Pharmacy & Therapeutics Committee	Inter-disciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
06/04, 03/06, 08/08, 07/09, 06/11, 06/14, 12/18	01/11, 11/13, 10/14, 01/15, 12/16, 12/18	01/11, 11/13, 10/14, 02/15, 03/17, **12/18**	06/11, 12/14, 05/17, **02/19**	06/11, 11/13, 01/15, 07/17, **03/19**	06/11, 02/14, 06/15, 10/17, **04/19**	06/11, 02/14, 06/15, 03/18, **07/19, 08/19**	06/15, 04/18, **n/a**	06/11, 02/14, 07/15, 04/18

c. Medications:
   i. Ondansetron (Zofran) **8** ~~8-4~~mg ODT times one (1), PRN for nausea~~, in patients 16 years or older.~~
d. Additional orders if patient presents with upper abdominal pain (above umbilicus or abdominal pain of unknown location) to rule out cardiac conditions:
   i. Cardiology:
      1) EKG STAT
         a) Print old EKG if available
         b) STAT ED EKG's will be completed with a goal of 10 minutes of being ordered and delivered directly to ED physician to rule out ST-elevation Myocardial Infarction (STEMI)
   ii. Labs:
      1) Creatine Kinase (CPK)
      2) CK, Mb Fraction (CKMB) if CK elevated
      3) Cardiac Troponin (Troponin I)
      ~~4) Lipase level~~

C. Asthma with Wheezing:
1. In patients who present to ED with wheezing and a stated history of asthma, the RN shall order the following:
   a. Nursing Orders:
      i. Pulse oximetry monitoring
   b. Medications:
      i. In patients who are greater than or equal to 12 ~~11~~ years of age.
         1) Albuterol 5 mg nebulized times one (1) with Ipratropium 0.5 mg nebulized times one (1) per Respiratory Therapy~~py~~.
      ii. ~~ii. in patients who are greater than 11 years of age.~~ **In patients who are aged 2-11 years~~, the RN shall order~~**
         ~~i.~~**1) Albuterol 2.5 mg nebulized x 1 with Ipatropium 0.5 mg nebulized x 1 per Respiratory Therapy**

D. Chest Discomfort in Patients ~~over 30 years of age~~**age 30 and over**:
1. In patients who present to the ED with chest pain, pressure, squeezing, shortness of breath, pain or discomfort in other parts of the body including one or both arms or shoulders, upper back, neck, jaw, abdomen, or female, elderly or diabetic patients with atypical symptom suspicious for acute coronary syndrome (ACS) such as diaphoresis, nausea, dizziness, altered level of consciousness the Registered Nurse (RN) shall order the following:
   a. Cardiology:
      i. EKG STAT
         1) Print old EKG if available
         2) STAT ED EKG's will be completed with the goal of 10 minutes of being ordered and delivered directly to an ED physician to rule out STEMI.
   b. Labs:
      i. CBCD
      ii. Metabolic Panel, Comprehensive
      iii. Creatine Kinase (CPK)
      iv. CK, Mb Fraction (CKMB) if CK elevated
      v. Cardiac Troponin (Troponin I)
   c. Nurse Orders:
      i. Bring patient to first available bed
      ii. Initiate at least one peripheral intravenous (IV) saline lock
      iii. Initiate cardiac monitor

iv. Initiate oxygen 2 liters per minute (LPM) per nasal cannula (NC) to maintain oxygen saturation by pulse oximetry (SPO2) greater than 92%

d. Medications:

i. Aspirin 325 mg one (1) tablet by mouth (PO) chewed times one (1) if not already administered

~~ii. Nitroglycerin (NTG) 0.4 mg sublingually, every five (5) minutes times three (3) doses for ongoing chest pain~~

e. Radiology:

i. X-Ray Chest 2 View

1) If patient is female and under 55, shield pelvis

E. Dysuria:

1. In patients who present to the ED with dysuria, hematuria, urgency, or frequency, the RN shall order:

a. Nurse Orders:

i. Routine urinalysis with reflex culture

ii. Urine HCG for females age 10-55

F. Extremity Trauma:

1. Notify physician STAT for open fractures, dislocations, or neurological or vascular compromise.

2. Consult physician for x-ray orders for back, skull, facial bones, chest, pelvis, hips, and ribs.

3. In patients who present to ED with injuries that are suspicious for fracture, the RN shall order the following:

a. Medications:

i. Acetaminophen

1) For ages 3 months-11 years, acetaminophen 15mg/kg PO or PR times one (1), round to nearest 5mg

a) Maximum ~~2600mg/day~~ **325 mg/dose**

b) Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.

2) For 12 years and older, acetaminophen 650mg PO or PR times one

a) Maximum ~~3000mg/day~~ **650 mg/dose**

b) Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.

b. Radiology:

i. Acromioclavicular Joints
ii. Ankle complete 4 views left
iii. Ankle complete 4 views right
iv. Heel left OS Calcis
v. Heel right OS Calcis
vi. Clavicle left
vii. Clavicle right
viii. Elbow left
ix. Elbow right
x. Femur left
xi. Femur right
xii. Finger left
xiii. Finger right
xiv. Foot 4 views left
xv. Foot 4 views right
xvi. Forearm left
xvii. Forearm right
xviii. Hand 4 views left

xix. Hand 4 views right
xx. Hip Left, with AP Pelvis
xxi. Hip Right with AP Pelvis
xxii. Humerus left
xxiii. Humerus right
xxiv. Knee left
xxv. Knee right
xxvi. Shoulder left
xxvii. Shoulder right
xxviii. Tibia/Fibula left
xxix. Tibia/Fibula right
xxx. Wrist 4 views left
xxxi. Wrist 4 views right
xxxii. X-ray extremity wound site if suspect foreign body

G. Fever in children ~~under 3 months of age~~**who are under 90 days old:**

1. In patients who are under ~~3 months~~**90 days** of age and who present to ED with rectal temperature of 38°C (100.4°F) or greater, assign an emergency severity index (ESI) level 2 and arrange for immediate placement in the treatment area. The RN shall order the following:
   a. Labs:
      i. CBCD
      ii. Metabolic Panel, Basic
      iii. C-Reactive Protein (CRP)
      iv. Blood Culture (only one required for less than 3 months of age)
   b. Nurse Orders:
      i. Routine urinalysis, catheter specimen
      ii. Urine culture
      iii. Pulse oximetry monitoring
      iv. Initiate intravenous (IV) saline lock
   c. Medications:
      i. Acetaminophen 15 mg/kg ~~PO or~~ PR times one (1)
         ~~1) Maximum 2600mg/day~~
         ~~2)~~**1)** Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
   d. Radiology:
      i. X-Ray: Chest 2 View PA and LAT

H. Fever in ~~patients~~ **children** ~~older than 3 months~~**from 91 days old to 18 years** of age:

1. In patients who present to the ED with fever, the RN shall order:
   a. Medications:
      i. Acetaminophen
         1) For ages ~~3 months~~**91 days** - 11 years, acetaminophen 15mg/kg PO or PR times one (1), round to nearest 5mg
            a) Maximum ~~2600mg/day~~ **325 mg/dose**
            b) Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
         2) For ~~12 years and older~~**patients who are greater than or equal to 12 years of age**, acetaminophen ~~325mg~~ **15mg/kg** PO or PR times one (1)
            a) Maximum ~~3000mg/day~~ **650 mg/dose**
            b) Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
      ii. Ibuprofen
         1) For ages 6 months to 11 years, ibuprofen 10mg/kg PO times one (1), round to nearest 5mg

a) Maximum ~~40mg/kg/day~~ **400 mg/dose**
b) Hold if the patient has received ibuprofen or ibuprofen containing products in the past 6 hours.

2) For 12 years and older, ibuprofen 400mg PO times one (1)
~~a)~~ ~~Maximum 3200mg/day~~
b) Hold if the patient has received ibuprofen or ibuprofen containing products in the past 6 hours.

I. Generalized Weakness, Syncope, Dizziness or Altered Mental Status

1. In patients who present to ED with generalized weakness, syncope, or dizziness, **or altered mental status** the RN shall order the following:

a. Cardiology:
i. STAT EKG
1) Print old EKG if available
2) STAT ED EKG's will be completed with a goal of 10 minutes of being ordered and delivered directly to an ED physician to rule out STEMI.

b. Labs:
i. CBCD
ii. Metabolic Panel, Comprehensive
iii. Creatine Kinase (CPK)
iv. CK, Mb Fraction (CKMB) if CK elevated
v. Cardiac Troponin (Troponin I)
~~v.~~**vi. TSH**

c. Nurse Orders:
i. Routine urinalysis, clean catch
ii. Urine culture, clean catch
iii. Serum HCG if female and 10 – 55 years of age

d. Radiology:
i. Chest X-ray 2 View PA and LAT
1) If patient female and under 50 years of age, shield pelvis

J. Gastro Intestinal (GI) Bleed

1. In patients ~~16 years or older~~ **greater than or equal to 16 years old** who present to **the** ED with the complaint of blood in the stool, vomiting of blood or coffee ground emesis, ~~and a systolic blood pressure (SBP) less than or equal to 90 mmHg,~~ the RN shall order the following:

~~a. Nurse Orders:~~
~~i. Initiate two 16 gauge (if possible) peripheral IVs~~

~~b. Medications:~~
~~i. Administer 500 ml~~ **mL** ~~0.9 NaCl IV fluid bolus times one (1), infuse over 30 minutes~~

~~c.~~**a.** Labs:
i. Type and Screen
ii. Check capillary blood glucose
iii. CBCD
iv. Metabolic Panel, Comprehensive
v. INR

b. Insert 18g IV

c. If SBP <=90, or HR > 120, the RN shall
i. insert 16g IV x 2
ii. Administer 500 mL 0.9 NaCl IV fluid bolus times one (1), infuse wide open
~~iv.~~

K. Psychiatric Evaluation

~~1. Patients who present to the ED with suicidal ideation, hallucinations, delusions, or who are an immediate safety risk to self or others will be assigned an Emergency Severity Index (ESI) Level 2 and moved to the treatment area as soon as possible. If immediate bed placement is not possible for psychiatric patients at risk, security should be notified for direct observation while bed placement is arranged.~~

1. ~~If the~~**In** patients ~~who~~ **who** present to the ED with **suicidal ideation, hallucinations, delusions, or who are an immediate safety risk to self or others** ~~the above complaints~~
2. ~~T~~the RN shall order the following:
   a. Labs:
      i. CBCD
      ii. Metabolic Panel, Comprehensive
      iii. Ethanol, Serum (Blood Alcohol Level)
      iv. Urine toxicology screen
      v. Cannabinoid level
      vi. TSH level
      vii. Serum HCG if female age 10 to 55
   b. Nurse Orders:
      i. Urinalysis, routine with reflex culture
   ~~i.~~**c. For the patient with suicidal ideation the RN shall implement suicide observation and precautions per the Patient Care Services Policy: Assessing and Managing Patient at Risk for Suicide.**

L. Sepsis

~~1. If patient presents to triage~~**In patients who are >= 18 years old** with signs/symptoms of SEPSIS including:

~~a.~~ Temperature **greater than (>=)** 38.3 or **less than (<)** 36 (or history of recent fever/ infection) ~~Plus~~**PLUS heart rate above 90 and/or respiratory rate above 20 and or Systolic Blood Pressure Below 90mmHg**

~~b.~~

~~c.~~**a.** ~~Plus heart rate above 90 and/or respiratory rate above 20 and or Systolic Blood Pressure Below 90mmHg~~

2. The **RN**~~Nurse~~ shall order the following:
   a. Laboratory:
      i. CBCD
      ii. Metabolic Panel, Comprehensive
      iii. Blood Cultures times 2
      iv. Lactate with repeat lactate **per sepsis protocol**
      v. JIC Blood Bank
      vi. Urinalysis with reflex to culture
      vii. Serum HCG if female and 10 to 55 years of age
      viii. Amylase
      ix. Lipase
      x. Magnesium
      xi. Phosphate
      xii. INR
      xiii. Troponin
      ~~vii.~~**xiv. PTT**
   b. Radiology: Chest Xray: **posteroanterior and lateral**
   c. Cardiology: Stat EKG
   d. Nursing:
      i. Start 18 gauge IV **(preferred)**
      ii. Fluid Bolus 500 mL Normal Saline **wide open**
      iii. Cardiac Monitor
      iv. Pulse oximeter

v. **O2 2 l/min by nasal cannula (titrate to keep O2 saturation above 92%)**

~~ii.~~**vi. Notify Physician to consider activating "Code Sepsis"**

M. Vaginal Bleeding, ~~Known~~ **Possible** Pregnancy:

1. In patients who present to the ED with vaginal bleeding, and ~~who are pregnant~~**states she is pregnant or could be pregnant,** the RN shall order the following:
   a. Labs:
      i. CBCD
      ii. ABORh Type
      iii. Beta HCG, Quantitative
      ~~i)~~**iv. Routine urinalysis with reflux culture~~, catheter specimen~~**
      ~~iii.~~
   b. Nurse Orders:
      i. If heart rate is greater than 120 BPM or the systolic blood pressure is less than 90 mmHg:
         1) Immediately notify physician of patient's condition
         2) Initiate two 16 gauge (if possible) peripheral IV's
         3) Set up for pelvic exam and notify physician
         4) ~~Routine urinalysis with reflux culture, catheter specimen~~
         ~~c.~~**5)** Medications:
            a) Administer 500 ml 0.9 NaCl IV fluid bolus times one, infuse over 30 minutes
   c. Radiology:
      i. **RN may order pelvic ultrasound after consultation with MD or PA**

N. Vomiting, Diarrhea, Dehydration:

1. In patients who present to the ED with vomiting, diarrhea and or dehydration the RN shall order the following:
   a. Laboratory:
      i. CBCD
      ii. Metabolic Panel, Comprehensive
      iii. Urinalysis with reflex to culture
      iv. Serum HCG if female and 10 to 55 years of age
   ~~a.~~**b.** Nurse orders:
      i. Initiate peripheral IV for severe vomiting
   ~~b.~~**c.** Medications:
      i. Adults (16 years of age and older):
         1) Ondansetron ~~8~~ 4 mg ODT times one (1)
         2) Ondansetron 4 mg IVP times one (1) for severe vomiting.
      ii. Pediatrics (0 to 15 years of age):
         1) Ondansetron 2 mg ODT times one (1) in patients less than 15 kg
         2) Ondansetron 4 mg ODT times one (1) in patients greater than 15 kg

O. General Pain Management

1. In patients who are greater than or equal to 12 years of age, who present to the ED with complaints of mild PAIN (1-3) from any cause, the RN may order the following
   a. Acetaminophen 15 mg/kg po x 1
      i. Maximum 650 mg/dose
      ii. Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours
   b. For moderate or severe pain, consult physician

2. In patients who are 6-11 years of age, who present to the ED with complaints of mild PAIN (1-3) from any cause, the RN may order the following:
   a. Acetaminophen 15 mg/kg po x 1
      i. Maximum dose 325 mg

ii. **Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours**

b. **For moderate or severe pain, consult physician**

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

A. Current California unencumbered RN license

~~A.~~B. Excellent customer service communication

~~B.~~C. Education: Successful completion of Standardized Procedure training

~~C.~~D. Initial Evaluation: Demonstrated competency

~~D.~~E. Ongoing Evaluation: Annually ~~skills lab.~~

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

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration. New standardized procedures or additions to existing standardized procedures will be approved by the Department of Emergency Medicine, Pharmacy and Therapeutics (if medications are involved) and the TCMC Board of Directors.

B. Review: Every two (2) years

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

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

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

A. Patient Care Services Policy: Assessing and Managing Patient at Risk for Suicide

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**GASTRIC INTUBATION (GI), ADULT**
Purpose:	To define the nursing management of adult or adolescent patients experiencing GI intubation (Nasal, Visceral, and Oral).
Equipment:	Nasogastric (NG), Orogastric **(OG)**, or small bore feeding tube, i.e., Keofeed tube Salem-Sump or suction device with tubing and suction container Irrigation set Sterile H_2O for irrigation Sterile Normal Saline Tap water Hydrogen peroxide Cotton swabs Fenestrated 4 x 4 Skin barrier Silk tape and/or tube holder 10 mL syringe Anti-reflux valve Water soluble lubricant

A. **POLICY:**

~~1. Ensure functionality of nasogastric tubes every hour~~

~~2. Keep all clamped tubes elevated above insertion site if possible to prevent leakage of contents~~

~~3. Unclamp any clamped tubing should nausea/vomiting occur and note amount of drainage~~

1. ~~Avoid accidental pulling of tube~~**Ensure the tube are secured properly at every shift**
2. Provide lip and oral care at least every 2 hours **for patient with NG, OG or small bore feeding tubes**
3. Maintain NPO status and oral care, unless otherwise ordered
4. If nasogastric/feeding tube is accidentally removed, contact physician for reinsertion orders.
5. Verify order for movement of tube in patients with gastric surgery
6. **Assess skin per Patient Care Services (PCS) Policy: Skin and Wound Care**
7. **Obtain physician order prior to irrigating gastric tubes for patients with gastric surgery.**
   - **a. For gastric surgical patients use 20 mL sterile normal saline or sterile water, unless otherwise ordered.**

~~5.~~**8. Sterile saline or water to be used in critically ill or immunocompromised patients**

~~6.~~**9.** See **Online Clinical Skills**~~Mosby's Nursing Skills~~ for the following comprehensive procedure:

- ~~a. Nasogastric (NG) Tube for Gastric Decompression~~
- ~~b.~~**a.** Nasogastric Tube: Insertion, Irrigation, and Removal
  - i. Tri-City Medical Center (TCMC) does not use pH testing for verification of placement
- ~~c. Small Bore Feeding Tube Insertion and Care~~
- ~~d.~~**b.** Feeding Tube: Small Bore Insertion and Care
  - i. TCMC does not use pH testing for verification of placement
- ~~e.~~**c.** Feeding Tube: Verification of Placement
  - **i.** TCMC does not use pH testing for verification of placement
- **d. Feeding Tube: Medication Administration.**
- ~~f.~~**e. Feeding tube: Enteral Nutrition via Nasoenteric, Gastrostomy or Jejunostomy tube**
- ~~g. Feeding Tubes: Irrigation~~

10. It is recommended that endotracheally intubated patients requiring gastric lavage, decompression or enteral feeding have an orogastric (OG) tube placed.

11. Medication Administration:

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Council	Department of Surgery	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/00, 03/03, 04/06, 01/08, 04/11, 04/15, 08/16	03/11, 04/15, 01/14, 11/16	03/11, 04/15, 01/17	06/15, 06/19	11/15, 07/19	08/19	04/11, n/a	04/11

a. **If tube is to suction and oral medications must be given, clamp the tube for 30 minutes before reattaching suction.**
b. **If the patient is receiving enteral feeding:**
   i. **Stop feeding infusion**
   ii. **Line should be flushed with 15 – 30 mL of water before and after each drug is administered**
   iii. **Resume feeding**
      1) **Pharmacist will notify nurse if feeds must be held for a longer period of time before/after drug administration to avoid drug interactions (e.g., phenytoin, carbamazepine, and fluoroquinolone antibiotics)**

B. **SPECIAL CONSIDERATIONS FOR NASOGASTRIC INTUBATION:**

1. **Ensure functionality of nasogastric tubes every 12 hours and PRN**
2. **Keep all clamped tubes elevated above insertion site if possible to prevent leakage of contents**
3. **Unclamp any clamped tubing should nausea/vomiting occur and note amount of drainage**
~~6.~~4. Irrigate tubing every 4 hours and PRN to maintain patency
   ~~b. Obtain physician order prior to irrigating gastric tubes for patients with gastric surgery.~~
      ~~i. For GI surgical patients use 20 mL sterile normal saline or sterile water, unless otherwise ordered.~~
   ~~c.~~a. For NG, OG, gastric or small bore feeding tubes use 20 **-** 30 mL tap water, sterile normal saline or sterile water **appropriate to patient's diagnosis**
      ~~i. Sterile saline or water to be used in critically ill or immunocompromised patients~~
   ~~d.~~b. Account for amount of irrigant.
~~7.~~5. Ensure the vent (blue lumen) has a patent anti-reflux valve connected at the end of the lumen.
   ~~b.~~a. Insert 20 mL of air into the anti-reflux filter (connector at the end of the blue lumen) every 2 hours and PRN (if gastric contents are in vent lumen) using a 10 mL syringe while patient is connected to suction.
   ~~c.~~b. Replace anti-reflux valve if not patent or if saturated with GI contents
~~8.~~6. Connect all nasogastric drainage tubes to low constant suction unless ordered otherwise.
   ~~b.~~a. Replace suction canisters when ¾ full. Add solidification gel to used canister and discard.
~~9.~~7. Elevate head of bed at least 30 degrees unless contraindicated.
~~10.~~8. Provide nares care every 4 hours with H_2O soluble lubricant.
   ~~b.~~a. Use anesthetic ointment should nares become tender with skin irritation.
~~11.~~9. Secure tubing to nose using tube holders (or silk tape/steri-strips if tube holder not available) to prevent unnecessary pressure on nares.

~~B.~~C. **SPECIAL CONSIDERATIONS FOR GASTRIC (G-TUBE) AND JEJUNOSTOMY (J-TUBE):**

~~6.~~1. Irrigate clamped tubes with ~~20~~30 mL sterile normal saline or tap water every 8 hours to ensure patency or as ordered
~~7.~~2. Clamp or plug proximal end of gastrostomy or jejunostomy tube at all times when not in use for feeding.
~~8.~~3. Perform site care daily and PRN
   ~~b.~~a. Cleanse around the tube at the insertion site with a cotton swab and sterile normal saline
      i. For crusty drainage cleanse with a cotton swab and diluted hydrogen peroxide (50% hydrogen peroxide and 50% sterile saline) until site is clear of drainage, then rinse with a cotton swab and sterile normal saline
      ii. If redness or maceration is noted, order a referral to Enterostomal Therapist if available.
   ~~c.~~b. Apply skin barrier
   ~~d.~~c. Apply dressing

i. DO NOT use scissors to cut the dressing from around the tube.
ii. Place pre-cut drain sponges around tube and secure with tape sparingly.
iii. Coil the clamped tube over and lay it on top of dressing to reduce tension on suture line/insertion site

~~9.~~4. Administer feedings as ordered
   ~~b.~~a. Maintain patient in a semi-Fowlers position during and for 30 minutes following any feeding/instillation.
   ~~c.~~b. Observe for a sense of fullness and/or regurgitation after the feeding, or leakage around the tube at the insertion site.
   ~~d.~~c. Cleanse all containers and tubing thoroughly with warm water to reduce possible bacterial growth.
   ~~e.~~d. Avoid air bubbles in the system to reduce chance of abdominal distention.
~~10.~~5. In case of tube dislodgement/accidental removal, cover opening with sterile 4x4 gauze dressing and notify physician.

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

1. Bard Medical Division (2004). Bard NG tubes: Complete system for comprehensive care. Retrieved November 2016~~4~~ from http://www.bardmedical.com.
2. Perry, A.G. ~~and~~ Potter, P.A., **and Ostendorf, W. R.** (2010~~4~~). Clinical nursing skills and techniques: ~~Nasogastric tubes for gastric decompression~~ **Feeding tube: Medication administration**. (~~7~~8th ed.) St. Louis: Mosby. Retrieved November 2010~~6~~ from TCMC Intranet.
3. **Perry, A.G. Potter, P.A., and Ostendorf, W. R. (2014). Clinical nursing skills and techniques: Feeding tube: Enteral nutrition via nasoenteric, gastrostomy, or jejunostomy tube. St. Louis: Mosby. Retrieved November 2016 from TCMC Intranet.**
~~2.~~4. **Williams, N. (2008). Medication Administration Through Enteral Feeding Tubes. *American Journal of Health-System Pharmacy, 65*(24), 2347 – 2357.**

Tri-City Medical Center
Oceanside, California

DELETE – not needed, will obtain physician order PRN

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: LOCAL ANESTHETIC PRIOR TO INTRAVENOUS INSERTIONS

I. **POLICY:**
- A. Function:
  1. Administration of a local anesthetic for pain management during insertion of intravenous (IV) lines.
- B. Circumstances:
  1. Setting: Patient Care areas
  2. Population: Adult, Pediatrics and infant patients
  3. Contraindications: Allergy to lidocaine or prilocaine
  4. Supervision: None required

II. **PROCEDURE:**
- A. Pre procedure
  1. Criteria for use:
     - a. Deeper insertion
     - b. Patient anxiety due to IV insertion
     - c. Difficult insertion
     - d. Patient request
  2. Assess for appropriate IV insertion site.
  3. Explain rationale for use of topical anesthetic prior to IV insertion to patient/parent/caregiver/significant other.
- B. Procedure
  1. Topical Anesthetic Cream (lidocaine and/or prilocaine) Administration
     - a. Equipment: Tegaderm patch or tape
       - i. Alcohol or chlorhexidine wipe
       - ii. Topical Anesthetic Cream (EMLA/ELA-MAX)
     - b. Administration:
       - i. Swab insertion site with alcohol or chlorhexidine wipe.
       - ii. Apply generous 1 inch square of topical anesthetic cream over insertion site.
       - iii. Cover with Tegaderm or tape per manufacturer's instructions.
       - iv. Wait for minimum amount of time per manufacturer's instructions.
     - c. Insert IV per policy
  2. Intradermal Lidocaine Administration
     - a. Equipment:
       - i. TB syringe with appropriate 27 g needle attachment
       - ii. Alcohol or chlorhexidine wipe
       - iii. Lidocaine 1% without epinephrine
     - b. Administration:
       - i. Draw up 0.1 mL of Lidocaine in a syringe.
       - ii. Swab insertion site with alcohol or chlorhexidine wipe.
       - iii. Inject Lidocaine intradermally to form a wheal at insertion site.
       - iv. Wait at least 1 minute.
       - v. Insert IV per Online Clinical Skills: Intravenous Therapy: Initiation.
  3. Post procedure
     - a. Assess and monitor the following:
       - i. Erythema

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Interdisciplinary Practice Committee	Medical Executive Committee	Admin	Professional Affairs Committee	Board of Directors
07/15	09/15, 01/19	09/15, 01/19	n/a	12/15, 03/19	07/16, 04/19	09/16, 07/19	08/19	10/16, n/a	11/16

ii. Swelling
iii. Potential allergic reaction
b. Educate patient/parent/caregiver/significant other on complications listed above.

III. **DOCUMENTATION:**
A. Complete documentation in the Electronic Health Record (EHR)
B. Enter order for initiation of standardized procedure per policy.
C. Medications are documented in the Medication Administration Record (MAR).
D. Insertion procedure and patient response is documented in the IVIEW band.

IV. **EXTERNAL LINKS:**
A. Online Clinical Skills: Intravenous Therapy Initiation

V. **REQUIREMENTS FOR CLINICIANS PROVIDING INTERVENTIONS:**
A. Current California RN license
B. Initial Evaluation: Orientation
C. Ongoing Evaluation: Ongoing

VI. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**
A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine and Administration.
B. Review: Every 2 years or review procedure per Hospital policy.

VII. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**
A. All Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform Local Anesthetic Prior to Intravenous Insertions.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**01/86**	**SUBJECT:**	**Organ Donation, Including Tissue and Eyes**
REVISION DATE(S):	**01/90, 04/94, 03/97, 07/03, 10/05 07/07, 05/08, 01/11, 08/11**	~~**POLICY NUMBER: IV.P.2**~~	

Patient Care Services Content Expert Approval:	**05/19**
Clinical Policies & Procedures Committee Approval:	~~**10/15**~~**07/19**
Nurse~~ing~~ Executive Committee~~uncil~~ Approval:	~~**10/15**~~**07/19**
Medical Staff Department or Division:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	~~**11/15**~~**07/19**
Administration Approval:	**08/19**
Professional Affairs Committee Approval:	~~**01/16**~~ **n/a**
Board of Directors Approval:	**01/16**

A. **PURPOSE:**

1. This policy provides staff with guidance for:
   a. Recognition of imminent death and provision of patient and family care needs.
   b. The hospital's obligations for the referral of potential donors for organ, tissue, and eye donation.
   c. Delineation of the hospital's responsibilities and the Organ Procurement Agency's responsibilities in completing the referral and donation of anatomical gift process.
   d. The management of potential donors to include billing responsibilities.

B. **DEFINITIONS:**

1. Anatomical Gift: Donation of all or part of a human body to take effect upon or after death. Donation categories are as follows:
   a. Organ Donor:
      i. A brain dead individual whose cardiopulmonary function is being artificially maintained for the purpose of solid organ donation.
      ii. An individual whose organ(s) can be recovered for transplant after the heart has stopped (Donation after~~-Cardiac~~ **Circulatory** Death/DCD.)
   b. Tissue Donor: Brain dead or cardiac dead individual who may donate their skin, heart valves, bone or cartilage.
   c. Eye Donor: Brain or circulatory dead individual who may donate their eyes.
2. Imminent Death: Anticipated death of a patient on a ventilator or potentially brain dead. Guidance for determining imminent death include the following:
   a. A ventilated patient with a devastating illness or injury who is in Intensive Care Unit or Emergency Department; and, in addition has one of the following:
      i. Clinical findings that are consistent with a Glasgow Coma Scale (GCS) that is less than or equal to 4 (<4) without sedation or paralytics; or:
   b. For whom physicians are evaluating a diagnosis of brain death; or
   c. For whom a physician is considering that life-sustaining therapies be withdrawn, pursuant to the family's decision.
   d. Reference ~~Attachment A: p~~Patient Recognized as Imminent Death Flowchart
3. Brain Death: An irreversible cessation of all functions of the entire brain, including the brain stem. (Health and Safety Code Section 7180). A physician may determine an individual has

suffered brain death (as defined by statute.) Law requires that a second physician independently confirm the patient's brain death. (Health & Safety Code Section 7181.)

4. Circulatory Death: Irreversible cessation of cardiac and respiratory functions. Declaration of death will be determined when there is no palpable pulse, no heart beat by auscultation (mechanical heart beat), and no respiratory efforts. A five minute wait period is required to confirm cessation of vital functions to declare circulatory death.
5. Designated Requestor: Staff from the Organ Procurement Agency, Lifesharing or the San Diego Eye Bank or their representative who has completed appropriate training. Training includes the methodology for approaching potential donor families and informed consent process for requesting organ, tissue and eye donation.
6. Organ Procurement Organization (Agency): Lifesharing has been designated by the United States Department of Health and Human Services (DHHS) as the organ procurement agency for San Diego and Imperial Counties within the meaning of 42 C.F.R. 486.301 et. Sew.; is a member, in good standing, of the Organ Procurement and Transplantation Network established under the Act; and is a certified member, in good standing, of the American Association of Tissue Banks.
7. CDCR: California Department of Corrections and Rehabilitation
8. SDSD: San Diego County Sheriff Department

C. **PERSONNEL:**

1. Care Team Members: Registered Nurses, Physicians, Social Services, Case Managers, Chaplains, or members of Spiritual Care Services.

D. **POLICY:**

1. Tri-City Medical Center recognizes that patients and families facing imminent death have special needs and to the extent possible, will be afforded any reasonable religious or cultural practices surrounding the issue of death. Families or next of kin will be afforded time to gather family or next of kin at the patient's bedside and understand the diagnosis and treatment options as well as the patient's right to donate or not donate organ and tissues.
2. Tri-City Medical Center is committed to ensuring that every individual or family of a potential donor in collaboration with Lifesharing (Organ Procurement Organization) is informed by a designated requestor of their option to donate organs or tissue or not to donate. Additionally, Lifesharing, San Diego Eye Bank and Tri-City Medical Center are dedicated to educating staff of donation issues and are accountable for the Organ Procurement Program effectiveness.
    a. Lifesharing is the federally designated organ procurement agency for TCMC. Lifesharing has:
        i. Consulted with the San Diego Eye Bank and developed a protocol for identification and notification of potential eye donors.
        ii. Specified the San Diego Eye Bank as an appropriate third party for death notification on potential eye donors.
    b. Hospital obligations at time of death and imminent patient death:
        i. Make a reasonable search for a document of anatomical gift or donation, e.g. advance directive, statement attached to driver's license, or other information specifying refusal of donation, if there is not immediately available any other source of that information.
        ii. Refer to Lifesharing, in a timely manner, of all deaths and imminent deaths that occur in the hospital (regardless of the deceased's medical suitability for organ donation and regardless if patient is in CDCR or SDSD Forensics/Custody.
            1) Neonatal death defined as live birth delivery requiring death certificate is reportable.
        ~~iii.~~ ~~Live birth defined as:~~
        iv. Miscarriage/abortion or fetal deaths are not reportable.

c. Lifesharing staff/representative, as Designated Requestors, are responsible for approaching potential donor families and obtaining authorization in the process of requesting organ, tissue and eye donation.
d. Lifesharing will ensure there is a diligent search for a legal representative or evidence of an individual's wishes regarding donation. If a search does not reveal a legal representative or documentation of wishes, a release from the Medical Examiner Office will be obtained and the Hospital Risk Manager contracted to facilitate donation authorization from hospital administration.

3. All healthcare providers will display discretion and sensitivity with respect to the circumstances, views, wishes, and beliefs of the families of potential donors.
4. Lifesharing shall monitor and provide reports of eligible organ donors and organ donor conversion rates for inclusion in the hospital performance improvement activities.

E. **RESPONSIBILITIES:**

1. Hospital
   a. Primary nurse or physician must notify Lifesharing referral service of all imminent deaths as soon as possible, and within one hour of circulatory death.
      i. Nurse/physician is not responsible for screening potential donors. This is the responsibility of Lifesharing or its designated representatives, such as the San Diego Eye Bank..
   b. At the time of referral, provide the following information:
      i. Name and medical record number;
      ii. Age/Sex/Race;
      iii. Height and weight;
      iv. Time and cause of death (for cardiac death.)
   c. Document all referrals including imminent deaths on Expiration Record in Cerner or if necessary on a hard copy Release of Deceased form. (Refer to Patient Care Services Procedure Manual, Release of Deceased) Documentation includes::
      i. Date and time of referral
      ii. Name of person contacted at Lifesharing;
      iii. Referral number (when provided by Lifesharing);
      iv. Determination by procurement agency
      v. Either:
         1) Patient was declined as donor; or
         2) Agency will further evaluate patient as a potential donor and approach the family for donation.
2. Ensure families are not approached regarding potential donation until:
   a. Attending physician (or his/her representative) has informed family of patient's irreversible condition, brain death or imminent death.
   b. Circulatory death has occurred and patient's death has been reported via donor referral service.
3. Family Notification of Donation Options and Discussion:
   a. The health care team members should not initiate the donation discussion with the family. Health care team member having a relationship with the patient or family should, when possible, collaborate with, and facilitate the discussion between the Lifesharing Designated Requestor and the family regarding options for organ and tissue donation.
   b. If the patient's family initiates discussion regarding donation, Lifesharing will be notified immediately and the family informed that all their questions can be fully answered by staff from Lifesharing or the San Diego Eye Bank. Lifesharing or the San Diego Eye bank shall notify the nurse or physician of the potential donor's suitability for donation.
   c. Upon notification by Lifesharing and/or the San Diego Eye Bank that the potential donor is found to be registered on the Donate Life California Organ and Tissue Donor Registry, collaborate with them to confirm:
      i. The identity is correct per the legal decision maker

ii. Plans are consistent with any expressed wishes in a valid document pursuant the **Uniform Anatomical Gift Act** (UAGA) as defined in California Law (CA H&S 7150), and the Motor Vehicle Code (CA MVC 12811), an anatomical gift, that is not revoked by the donor before death, is irrevocable and does not require authorization or concurrence of any other person after the donor's death. This includes an anatomical gift that is made by means of and/or is registered in the California Organ and Tissue Donor Registry or other State registry designated by law.

iii. In circumstances of preauthorization by the patient, support Lifesharing efforts with sensitivity and cultural consideration, to communicate to the legal decision maker, the plans to proceed with donation.

4. Physician
   a. The medical management of the patient prior to brain/circulatory death remains the responsibility of TCMC attending physician. Medical Management to ensure organ viability will be continued until Lifesharing confirms suitability and options have been presented to the family.
   b. When a hospital refers an individual at or near death to a procurement organization, the organization may conduct any reasonable examination necessary to ensure the medical suitability of an organ/tissue that is or could be the subject of an anatomical gift for transplantation, therapy, research, or education from a donor or a prospective donor. During the examination period, measures necessary to ensure the medical suitability of the part may not be withdrawn unless the hospital or procurement organization knows that the individual expressed a contrary intent.
5. Lifesharing
   a. Screen each referred patient based on current medical criteria for organ, tissue and eye donation. Lifesharing will refer circulatory dead patients to the appropriate agency for screening for potential eye and tissue donation.
   b. The "Designated Requestor" (in collaboration with the health care team when possible) will initiate contact with family about donation options and obtain authorization from the legal decision-maker upon report of death, imminent death or brain death.
   c. Collaborate with the primary physician to provide physiological maintenance while suitability for donation is being evaluated. The cost associated with a procedure required or medication given solely for the purpose of maintaining organ viability for donation will be assumed by Lifesharing.
   d. Document authorization on Lifesharing Form "Authorization for Organ and Tissue Donation".
      i. Authorization may be obtained via telephone utilizing recording device, a hospital staff witness or a recorded line.
      ii. Provide family with a copy of the authorization form.
      iii. Place original copy of the authorization form in the patient's medical record.
   e. Screen all deaths for Medical Examiner criteria and obtain consent from the Medical Examiner for donation, if applicable.
   f. Inform the Medical Examiner of the intent to pursue Donation by Circulatory Death.
   g. Advise hospital staff of suitability for donation and subsequent steps to follow, i.e. implement corneal protective measures or provide the reason for the patient being declined as a donor.
   h. Update nurses, physicians, operating room staff and others as appropriate for status of donation.
   i. Document all events, procedures and donor management in the medical record.
   j. Notify appropriate hospital staff of final outcome of referral.

F. **PROCEDURES:**

1. Primary nurse in collaboration with or the physician must notify Lifesharing referral service by calling 1-888-4ADONOR (1-888-423-6667) for all circulatory deaths within one hour and in the

case of recognition of imminent death, as soon as possible, ideally within one hour. (~~Attachment A:~~**See** Patient Identified as Imminent Death Flowchart)

2. Management of Brain Death Donation (~~Attachment C:~~**See** Brain Death Donation Option Flowchart).
   a. Once family is informed of brain death, assess and document in plan of care spiritual, cultural needs and accommodate as possible. Encourage family/health care decision maker to obtain as much information as possible from the clinical staff to understand the diagnosis and prognosis provide family reasonable brief period of time (generally not greater than 24 hours) to gather family/next of kin at bedside and agree to discontinuation of cardiopulmonary support.
   b. Primary nurse and physician will collaborate regarding status of potential donor and confirmation of brain death diagnosis with Lifesharing.
   c. Refer to the Lifesharing Catastrophic Brain Injury Guidelines at Lifesharing's website at http://www.lifesharing.org
   d. Primary nurse will assist Procurement Coordinator to maintain potential internal organ donors on support systems until recovery of organs can occur in the operating room.
3. Management of the process for Donation after Circulatory Death (~~Attachment D:~~**See** Circulatory Death Donation Option Flowchart)
   a. A note by the physician, documenting the decision to withdraw life supporting therapy must be placed in the chart prior to requesting decision to withdraw life sustaining treatment or advise the family or hospital regarding medication used or procedure for withdrawal of support.
   b. Lifesharing is notified to determine suitability for the purpose of establishing donation options to be offered to the family.
   c. Care staff allows family time to plan end of life care decisions, autopsy, and timing of withdrawal, palliative care options, and spiritual care.
   d. Lifesharing Designated Requestor advises the family of donation options. Family selects option and Lifesharing obtains all required authorizations. If the family does not select any donation option, the patient may be transferred to the appropriate level of care and palliative care will continue as planned.
   e. If the family authorizes the option of donation after circulatory death, the hospital care team will continue to provide the treatment to optimize organ viability until life sustaining measures are withdrawn. This may include line placement, laboratory testing, medications to improve organ function and reduce possibility of infection, and procedures to establish organ suitability, i.e. bronchoscope, x-rays, ultrasound, CT scan. All procedures and invasive studies and heparin will require separate authorization from the family and orders from the physician of record.
   f. Plan with the family when and where life support will be discontinued and transfer patient as necessary. Consider accommodations for the family as requested. Withdrawal of life sustaining treatment will proceed as agreed upon by the family and care team.
   g. Lifesharing personnel will be available to support the family and act as official time keeper for organ viability. This may include the presence of the Lifesharing Coordinator during withdrawal of life support. Lifesharing surgeons will not be present during withdrawal of life sustaining treatment.
   h. After circulatory death is declared, includes a five minute wait period to confirm cessation of vital functions by a physician or nurse with validated competency (not associated with the procurement team or a hospital transplant team), organ recovery will proceed as directed by Lifesharing team.
   i. If circulatory death does not occur within the timeframe for viable recovery, likely not to exceed two (2) hours, of the withdrawal of life support, the organ recovery plan will be terminated and the patient may be transferred to the appropriate level of care and palliative care will continue as planned.
4. Management of Potential Eye Donor
   a. Implement corneal integrity protective measures:

i. Close eyelids;
ii. Elevate head;
iii. Place light eye packs over closed eyelids within two (2) hours of death. Be sensitive to the family. This may be done after the family has left.

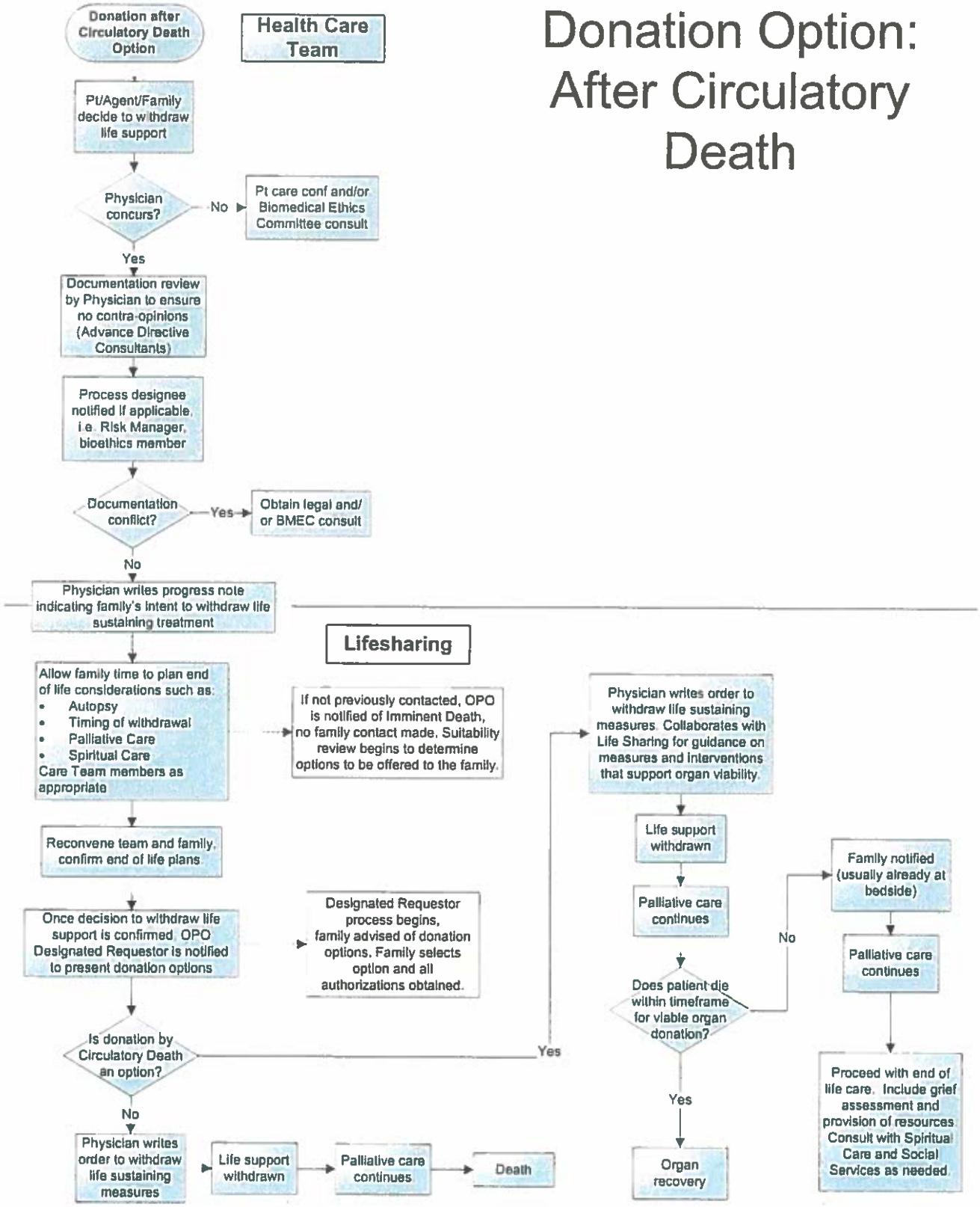
5. Billing Process
   a. No charges related to organ, tissue or eye donation will be billed to the donor, the donor's family or estate, or donor's third party payer. The appropriate recovery agency will assume all charges related to donation.
6. Organ Procurement Program Effectiveness
   a. Health Information Department will, on monthly basis or as requested, provide Lifesharing with the following data:
      i. Patient name;
      ii. MR number;
      iii. Admit date;
      iv. Date of Birth;
      v. Date of death;
      vi. All ICD10 diagnoses assigned to patient during hospitalization.
   b. Lifesharing will review records on a monthly basis, or as needed, to evaluate referral effectiveness of imminent and actual deaths for the opportunity of organ and tissue donation.
   c. Lifesharing will analyze data and provide organ donor conversion rates to the hospital as requested.
   d. Lifesharing will collaborate with performance improvement representatives to analyze data and identify actions to improve process where applicable.

G. **RELATED DOCUMENT(S):**
1. Donation Option: After Circulatory Death Flowchart
2. Donation Option: Brain Death Flowchart
3. Patient Recognized as Imminent Death Flowchart

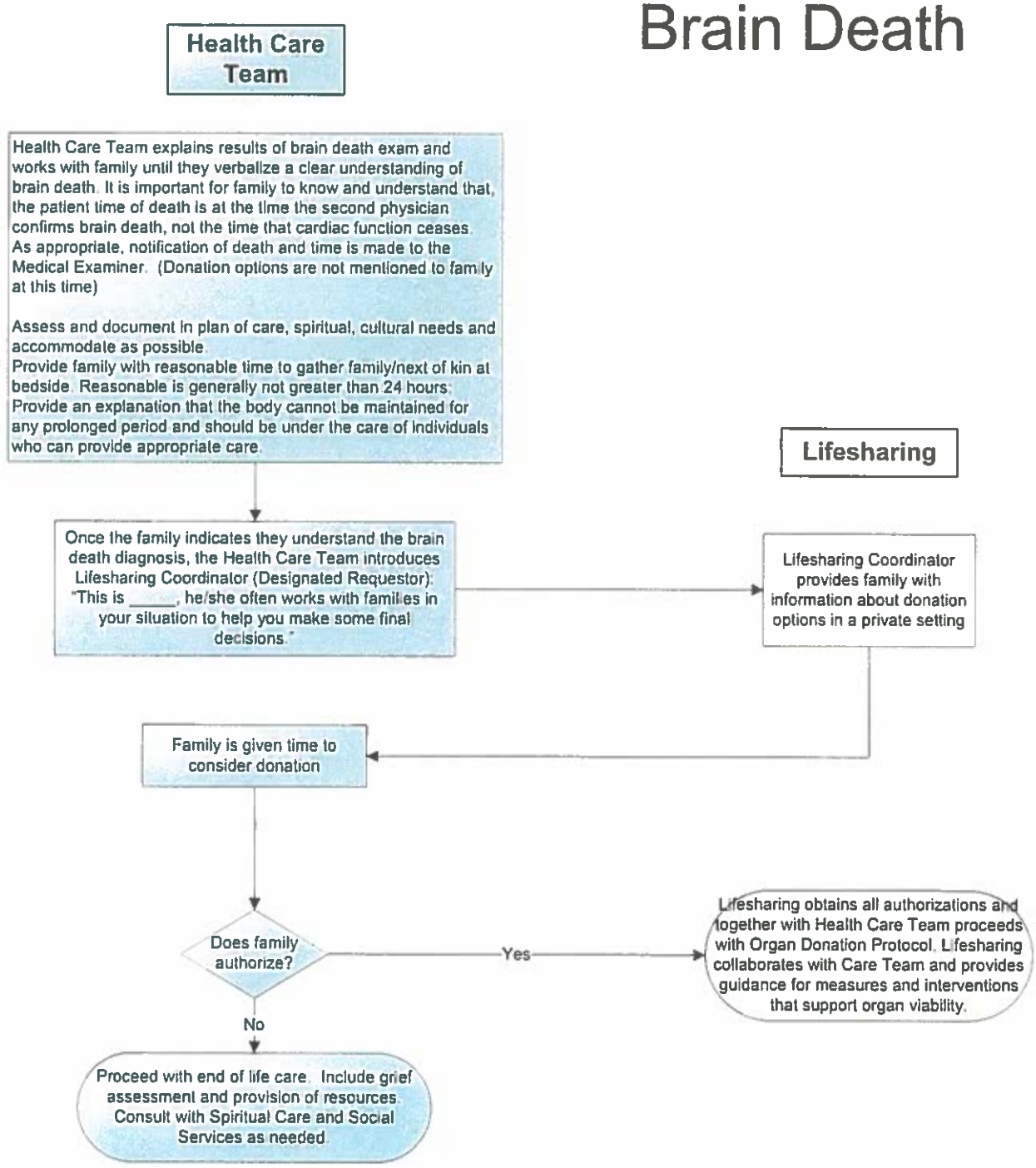
H. **EXTERNAL LINK(S):**
~~3.~~1. **http://www.lifesharing.org**

~~H.~~I. **REFERENCE(S):**
1. 42 CFR 482.45
2. American Academy of Neurology, current evidenced-based guidelines for Determining Brain Death
3. California Hospital Association, Consent Manual, Current Edition
4. California's Uniform Anatomical Gift Act (Health and Safety Code Sections 7150-7156.5, 7184. 1254/4
5. Lifesharing website: www.lifesharing.org
6. Physiologic Maintenance of Patients with Catastrophic Brain Injuries (Lifesharing)
7. San Diego Eye Bank website: www.sdeb.org
8. Section 9318 OBRA Hospital protocol

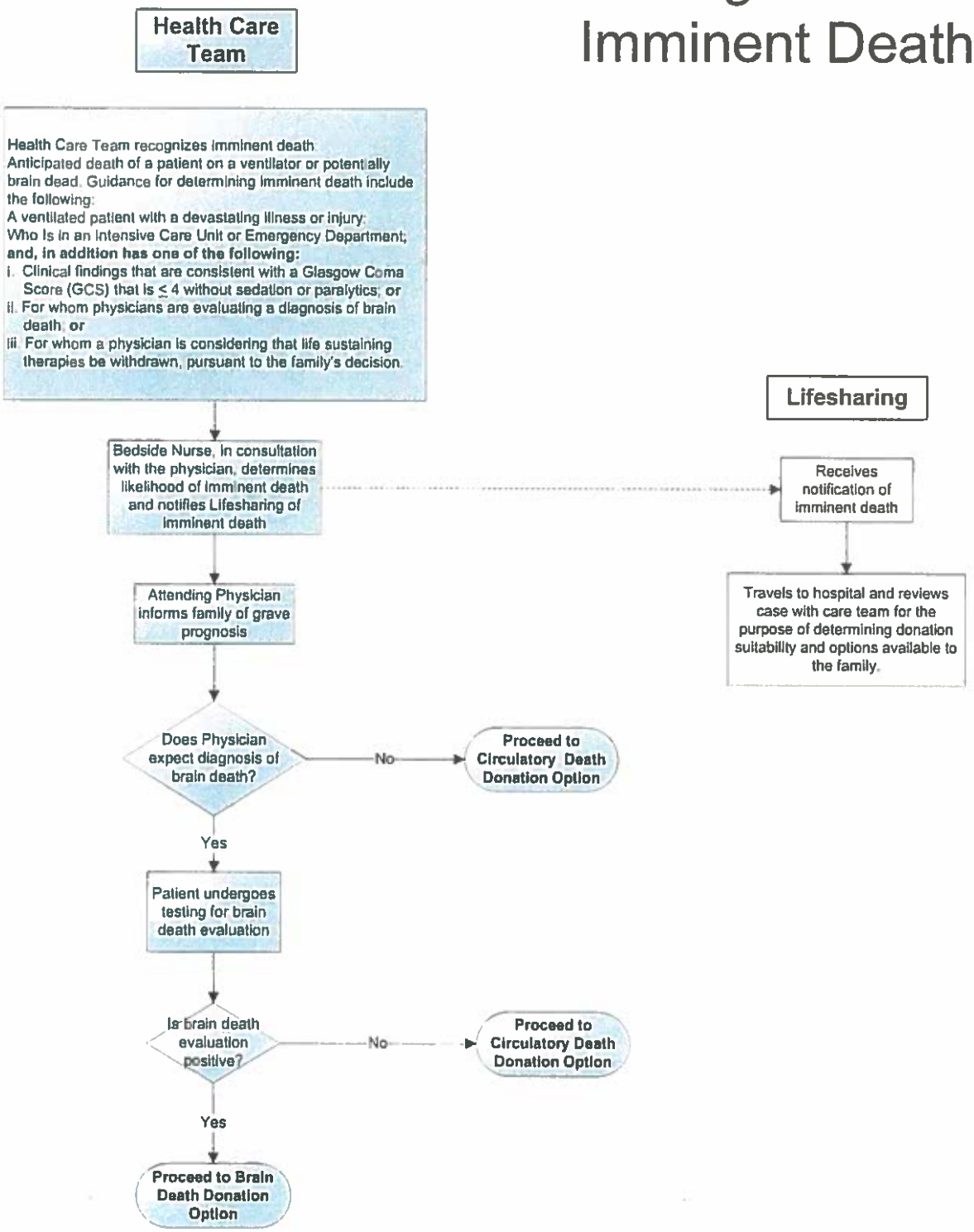
Donation Option: After Circulatory Death



Donation Option: Brain Death



Patient Recognized as Imminent Death



Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**01/06**	**SUBJECT:**	**Restraints~~,~~ Used for Non-Violent/Non-Self-Destructive Behavior**
REVISION DATE(S):	**6/07; 08/09; 10/09; 01/11 07/11; 08/12; 01/16**		

Patient Care Services Content Expert Approval:	**06/19**
Clinical Policies & Procedures Committee Approval:	**~~10/15~~06/19**
Nurse~~ing~~ Executive Council Approval:	**~~10/15~~06/19**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee	**~~11/15~~07/19**
Administration Approval:	**08/19**
Professional Affairs Committee Approval:	**~~01/16~~ n/a**
Board of Directors Approval:	**01/16**

A. **PURPOSE:**
1. To provide a consistent standardized organizational-wide policy for the use of non-violent/non-self-destructive behavior restraint.

B. **PHILOSOPHY:**
1. Tri-City Healthcare District acknowledges restraint may be necessary for certain patient populations.
2. Restraint shall only be used when essential to protect patients from harming themselves, other patients, or staff.
3. The ultimate goal is to minimize the use of restraints and achieve a restraint-free environment. In the event restraint of a patient becomes necessary, Tri-City Medical Center (TCMC) supports a philosophy which will protect the patient's health and safety and preserves his/her dignity, rights and well-being.
4. Restraints of any type should not be used as a punishment, retaliation, coercion, or for the convenience of staff, and should be discontinued as soon as possible.
5. All patients are given information regarding patients' rights upon admission.
6. The use of restraint is not based on a patient's restraint history or behavior history.

C. **DEFINITIONS:**
1. Restraint – Direct application of physical force to a patient, with or without the patient's permission, to restrict his or her freedom of movement. The force may be human, mechanical devised or a combination thereof.
   a. Physical Restraint: Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his/her arms, legs, body, or head freely.
   b. Hand Mitts
      i. That do not allow a patient to bend all fingers and thumb, mitts that look like boxing gloves whether tied down or not
      ii. That are gloves to keep a patient from scratching when tied to a bed or chair frame

c. Four (4) side rails in the up position if the patient cannot lower the side rails and exit the bed.
d. Chemical restraint or seclusion is not used for non-violent behaviors.

2. Physical Escort – A physical escort would include a "light" grasp to guide the patient to a desired location. If the patient can easily remove or escape the grasp, this would not be considered physical restraint. However, if the patient cannot easily remove or escape the grasp, this would be considered physical restraint.
3. Physician/Allied Health Professional (AHP) – any physician, dentist, or podiatrist who is a Medical Staff member and/or who exercises clinical privileges at TCMC as context requires, unless otherwise expressly limited.
4. Qualified/Specially Trained Staff – Staff who are trained and who have demonstrated competency in the use of restraint and/or seclusion in accordance with their scope of licensure and patient population served.

D. **EXCLUSIONS:**

1. The specific device used to restrain a patient does not in itself determine whether the restraint standards apply. Rather, it is the device's intended use (such as physical restriction), its involuntary application, and/or the identified patient need that determines whether use of the device triggers the implementation of the restraint policy.
2. For the purposes of this policy, the following are ***not*** considered restraint:
   a. Side rails
      i. Used for safety or support
      ii. Four (4) side rails in the up position at the same time that can be lowered by the patient to allow the patient to exit the bed
      iii. During procedures for patient safety
      iv. Seizure precautions with padded side rails
      v. Patient in the Intensive Care Unit (ICU) or patient outside of the ICU placed in a bed used in the ICU
   b. Standard practices that include limitations of mobility or temporary immobilization during medical, dental, diagnostic, or surgical procedures, and the immediate post-procedure care processes when these practices are considered an inherent part of the procedure i.e., surgical positioning, intravenous (IV) arm boards, papoose, protection of surgical and treatment sites in pediatric patients.
   c. Adaptive support in response to assessed patient needs i.e., orthopedic prescribed devices, postural support, table top chairs, and specialty mattress.
   d. Protective equipment such as helmets.
   e. Hand mitts (gloves only) to keep from scratching self that are not secured (tied) to a bed frame or chair
      i. Pinning wrists down with mitts and/or hand or fingers are immobilized are considered a restraint
   f. Methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm
   g. Devices that permit the patient to participate in activities without the risk of physical harm
   h. Forensic and correctional restrictions imposed by correctional authorities and used solely for security purposes i.e., handcuffs shackles.
3. Safe transportation of patients on or off the unit for procedures or tests:
   a. Patients may be secured in a transport gurney or chair with a safety device (i.e. Velcro strap, side rails) upon transport on or off the unit.
   b. Patients may be secured with a safety device while obtaining a procedure or test.
   c. Patients may not be left unattended.
4. Restraint use for violent or self-destructive behavior (the restraint standards for violent or self-destructive behavior apply). See the Patient Care Services Restraints/Seclusion for Violent/Self-Destructive Behavior Policy which includes definitions for the following:

a. Chemical Restraint
b. Time-out
c. Physical Escort
d. Physical Holds
e. Qualified/Specially Trained Staff

E. **PRECAUTIONS:**

1. Restraint of patients with deformities may preclude proper application of restraining devices.
2. Restraining of patient in the prone position may predispose the patient to suffocation. Prone restraint is prohibited.
3. Certain vulnerable patient populations are at a greater risk of experiencing adverse effects from restraint use including but not limited to those who are cognitively impaired, physically impaired, elderly and/or those with a history of sexual or physical abuse that would place them at greater psychological risk.
4. Patients at risk for entrapment, including physical, mental and behavioral or medication impairment.
5. A patient in a room not under continuous observation by staff is at greater risk for self-injury or adverse occurrences.

F. **ORDERS:**

1. Restraint is used upon the order of a physician/AHP.
2. Physician/AHP orders are valid until criteria for release is met.
3. If a physician/AHP is not available to issue such an order, a Registered Nurse (RN) may initiate restraint use based on an appropriate assessment of the patient.
   a. Once placed in restraints, a physician/AHP shall be notified as soon as possible of the initiation of restraint, and a telephone or written order shall be obtained from that physician/AHP and entered in the patient's medical record.
   b. If the initiation of restraint is based on a significant change in the patient's condition, the RN shall immediately notify the physician/AHP.
4. The attending physician must be consulted as soon as possible if restraint is not ordered by the patient's attending physician.
5. A written order, based on examination of the patient by a physician/AHP is entered into the medical record on the initiation of restraint.
6. Orders for restraint are not written as standing orders or on an as needed basis i.e., PRN.
7. Orders for non-violent/non-self-destructive restraint must include: action justifying restraint, type of restraint, and criteria for release.
8. The RN shall assess the discontinuation of the use of restraints as soon as it is safely possible.
9. When restraint is discontinued and/or alternatives methods are not effective and restraint must be reapplied, a new order must be obtained.

G. **INITIATION AND DOCUMENTATION:**

1. Alternatives must be considered and tried before using restraint. Refer to examples of alternative interventions on Appendix A.
2. If alternatives are not effective, the least restrictive restraint shall be used in order from least to most restrictive based on the assessment of the RN.
3. The RN shall document initiation of restraint in the medical record on the appropriate restraint electronic form or paper restraint flowsheet. The following shall be documented:
   a. Restraint Reason i.e., Non-violent/ Non-Self Destructive Behavior Restraint
   b. Restraint Initiation Date and Time
   c. Restraint Type i.e., chair with lap table, mitts that look like boxing gloves, soft ankle, soft wrist, vest
   d. Restraint Location i.e., left or right upper or lower extremity, torso
   e. Action Justifying use of Restraint
   f. Description of other behavior requiring restraint, if applicable

g. Pre-restraint alternatives attempted
h. Effectiveness of Pre-restraint alternatives
i. Education provided to patient/family education

H. **ONGOING MONITORING AND DOCUMENTATION:**

1. Patient in restraint may need more frequent monitoring because of age, physical or mental conditions or other needs/conditions based on clinical judgment and knowledge of the patient and their individual needs
2. If the patient is sleeping, the RN shall observe the patient to ensure a safe environment.
   a. Clinical judgment and knowledge of the patient and their individual needs shall be used to determine when and what items need to be evaluated.
3. Patient Care
   a. The RN or designee trained and competent in use of restraint shall address and document the following patient care needs approximately every 2 hours
      i. Range of Motion (when awake)
      ii. Elimination and hygiene
      iii. Nutrition/Hydration
      iv. Allowance for the patient to have maximum movement
4. Assessment and Reassessment
   a. The RN shall reassess patients in restraint approximately every 2 hours or more frequently if necessary.
   b. The patient will be assessed for the following:
      i. Mental status and behavior
      ii. Physical/emotional well-being
      iii. Respiratory status
      iv. Limb circulation
      v. Maintenance of the patient's rights, dignity, and security
      vi. Monitoring of the correctness of the application, removal and reapplication of restraint
      vii. Skin
   c. Document assessment and reassessment findings in the medical record.

I. **PLAN OF CARE:**

1. Ensure the appropriate **Interdisciplinary Plan of Care** (IPOC) is implemented with the initiation of restraint.
   a. Review and update per the IPOC policy.
2. Discontinue the restraint IPOC when restraint is discontinued

J. **PATIENT/FAMILY EDUCATION:**

1. The following education shall be provided to the patient/family:
   a. Clinical reason for restraint
   b. Purpose and use of restraint
   c. Monitoring and care that shall be provided
   d. Criteria necessary for termination of restraint
   e. Additional information necessary to assure the safety and comfort, dignity, preservation of rights and well-being of the patient
2. Appropriate family members shall be notified when a patient is placed in restraint when it meets with the patient's wishes and/or Health Insurance Portability and Accountability Act (HIPAA) and other regulatory standards.

K. **DISCONTINUATION:**

1. Restraint shall be discontinued when criteria for release are met.
2. Document discontinuation of restraint in the medical record on the appropriate restraint electronic form or paper restraint flowsheet.

L. **COMPETENCY AND EDUCATION:**

1. All direct patient care staff in keeping with their scope of practice, shall be assessed for competence before participating in the application and monitoring of restraint, and shall undergo education and training in the proper and safe use of restraint during initial orientation and annually thereafter.
2. Training requirements include but are not limited to:
   a. The determination of who has authority to order restraint
   b. The determination of who has authority to discontinue the use of restraint
   c. The determination of who can initiate the use of restraint
   d. The circumstances under which restraint is discontinued
   e. The requirement that restraint is discontinued
   f. A definition of restraint
   g. A definition or description of what constitutes the use of medications as a restraint
   h. A determination of who can assess and monitor patients in restraints
   i. Time frames for assessing and monitoring patients in restraints
3. Agency or other temporary staff who work in direct patient care roles shall be given a self-learning module to complete before participating in the application or monitoring of restraint.
   a. A qualified staff member shall be assigned as a resource, when the initiation of restraint is necessary on an assigned patient to ensure proper safety procedures, orders and monitoring are implemented.
4. Physicians/AHP's shall be educated in the use of restraint

M. **STAFFING:**

1. Staff assignments shall be based on qualifications, physical design of the environment, patient diagnosis, co-occurring conditions, patient acuity, age, and developmental functioning of the patient. These elements are addressed in the staffing mix of the unit.

N. **NOTIFICATION:**

1. The hospital shall report required information to Centers for Medicare and Medicaid Services (CMS) per regulations. See the examples below:
   a. Each death that occurs while a patient is in restraint or seclusion
   b. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion
   c. Each death known to the hospital that occurs within one week after restraint or seclusion was used
2. Regulatory Compliance shall document in the patient's medical record the date and time the death was reported to CMS.

O. **PERFORMANCE IMPROVEMENT:**

1. Data shall be collected on restraints and submitted to the Restraint Committee and reviewed by the ~~Joint Commission~~**Patient Safety** Committee to identify opportunities to maintain patient safety, reduce restraint use and to identify opportunities for performance improvement.
2. Performance improvement seeks to identify opportunities to introduce preventive strategies, alternatives to use, and process improvements that reduce the risks associated with restraint use.

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

1. **Alternatives to Restraint**
2. **Restraint Education/Competency for Non-Violent/Non-Self-Destructive**

~~P.~~Q. **REFERENCE(S):**

1. California Code of Regulations. Title XXII.

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

Separating from policy and linking as a separate related document

~~APPENDIX A:~~ ALTERNATIVES TO RESTRAINT

A. Psychosocial Alternatives

- Diversion activities such as: TV, soothing music, books, or folding washcloths
- Family interaction
- Orientation today, time and place
- Pastoral visit
- Reassurance
- Reading
- Relaxation techniques
- Interpreter services
- Quiet area
- One-on-one discussion
- Encourage verbalization of feelings
- Validate patient's feelings
- Respect patient's need for personal space
- Decreased stimulation
- Change in environment
- Re-establishing communication
- Setting limits
- Use de-escalation and verbal redirection techniques
- Sitter

B. Environmental Alternatives

- Commode at bedside
- Decreased noise
- Music/ TV
- Night light
- Room close to nursing station
- Call light within reach
- Place personal items within reach
- Keep in low position and locked in place
- Sensory aids available (glasses, hearing aid)
- Decreases stimulation
- Providing quiet area
- Physical activity
- Orientation to surroundings

C. Physiological Alternatives

- Toileting
- Address hygiene needs and comfort measures
- Fluids/nutrition/snack
- Positional devices
- Pain intervention
- Assisted ambulation
- Re-positioning
- Rest/sleep
- Providing assistance
- Additional warmth
- Room temperature at comfort level
- Check lab values
- Pharmacy consult

Separating from policy and linking as a separate related document

Restraint Education/Competency Based Upon Scope of Practice

Restraints for Non-Violent/Non-Self-Destructive Behavior										
	Registered Nurse	CNA/ NA ACT/MHW/ET	Rad. Tech	Transporter Lift Team	Physical Therapist/ RCP	Occupational Therapist	Security	Patient Safety Technician		Regulatory
Initiation	✓									
Orders	✓									
Pre-Restraint Alternatives	✓	✓								
Ongoing Monitoring	✓	✓								
Observation	✓	✓								
Patient Care	✓	✓								
Assessment/Reassessment	✓									
Discontinuation	✓									
Documentation	✓	✓	✓		✓	✓				
Release and/or Re-secure	✓	✓	✓	✓	✓	✓	✓	✓		
Report restraint related death to CMS										✓
Document CMS notification in Patient's medical record										✓

✓= Required for scope of practice

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**UNIVERSAL BLOOD SATURATION SCREENING FOR CRITICAL CONGENITAL HEART DISEASE (CCHD)**
Purpose:	**To provide guidelines for universal blood saturation screening for newborns who are discharged from Tri-City Medical Center**
Supportive Data:	**Pulse oximetry is a simple, non-invasive way to rule out CCHD in the newborn. In a joint statement the American Academy of Pediatrics (AAP) and American Heart Association (AHA) state: "Routine pulse oximetry performed on asymptomatic newborns after 24 hours of life, but before hospital discharge may detect CCHD. Routine pulse oximetry performed after 24 hours in hospitals with on-site pediatric cardiovascular services incurs very low cost and risk of harm."**
Equipment:	**Pulse Oximeter**

~~Tri-City Medical Center~~
~~Oceanside, California~~
~~PATIENT CARE SERVICES~~

~~A. STANDARDIZED PROCEDURE: UNIVERSAL BLOOD SATURATION SCREENING FOR CRITICAL CONGENITAL HEART DISEASE (CCHD)~~

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

~~1. To provide guidelines for universal blood saturation screening for all newborns who are discharged from Tri-City Medical Center~~
~~a. The RN must adhere to the policies of the institution and remain within the scope of practice as stated by the Nurse Practice Act of the State of California~~
~~2. Circumstances:~~
~~a. Setting: Labor & Delivery, Mother/Baby, Admission Nursery, and or Neonatal (NICU).~~
~~b. Supervision: None~~
~~c. Contraindications: None~~
~~3. Rationale: Pulse oximetry is a simple, non-invasive way to rule out CCHD in the newborn. In a joint statement the American Academy of Pediatrics (AAP) and American Heart Association (AHA) state: "Routine pulse oximetry performed on asymptomatic newborns after 24 hours of life, but before hospital discharge may detect CCHD. Routine pulse oximetry performed after 24 hours in hospitals with on-site pediatric cardiovascular services incurs very low cost and risk of harm."~~
~~4. Inclusion criteria for NICU: Screen is to be done when baby is not on oxygen for approximately 12 hours at the discretion of the neonatologist~~
~~5. Exclusions:~~
~~a. An infant that has had an Echocardiogram performed~~
~~b. Transferred to another facility prior to test (out born)~~
~~c. An inborn baby who died before screening performed~~

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

1. Give parent/significant other parent education sheet at the time of the test or when parent/significant other available.
~~2.~~**a.** If the test is refused have parent read and sign Refusal form for Newborn Oxygen Saturation Screening for CCHD, document the refusal in the electronic **health**~~medical~~ record (EHMR) and notify provider.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Council	Department of Pediatrics	Pharmacy & Therapeutics Committee	Inter-disciplinary Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/12, 07/13, 06/18	07/12, 07/13, 4/15, 09/18	08/12, 7/13, 4/15, 11/18	05/15, 02/19	05/15, 03/19	09/12, 09/13, 09/15, 04/19	09/15, 07/19	08/19	09/12,10/13, 10/15, n/a	09/12, 10/13 10/15

~~3.~~2. Gather supplies and or equipment needed to perform the test.
   a. **If not using a disposable pulse oximeter, ~~U~~use** a clean pulse ox probe for each infant screened.

~~a. Pair the pulse oximetry screening with another standard of care screening performed at 24 hours of age, such as hearing screening. If early discharge is planned, screening should occur as late as possible.~~

3. Conduct the screening:
   ~~4.~~a. ~~in~~ **In** a quiet area. If possible, have the parent available to quiet and soothe the infant.
   ~~5.~~b. ~~Conduct the screening if possible w~~**W**hile the infant is quiet, awake, and calm.
      ~~a.~~i. Do not attempt to perform pulse oximetry on an infant while he or she is sleeping, crying or cold as oxygen saturations may be affected.
   ~~2.~~c. If baby discharged at less than 24 hours – perform the test as close to discharge as possible
      ~~a. Pass: notify Pediatrician of result for further follow up~~
      ~~i. Fail: follow steps below for fail~~

~~6. Use a clean pulse ox probe for each infant screened.~~

~~7.~~4. Perform pulse oximetry on the right hand and one foot after 24 hours of age; measurements should be taken in parallel or one after the other.
   a. Premature infants should have the screening performed when medically appropriate.
      ~~3.~~i. In NICU the test will be performed at 24-48 hours of life unless an Echocardiogram is performed or baby on oxygen within the last 12 hours at the discretion of the neonatologist

~~8.~~5. Ensure all readings are accurate by using the pulse oximetry equipment confidence indicators.
   a. Pass **criteria**
      ~~a.~~i. If the oxygen saturation is greater than or equal to 95% in either extremity, with a less than or equal to 3% difference between the two, the infant will "pass" the screening test and no additional evaluation will be required unless signs or symptoms of Congenital Heart Disease (CHD) are present.
   b. Fail **criteria**
      ~~b.~~i. If the pulse oximetry reading is less than 90% in either the hand or the foot, **immediately notify the infant's physician or in NICU the Neonatologist**~~transfer the infant to the NICU for further evaluation~~.
         ~~i. Immediately notify the Neonatologist in NICU and the infant's physician should be notified.~~
         ~~ii. Infectious and pulmonary pathology should be excluded.~~
   c. Rescreen **criteria**
      i. If oxygen saturations are ~~less than 90-94~~**95**% in both the hand and foot or there is a greater or equal to 3% difference **perform a second screening in one hour**~~between two measures separated by one hour transfer the infant to the NICU~~
      ii. **Upon second screening:**
         1) **If meets pass criteria, no additional evaluation will be required unless signs or symptoms of Congenital Heart Disease (CHD) are present.**
         2) **If meets the fail criteria, immediately notify the infant's physician or in NICU the Neonatologist**
         3) **If oxygen saturations are 90-94% in both the hand and foot or there is a greater or equal to 3% difference a second time, repeat the screen a third time in one hour.**
      iii. **Upon third screening:**
         1) **If meets pass criteria, no additional evaluation will be required unless signs or symptoms of Congenital Heart Disease (CHD) are present.**

2) **If meets the fail criteria, immediately notify the infant's physician or in NICU the Neonatologist.**

~~B.~~3) **If oxygen saturations are 90-94% in both the hand and foot or there is a greater or equal to 3% difference a third time, the infant meets the fail criteria and immediately notify the infant's physician or in NICU the Neonatologist**

~~c. The infant's physician should be notified.~~

~~d. Infectious and pulmonary pathology should be excluded.~~

~~9. When administering medications or implementing orders from a standardized procedure, the Registered Nurse (RN) shall enter the medication/order into the electronic health record as a standardized procedure. .~~

~~a.~~**d.** ~~Not required if a screening process triggers the order~~

~~10.~~6. Document:

a. Education given and verbalized to parent(s) or guardian(s)

b. Results of screening

i. Pulse oximetry reading (preductal and postductal)

ii. If parent or guardian refused the screening

iii. If infant passed, failed

iv. **If** ~~H~~**had an Echocardiogram was** performed

v. Transferred to NICU

vi. Failure information **given** to the parents **"Parent Fail Letter"**

c. Provider notifications in the newborn's electronic medical record.

~~D. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:~~

~~1. Current California RN license.~~

~~2. Initial Evaluation: Orientation~~

~~3. Ongoing Evaluation: Annually~~

~~E. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:~~

~~1. Method: This standardized procedure was developed and approved through collaboration with an authorized representative from Nursing Administration, Administration and Medical Staff.~~

~~2. Review: Every two years~~

~~F. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:~~

~~1. Women and Newborn Services RNs~~

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

~~II.1. Parental Fail Letter – English – Sample~~

~~2. Parental Fail Letter – Spanish – Sample~~

1. **Parental Refusal ~~form for~~of ~~Newborn Oxygen Saturation~~ Screening for Critical Congenital Heart Disease 7400-1069 – English – Sample**
2. **Parental Refusal of ~~Newborn~~ Screening for Critical Congenital Heart Disease 7400-1071 – Spanish – Sample**

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

1. **Newborn CCHD Pulse Oximetry Screening Algorithm**

~~A.~~C. **REFERENCE(S):**

1. Advances in Neonatal Care, (2012), A Nurse-Driven Algorithm to Screen Congenital Heart Defects in Asymptomatic Newborns.
2. American Academy of Pediatrics,(2012), Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease , Pediatrics, 129, 190-192.

3. American Academy of Pediatrics, (2013), Oxygen Saturation Nomogram in Newborns Screened for Critical Congenital Heart Disease; 131, e 1803-1810.
4. American Academy of Pediatrics, (2013), Strategies for Implementing Screening for Critical Congenital Heart Disease, Pediatrics, 128, e1259-e1267.
5. Advisory Committee on Heritable Disorders in Newborns and Children. (2010, October 15). Letter to the Secretary of the U.S. Department of Health and Human Services. Retrieved April 25, 2011, from www.hrsa.gov/heritabledisorderscommittee/correspondence/October15th2010letter.htm.
6. Congenital Heart Disease Screening Toolkit, A toolkit for Implementing Screening, 2nd edition, Children's National Medical Center, 2011.
7. Hoffman J. I. E. (2011). It's time for routine neonatal screening by pulse oximetry. *Neonatology. 99,* 1-9.
8. Kemper AR, Mahle WT, Martin GR, Cooley WC, Kumar P, Morrow WR, Kelm K, Pearson GD, Glidewell J, Grosse SD, Lloyd-Puryear M, Howell RR. Strategies for Implementing Screening for Critical Congenital Heart Disease. *Pediatrics.* 2011; 128:e1-e8
~~8.~~**9. Center for Disease Control and Prevention: Morbidity and Mortality Weekly Report June 19, 2015, Vol. 64 No.23, State Legislation, Regulations, and Hospital Guidelines for Newborn Screening for Critical Congenital Heart Defects-United States, 2011-2014.**

SAMPLE

Date _____

Dear Parent/Guardian of Baby _____

Your baby did not pass (failed test=had a low result) the Newborn Pulse Oximetry Screening text for Critical Congenital heart Disease (CCHD).

The pulse oximetry (also called "pulse ox") is a simple test to measure oxygen in the blood. This is done by using a small sensor placed on the baby's right hand and one foot. The pulse ox looks for low oxygen levels in the blood. Screening is a w[DELETE]borns.

A low pulse oximetry result (faile[DELETE]aby has critical congenital heart disease (CCHD). It means more tes[DELETE]D or other problems. You will discuss plans for more testing with your baby's medical team. Different types of tests that may be needed for example are:

- Heart ultrasound (also called "echocardiogram" or "heart echo")
- Blood Tests
- Chest x-ray
- Tests for infection

A Echocardiogram is an ultrasound of the heart that uses sound to make a picture of the heart. The picture will be read by a doctor. You will discuss results and next steps with your baby's medical team. For the safety of your baby it is important to follow the medical team's instructions for testing and follow-up.

CCHD means that the heart or a major blood vessel did not form correctly before birth. The heart may not work well. A baby with CCHD may not have enough oxygen in the blood. The body needs oxygen to grow and be healthy. CCHD may or may not run in families. The cause is different for each child. A child with CCHD should see their regular doctor and a doctor who specializes in child with heart disease (called a pediatric cardiologist). Your child's medical team will talk to you about the treatment options if needed. Prompt and careful treatment helps most children with CCHD live the healthiest lives possible.

<u>Treatment for CCHD varies and can include:</u>

- Medicine, Medical procedures or Surgery

I _____ (Parent/Guardian of the baby) have received this information.

Signature | Relationship to Baby | Date / Time

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

Affix Patient Label

7400-1068
(Rev. 11/13)

PARENTAL FAIL LETTER

White - Chart Yellow - Patient

SAMPLE

Tri-City Medical Center ADVANCE

«Fecha_____»

«Estimado padre (mamá/papá) o guardián del bebé _____

Su bebé no pasó (falló la prue[illegible]Oximetría de Pulso para Recién Nacidos para detectar Enf[illegible](CCHD por sus siglas en inglés. Note que se le referirá con[illegible]

DELETE

La oximetría de pulso (a la qu[illegible]e ox") es una prueba sencilla para medir la cantidad de [illegible] pequeño sensor que se coloca en la mano derecha del bebé y en un pie. El "pulse ox" detecta los niveles bajos de oxigeno en la sangre. Esta prueba es una de las formas de encontrar condiciones críticas en el corazón de los recién nacidos.

Una oximetría que indica un pulso bajo (falló la prueba) no significa que su bebé tiene una enfermedad congénita crítica del corazón (CCHD). Significa que se necesitan más pruebas. Su bebé podría tener CCHD u otros problemas. Usted evaluará los planes para más pruebas con el equipo médico del bebé. Existen diferentes tipos de pruebas que se podrían necesitar e incluyen, por ejemplo:

- Ultrasonido del corazón (se le llama también ecocardiograma o eco del corazón)
- Analisis de sangre
- Rayo X del pecho
- Pruebas para determinar si hay infección

Un ecocardiograma es un ultrasonido del corazón que utiliza sonidos para crear una imagen del corazón. El médico leerá la imagen. Usted analizará los resultados y próximos pasos a dar con el equipo médico del bebé. Para la seguridad de su bebé, es importante que usted siga las instrucciones del equipo médico en cuanto a las pruebas y al seguimiento que hay que dar.

CCHD significa que el corazón o uno de los principales vasos sanguíneos no se formaron correctamente antes de nacer. El corazón podría no funcionar bien. Un bebé con CCHD podría no tener suficiente oxigeno en la sangre. El cuerpo necesita oxigeno para crecer y estar saludable. CCHD podría o no estar presente en las familias o ser hereditario. La causa es diferente en cada niño(a). Un(a) niño(a) con CCHD debería atenderse con su médico regular y con un médico especializado en niños con padecimientos del corazón (llamado cardiólogo pediatra). El equipo médico de su niño(a) conversará con usted acerca de las opciones de tratamiento si fuesen necesarias. El tratamiento temprano y cuidadoso ayuda a que la mayoría de los niños con CCHD vivan lo más saludablemente posible.

El tratamiento para CCHD varía e incluye:

- Medicamentos, Procedimientos médicos o Cirugía.

Yo, _____ (Padre/Guardián del bebé) he recibido esta información.

_____

Firma Relación con el bebé Fecha

SAMPLE

Parental Refusal of Newborn Screening for Critical Congenital Heart Disease

By signing this form, I understand that I am choosing NOT to have my child receive newborn screening for Critical Congenital Heart Disease (heart defects). The method of testing for CCHD is with pulse oximetry. Pulse oximetry is a simple and painless test that measures how much oxygen is in the blood. The screening does not detect all heart defects, but combined with physical examination, pulse oximetry can be an important indicator of heart problems in newborns.

REFUSAL OF SCREENING:

- ○ I, as an individual and as parent or guardian of the child named below, choose not to have my child receive a non-invasive, point of care screening for Critical Congenital Heart Disease (heart defects).

I, as an individual and as the parent or guardian of the infant named below, understand that:

Choosing not to have my newborn screened for heritable and congenital disorders may result in delayed treatment if she or he has a disease that can be detected by newborn screening.

Initial here: _____

Delayed treatment for diseases detected by newborn screening may result in my child suffering from permanent damage, which may include profound neurological or developmental delay, growth failure, organ failure, and/or death.

Initial here: _____

I, as an individual and as parent and guardian of the child named below, further understand that diseases detectable by newborn screening may cause permanent health problems prior to the onset of symptoms, which may not appear until several days, weeks, or months after birth.

Initial here: _____

Release of Hospital from Liability: I, as an individual and as parent and guardian of the child named below, hereby release Tri-City Medical Center and its employees and agents for any injury or ill effects which may result from my refusal of CCHD screening for my child.

Initial here: _____

_____

Parent or guardian signature Date / Time

_____

Parent or guardian printed name Date / Time

_____

Relationship to child

_____

Affix Patient Label

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

7400-1069
(Rev. 7/13)

PARENTAL REFUSAL

White - Chart Yellow - Patient

SAMPLE

Rehúso de los Padres - Examen de Enfermedad Cardíaca Congénita Crítica para Recién Nacidos

Comprendo que, al firmar este formulario, estoy eligiendo REHUSAR a que mi criatura reciba un examen para detectar en los recién nacidos defectos del corazón, o lo que se llama Enfermedad Cardíaca Congénita Crítica (CCHD por sus siglas en inglés). El método que se utiliza para el examen de CCHD es la oximetría de pulso. La oximetría de pulso es un examen sencillo sin dolor que mide cuánto oxígeno hay en la sangre. El examen no detecta todos los defectos cardíacos (del corazón) pero en combinación con el examen físico, la oximetría de pulso puede ser un indicador importante de problemas del corazón en los recién nacidos.

REHÚSO AL EXAMEN:

Yo, como individuo y como padre/madre o guardián de la criatura nombrada abajo, elijo que mi criatura no reciba un examen no invasivo de diagnóstico inmediato para detectar la Enfermedad Cardíaca Congénita Crítica (defectos del corazón).

Yo, como individuo y como padre/madre o guardián del infante nombrado abajo, comprendo que:

Elegir que no examinen a mi recién nacido para detectar trastornos hereditarios y congénitos, podría resultar en que se retrase el tratamiento si él o ella tuviera una enfermedad que puede ser detectada por el examen para los recién nacidos.

Iniciales aquí: _____

Retrasar el tratamiento para enfermedades detectables por medio del examen para los recién nacidos podría resultar en que mi criatura sufriera daño permanente, que podría incluir retrasos severos neurológicos o del desarrollo, falla en el crecimiento, insuficiencia o fallas en los órganos y/o la muerte.

Iniciales aquí: _____

Yo, como individuo y como padre/madre o guardián de la criatura nombrada abajo, entiendo además que las enfermedades que son detectables por medio del examen para los recién nacidos pueden ocasionar problemas de salud permanentes antes de que aparezcan los síntomas, los cuales pudieran aparecer hasta varios días, semanas, o meses después del nacimiento.

Iniciales aquí: _____

Liberación de Responsabilidad del Hospital: Yo, como individuo y como padre/madre y guardián de la criatura nombrada abajo, por la presente libero a Tri-City Medical Center y a sus empleados y agentes de cualquier lesión o efectos nocivos que pudieran resultar de mi rechazo del (rehúso al) examen de CCHD para mi criatura.

Iniciales aquí: _____

Firma del Padre/Madre o guardián — Fecha / Hora

Imprima el nombre del Padre/Madre o guardián — Fecha / Hora

Relación con la criatura

Affix Patient Label

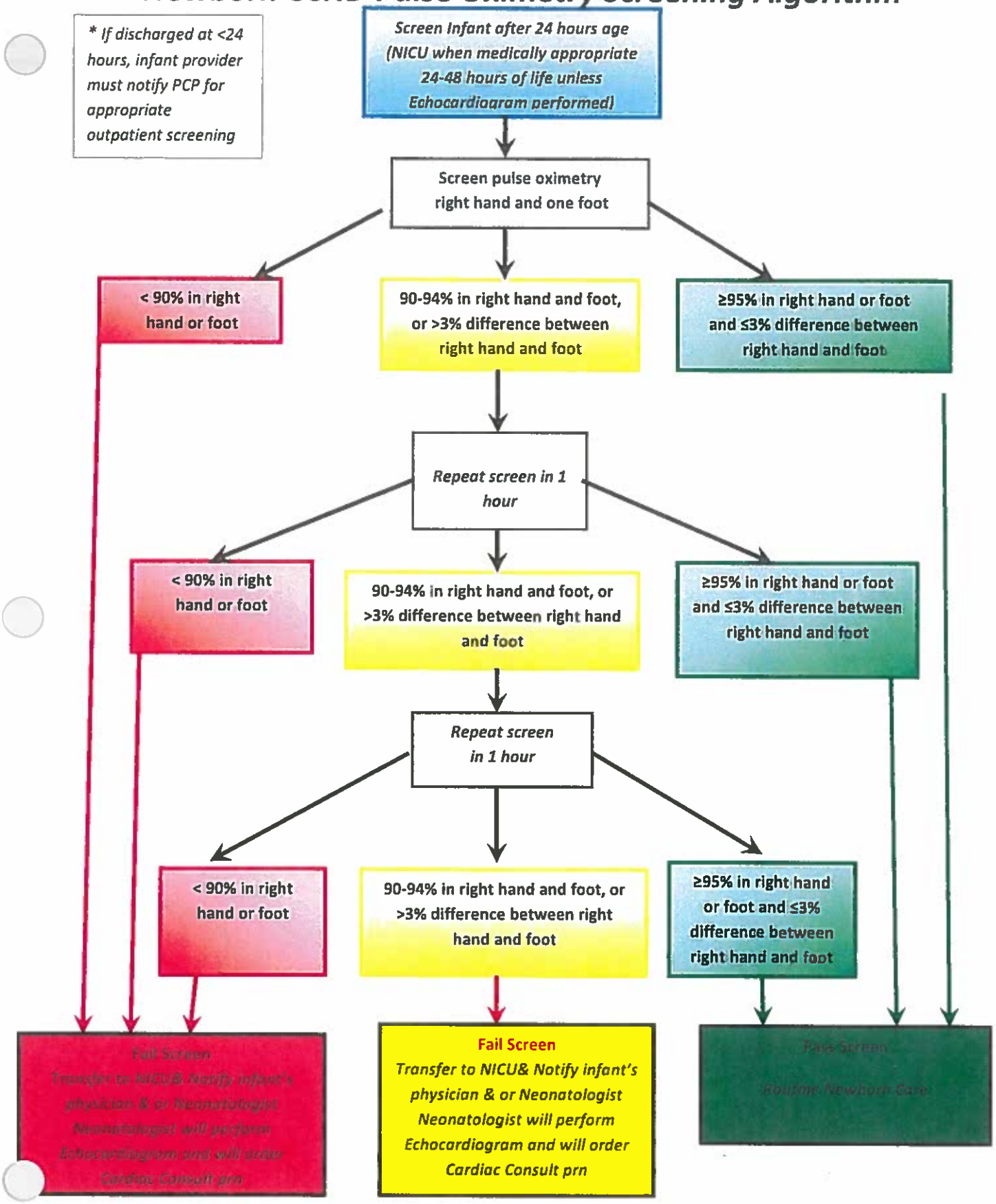
Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

7400-1071
(Rev. 12/14)

PARENTAL REFUSAL
(REHÚSO DE LOS PADRES)

White - Chart Yellow - Patient

Newborn CCHD Pulse Oximetry Screening Algorithm



Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 02/89

SUBJECT: Witnessing a Patient Signature on Patient's Personal Documents

REVISION DATE(S): 06/94, 07/99, 07/02, 03/06, 03/11

~~**POLICY NUMBER: 8610-341**~~

Patient Care Services Content Expert ~~Department~~ Approval ~~Date(s)~~:	~~03/16~~05/19
Clinical Policies ~~and~~& Procedures Committee Approval ~~Date(s)~~:	~~04/16~~06/19
Nurse Executive Committee Approval ~~Date(s)~~:	~~04/16~~06/19
Administration Approval:	08/19
Professional Affairs Committee Approval ~~Date(s)~~:	~~05/16~~ n/a
Board of Directors Approval Date(s):	05/16

A. **POLICY:**

1. Witnessing of signatures on patients' personal documents by hospital personnel shall not be permitted. This policy is for the purpose of avoiding any conflict of interest and to avoid any inference of impropriety.

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

1. Witnessing of Personal Documents

C. **REFERENCE(S):**

1. California Hospital Association Consent Manual 2015
2. California Probate Code

WITNESSING OF PERSONAL DOCUMENTS

TYPE	REQUIREMENT
I. Advance Directives Advance Health Care Directive • By law, may not be healthcare providers or employees • Volunteers and Contracted Agencies are agents of hospital for purposes of this policy.	No witnessing permitted by staff, except Notary Public.
II. Wills Typed Wills: • Witnessed by 2 persons who are not beneficiaries under the Will. • Should not be notarized. Holographic Wills: • Entirely in patient's own handwriting, dated. • No need to be witnessed.	Patients or designee will secure their own witnesses. Hospital staff may not witness. No witness required.
III. Financial Documents Real Estate: • Notary required. Power of Attorney/Finance Bank Transactions • Notary required.	Notary only. Patient or Designee will secure their own witnesses Hospital staff may not witness. Notary only.

NOTES:

- Witnessing of any patient personal documents by an employee is not permitted.
- Advising patients and visitors regarding legal documents is not permitted.

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE ~~Manual~~Policy
HUMAN RESOURCES

ISSUE DATE: 06/87 **SUBJECT:** Absences and Tardiness

REVISION DATE: 05/88, 02/97, 12/99, 10/02, 02/03, 07/05, 01/08, 07/10 **POLICY NUMBER:** 8610-408

Administrative Human Resources ~~Department~~ Content Expert Approval:	**~~10/15~~06/19**
Administrative Policies ~~and~~& Procedures Committee Approval:	**06/19**
~~Human Resources Committee Approval:~~	**~~10/15~~**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**08/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/16**

A. **PURPOSE:**

1. In order to ensure ~~that~~ **Tri-City Healthcare District** (TCHD) provides the highest quality **of** services, employees must report to work on a consistent and timely basis and must seek, except under extraordinary circumstances, to inform their supervisor(s) reasonably in advance of unscheduled Absences or Tardiness.

B. **DEFINITION(S):**

1. ~~-~~Absence: An Absence that is not authorized or previously scheduled under ~~the District's Leave of~~**Administrative Human Resources Policies: Leave of** Absence ~~Policy #~~**8610-**435 or Paid Time ~~-~~Off (~~PTO~~)**Program** ~~Policy #~~**8610-**433.
2. No-Call,~~-~~ No-Show: Any Absence on a scheduled workday along with the failure to notify the employee's supervisor~~/~~ **or** department manager at least two (2) hours prior to the scheduled starting time or in accordance with specific departmental policy.
3. Tardiness or Tardy: Reporting and being ready to work after the beginning of a scheduled shift, or after an authorized rest or meal period. Each instance of Tardiness is counted as a separate occurrence, thus an employee may have multiple Tardies within a single shift.
4. Abandonment of Position: Any of the following will be deemed Abandonment of an employee's positions:
   - **a.** ~~(a)~~ No Call, No Show for three (3) consecutive scheduled work days~~,~~
   - **b.** ~~(b)~~ Failure to return to work following **an** authorized leave or scheduled **paid time off** (PTO)~~,~~
   - **c.** ~~(c)~~ Absence during any period for which the employee has requested ~~authorized~~ leave **of absence (LOA)** or ~~scheduled~~ PTO ~~when~~ **and** such request has been denied~~, or~~
   - ~~4.~~**d.** ~~(d)~~ Leaving the work assignment without authorization~~.~~

C. **POLICY:**

1. Except where such notice is not reasonably feasible, each employee will notify~~, by telephone, his/her~~**their** supervisor,~~/~~ department manager or designee of any Absence at least two (2) hours prior to the employee's scheduled starting time ~~(~~or in accordance with **the** specific departmental policy~~)~~.
   - ~~1.~~**a.** Except ~~as provided in C.2 below~~**if considered a Tardy**, any employee who fails to provide the required advance notice shall be considered a ~~"~~No Call, No Show.~~"~~

2. A**The** supervisor~~/~~ **or** department manager shall attempt to contact ~~an~~**the** employee who has not reported to work at the beginning of ~~a~~**the** scheduled shift to inquire whether the employee will report to work.
   a. ~~In such event, t~~**T**he employee must inform the supervisor~~/~~ **or** department manager when the employee expects to report to work~~,~~ and if the employee does report to work at the time specified, the employee shall not be considered a No Call, No Show but shall be considered Tardy. This ~~provision C.2 shall apply~~**ies** to the beginning of scheduled shifts only and not to failures to report following authorized rest or meal periods.
   ~~2.~~b. -The employee may not use PTO for ~~the~~**a** Tardy arrival.
3. In any instance where the employee is a No Call, No Show, the employee's supervisor~~/~~ **or** department manager may replace the employee for the shift.
   a. ~~In such case, t~~**T**he employee shall not be permitted to report to work and shall also be deemed Absent for the entire shift.
   ~~3.~~b. The employee may not use PTO for the "No call, No Show.
4. When an employee's Absence extends beyond one **(1) work**day, the employee must provide the required advance notice to ~~his/her~~**their** immediate supervisor, ~~/~~department manager or designee for each day of the Absence.
   ~~4.~~a. In the case of Absence due to the employee's own illness or injury, ~~an~~**the** employee may satisfy this requirement by providing a medical certification from the employee's health care provider showing the employee's anticipated ~~date of~~ return to work **date**. If the employee ~~complies with this Section C.4~~**provides the medical certification**, the Absence over multiple days shall be counted as a single occurrence.
5. Under some circumstances, an Absence may be converted to **an** authorized ~~leave~~**LOA** or PTO if the employee can demonstrate ~~that he/she~~ meet**sing** the requirements for such ~~leave~~ **LOA** or PTO ~~but only~~ with the approval of the supervisor~~/~~ **or** department manager.
   ~~5.~~a. Conversion of an Absence ~~on any day~~ with respect to which the employee has requested and been denied PTO or other scheduled ~~leave~~**LOA**, or on any day immediately preceding or following a recognized holiday under **Administrative Human Resources** Policy: **Paid Time-Off Program #** ~~[~~**8610**-433~~]~~ shall require the approval of the **Chief Operating Officer** (COO) or **Chief Nurse Executive** (CNE).
6. Supervisors~~/~~ **or** department managers are responsible for reporting Absences, No Call, No Shows and Tardiness to ~~[p~~**P**ayroll~~]~~.
7. Employees who are Absent from work for more than three (3) consecutive scheduled work days must ~~call Employee Health Services~~**request a LOA** ~~to verify whether a~~**and provide a** physician's release ~~is required~~ before the employee may return to work **per Administrative Human Resources Policy: Leave of Absence 8610-435**. Any employee who fails to obtain a required release shall not be permitted to return to work and shall be treated as a "No Call, No Show" and as Absent from work.
8. All employees must inform their supervisors~~/~~ **or** department manager~~s~~ if leaving ~~the District~~**TCHD** grounds **at** any time during an assigned shift other than during an authorized rest or meal period or on ~~District~~**TCHD** business approved in advance by the ~~employee's~~ supervisor~~/~~ **or** department manager.
9. If an employee is unable to complete ~~his/her~~**their** assigned shift, the supervisor~~/~~ **or** department manager will determine if this occurrence is an Absence.
10. Employees who fail to be present during ~~his or her~~**their** scheduled shift for unauthorized Absences **and/or Tardies** will be subject to appropriate disciplinary action up to and including termination.
    ~~9.~~a. **See Absences and Tardiness Guidelines.**
~~a.~~**11.** An unscheduled Absence after **the** denial of a request for time off, ~~or~~ an unscheduled Absence following corrective action or any misrepresentation of facts relating to attendance may result in disciplinary action up to and including termination.
12. Any violation of this policy will result in disciplinary action, up to and including termination.

~~b.~~**13. To the extent that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.**

D. **EXEMPT EMPLOYEES:**

1. Exempt employees are expected to be present and available to work during regular business hours for TCHD or **as required by** their ~~if~~ departments.

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

1. **Absences and Tardiness Guidelines ~~Grid~~**
2. **Administrative Human Resources Policy: Leave of Absence 8610-435**
3. **Administrative Human Resources Policy: Paid Time-Off Program 8610-433**
4. **Administrative Human Resources Policy: Coaching and Counseling for Work Performance 8610-424**

~~1.~~**5. Kin Care Fact Sheet: http://tricityintranet.com/tcmc/kin-care-fact-sheet/**

Tri-City Health Care District
Oceanside, California

INFECTION CONTROL

ISSUE DATE: 09/95

SUBJECT: Aerosol Transmissible Diseases and Tuberculosis Control Plan ~~IC 11~~

REVISION DATE(S): 09/01, 09/02, 10/03, 10/06, 10/08, 07/09, 10/09, 07/11, 08/14, 01/16 01/17, 02/18, ~~6/19~~

Infection Control Department Approval:	~~05/18~~06/19
Infection Control Committee Approval:	~~07/18~~07/19
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~08/18~~07/19
Administration Approval:	09/18
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	09/18

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

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

B. **PURPOSE AND POLICY:**

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

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

iii. Diseases requiring Droplet Precautions;

~~ii.~~iv. **See Type and Duration of Precautions - Disease Specific (formerly Short Sheet)**

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

~~iii.~~v. Ebola disease: Special considerations: Please refer to Tri City Medical Center Infection Control Ebola Plan Policy for management of a patient with confirmed or suspected Ebola.

1) Patients are screened at Triage and/or admission to the facility
2) Place patient in negative pressure room C26
3) Patients without symptoms of bleeding, vomiting, diarrhea or clinical condition that may warrant invasive or aerosol-generating procedures must wear extended personal protective equipment (PPE) (Covers all surfaces of the body including head and neck, coverings for the eyes, mouth, nose and skin). The hair must be completely enclosed. Full face shield with N95 respirator or higher.

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

C. **SCOPE:**

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

D. **RESPONSIBILITY:**

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

recirculators and providing portable HEPA recirculators to units as needed.

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

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

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

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

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

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

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

   v. Implement control measures when ATD is suspected.

E. **AVAILABILITY OF THE PLAN:**

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

F. **FUNDAMENTALS OF TUBERCULOSIS INFECTION CONTROL:**

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

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

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

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

G. **TUBERCULOSIS RISK ASSESSMENT:**

1. Risks assessment will be performed annually by the Infection Preventionist and reviewed by the Infection Control and Environment of Care Committees. The purpose of this assessment is to evaluate the risk of transmission of Tuberculosis so that appropriate interventions can be developed. The assessment will include:

a. Community TB profile from public health department data
b. Number of infectious TB patients treated in outpatient and inpatient areas.
c. Drug susceptibility patterns of TB patients
d. Analysis of staff PPD test results by area
e. Review medical records for appropriate precautions, timing of specimens, duration of precautions and timely communication with public health.
f. Observation of practice and review of engineering controls.

2. Considerations for determining the hospital's risk classification will be based on the following:

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

3. Early identification of suspected and active TB patients can initiate prompt treatment and prevent transmission of the disease. This is the most effective method for controlling the spread of tuberculosis, an Administrative Control. A suspected case of TB is defined as:
   a. A patient with unexplained cough, cough with bloody sputum, and/or a cough lasting longer than 3 weeks
   b. A patient with unexplained fever, night sweats, weight loss and anorexia
   c. Readmission of patients recently diagnosed with Tuberculosis
4. A high index of suspicion for Tuberculosis should be maintained for the following
   a. Patients requiring high-risk procedures such as aerosolized pentamidine and sputum induction for Acid Fast Bacilli (AFB)
   b. Patients who belong to a group with a higher prevalence of TB infection: medically under-served, foreign born from a developing country, homeless, current or past justice involved , alcoholic, injecting drug-user, elderly, or extended contact with an active TB case.
   c. Patients who belong to a group with a higher risk to progress from latent TB to active disease: immunocompromised (HIV, organ transplant, or on high dose steroids), silicosis, status post gastrectomy or jejunoileal bypass surgery, >10% below body weight, chronic renal failure, diabetes mellitus, infected within past two years, or child >5 years old.
5. In outpatient areas where patients with undiagnosed Tuberculosis may be present, precautions must be taken to minimize the risk of transmission.
   a. Instruct patients to cover their mouths with a handkerchief or tissue, and give them a surgical mask to wear. Tissues and masks must be readily available in the waiting areas.
   b. Questionnaires will be utilized in all outpatient areas and Emergency Department to assist in the early identification of suspected cases.
   c. Patients with symptoms suggestive of Tuberculosis will be removed from the common area and placed in a designated waiting area.
   d. Patients unable to wear a mask can be placed outside with appropriate supervision until an appropriate room is available.
6. For departments in main hospital building without a built in negative pressure room, staff shall obtain HEPA recirculator from the Engineering department to enhance circulation in the exam or treatment room to be used by the patient. Contact Engineering for placement assistance.

Please note: The patient must be placed in an AIIR room within 5 hours of identification.

a. Staff wear N95 particulate respirators and visitors wear surgical masks when entering this area.
b. If the patient is suspected or known to have infectious TB, the room must remain vacant per Section M: Room Shut Down Time. The door is to remain closed and the filter running.
c. Personnel may enter the area but must continue to wear respiratory protection until the time has lapsed.

7. For off-site areas, the patient will be asked to wear a surgical mask while inside the building.
8. Any possibility of TB as a diagnosis should be communicated by telephone to other departments, prior to transporting the patient to those areas.
9. Patients seen in the ED with confirmed or suspected Pulmonary or Laryngeal TB might require hospitalization to control the spread of infection.
   a. Emergency Department rooms should remain closed **per Section M: Room Shut Down Time**~~for 30 minutes after the patient leaves to ensure 99.9% removal of contaminants~~. Personnel may enter the room before this time has lapsed but must wear an appropriate respirator.

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

1. Staff who are the first points of contact should ask questions that will facilitate identification of patients with signs and symptoms suggestive of TB. See the Admission Assessment Patient History form>TB Screening form>to assess for TB risk factors and symptoms.
2. Upon identification of a patient with active or suspected Tuberculosis, the nurse must place the patient in an AIIR (i.e. negative pressure room: C-26, 143, 243, 287, 387, 443, 487, Maternal Child room 200, **201**-and Progressive Care Unit (PCU) Rooms 301, 312 and 326,~~).~~ The door must be closed and the HEPA filter running. Post the Airborne Precautions sign outside the room.
   a. If a designated room is not available, notify the charge nurse and the bed coordinator of the need for an Airborne Precautions room. Remove any roommates and call Engineering for the HEPA filter. Keep the door closed and post the Airborne Precautions sign. Staff wear N95 particulate respirators and visitors wear surgical masks when entering this room.
   b. Patients with TB must not be placed together in the same room unless they have culture- confirmed TB, have drug susceptibility test available on current specimens obtained during the present hospitalization, have identical drug susceptibility patterns on these specimens and are on effective therapy.
3. Reporting:
   a. The Unit Secretary notifies Engineering (by placing a worker order) that an Airborne Precautions room is in use for tuberculosis.
   b. On weekends and holidays, the charge nurse or the primary nurse will notify the Public Health Nurse by calling cell phone number (619) 540-0194. Go to http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/TB-216TBSuspectCaseReport.pdf for a copy of the report.
   c. Laboratory Results: Hospitals and staff are required by law to report TB to protect the public. This must be done within one day of identification of the case or suspected case.
   d. The Microbiology department will notify the nursing unit and the Infection Preventionist of a positive AFB smear or culture results. A fax report of all positive AFB smears and cultures is sent to the Public Health.
   e. The Infection Preventionist (x 7410 or x 5696) or designee is responsible for reporting to public health. Tuberculosis (TB) Program Nurses are available 8:00am to 5:00pm, 7 days a week and all holidays on cell phone number (619) 540-0194 TB control does not have personnel available between the hours of 5:00 pm and 8:00 am Persons with routine questions or questions about TB exposure should call phone number (619) 692-8610 after 8:00am on the following day.
   f. Person wanting to report a case of TB after 5:00pm should do one of the following:

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

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

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

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

4. Staff (fit-tested and approved for use) will wear an N95 respirator when entering the patient's room. See the Respiratory Protection Program under the Employee Health & Wellness Policy Manual.
5. Pediatric patients with suspected or confirmed TB must be evaluated for potential TB according to the same criteria, as adults. Parents and other visitors of pediatric patients must be evaluated for TB as soon as possible. Until they are evaluated, they must wear surgical masks when in areas of the facility outside of the child's room.
6. Diagnostic and treatment procedures must be performed in the Airborne Precautions rooms to prevent transporting to other areas of the facility. If the procedure cannot be done in the isolation room, the patient must wear a surgical mask during transport. Procedures should be scheduled at times when they can be performed rapidly and when the areas are less crowded.
7. Limit the number of persons entering an isolation room to a minimum. All visitors (except staff who have been fit-tested for an N95 respiratory) wear a surgical mask when entering an Airborne Precautions room.
8. Facilities will verify airflow rates and negative pressures at the time the negative pressure room is established. Negative pressures will be verified daily and a log maintained by Facilities department.
9. Cough-inducing procedures will not be performed on patients who have or may have active Tuberculosis unless the procedures are absolutely necessary and can be performed with appropriate precautions.
a. The patient is in an Airborne Precautions room.
b. The portable air filtration system has been set-up in a regular room.
10. Staff must wear respiratory protection (N95 respiratory or Powered Air Purifying Respirator-PAPR) when present in rooms or enclosures in which cough-inducing procedures are being performed on patients who are being ruled out for Tuberculosis. See High Hazard Procedures.
11. After completion of the cough-inducing procedures, patients who may have infectious Tuberculosis will remain in the Airborne Precautions room until the coughing subsides. (If transport is necessary, patient will be provided with a surgical mask to wear.) Outpatients will wear surgical masks until they are outside of the hospital.
12. Before the Pulmonary Function Testing room is used again, after the booth has been in use, the HEPA filter is kept on and the door to the room closed for 1.5 hours. Staff entering the room

before the 1.5 hours are over will wear an N95 respirator. See High Hazard Procedures.

13. Bronchoscopy considerations
    a. The bronchoscopy room for all inpatient and outpatient procedures will be a negative pressure room. The air filtration system will remain in use whenever performed on a suspect TB patient. Respiratory protection must be worn. An N95 Respirator or Powered Air Purifying Respirator-PAPR must be worn by staff performing a Bronchoscopy on a suspect TB patient. The patient waiting for bronchoscopy will be provided a surgical mask and escorted to a non-communal waiting room.

I. **ADDITIONAL CONSIDERATIONS FOR SELECTED AREAS:**

1. Surgery/Peri-Anesthesia Nursing Services
    a. Postpone non-urgent or elective procedures on suspected/confirmed TB patients until the patient is no longer infectious.
    b. If procedures must be performed, they should be done in OR rooms with door closed and traffic at a minimum.
    c. Procedures should be done when other patients are not present in the operating suite e.g., end of day) and when minimum number of personnel are present. This applies to pulmonary and non-pulmonary surgical sites.
    d. Utilize the portable HEPA unit in the operating room during intubation and extubation. Turn off the HEPA unit during the procedure.
    e. For patients with known or suspected airborne infectious diseases staff must wear a N95 Respirator or Positive Air Purifying Respirator (PAPR). Order PAPRs from SPD (xt 7728)
        i. PAPRs cannot be used near the sterile field, wear N95 mask in place of PAPR.
    f. For additional information see Surgery Protocol for Active/Rule Out Tuberculosis (TB).
    g. Airborne Precautions are maintained in the Post Anesthesia Care Unit. Post-operative patients are placed in a private recovery room with a portable HEPA unit.
2. Autopsy Room
    a. Due to the probability of the presence of infectious aerosols, autopsy rooms should be at negative pressure with respect to adjacent areas, with room air exhausted directly to the outside of the building. ASHRAE recommends that autopsy rooms have ventilation that provides 12 total air changes per hour (ACH).
    b. Personnel performing autopsies on patients who may have had tuberculosis should wear respiratory protection (see high hazard procedures)
    c. In-duct HEPA filtered air re-circulation or UVGI may be used as a supplement to the recommended ventilation.
    d. The autopsy room should remain closed for one hour after the patient leaves to ensure 99.9% removal of contaminants. Personnel may enter the room before this time has lapsed but must wear an appropriate respirator.
    e. Deaths caused by a known or suspected contagious disease constituting a public health hazard are reportable to the Medical Examiner's Office. Autopsy performed on these cases will be performed by the Medical Examiner.
3. Home Health Services
    a. Staff entering the home of a patient with confirmed or suspected TB or ATD should wear appropriate respiratory protection.
    b. The patient should be taught to cover mouth and nose with a tissue when coughing or sneezing.
    c. Educate patient regarding importance of taking medication (and administering directly observed therapy).
    d. Immunocompromised persons or young children living in home with TB patient should be temporarily relocated until patient is no longer infectious.
    e. Cough-inducing procedures should be performed on patients with infectious tuberculosis only if absolutely necessary. If their performance is required a well-ventilated area away from other household members should be used (for example, go outside or open a window). Staff will wear respiratory protection during the procedure
    f. Specific processes and procedures pertaining to ATDs in the home are found in the

Home Health Care policy manual.

J. **DIAGNOSTIC EVALUATION:**

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

K. **AIRBORNE PRECAUTIONS:**

1. Airborne Precautions can be discontinued as soon as the diagnosis of TB has been ruled out, when another diagnosis is confirmed, or when the patient is no longer infectious.
   a. Airborne Precautions can be discontinued:
      i. In a patient with active tuberculosis when the patient is on effective therapy, improving clinically, and has had three consecutive negative concentrate sputum AFB smears
      ii. In a patient with suspect tuberculosis as soon as the diagnosis of TB has been excluded by three negative AFB sputum smears taken 8-24 hours apart with at least one from an early morning specimen, induced specimen, or BAL or when another diagnosis is confirmed
2. Continued isolation throughout the hospitalization should be considered for patients who have multi-drug resistant tuberculosis (MDR-TB) because of the tendency for treatment failure or relapse.

L. **DISCHARGE:**

1. Before leaving the hospital, TB patients must be approved for discharge by the Public Health Department. A discharge plan must include all of the following prior to approval from the TB Control Officer. TB Control can be contacted at: 619-692-8610 or 619-540-0194. The Tuberculosis Discharge Care Plan form can be accessed at: http://www.sandiegocounty.gov/hhsa/programs/phs/documents/TB-273TuberculosisDischargeCarePlan2014.pdf **Accessed 2/20/19**
   a. Patients in the Progressive Care Unit (PCU): Specific notification(s) must be obtained prior to discharging justice involved patients:

i. The Department of Health TB Control to the specific county in which the justice involved patient is residing
ii. The Public Health Department of the prison.

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

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

M. ROOM SHUT DOWN TIME:

1. **Keep the Airborne Precautions sign posted**
2. **Leave the HEPA filter running with door closed for specified time. Post a sign that specifies this time period.**

~~iii.~~**a. AIIR Negative Pressure Room**

AIIR/Negative Pressure Rooms	Length of Time AIIR Negative Pressure Room is Closed
ED-C26, 143, 243, 443, 287, 387, 487, NICU	30 min
Bronchoscopy, 200, 201	1 hour
PCU 301, 312, 326	2 hrs

b. **Non-Negative Pressure room**

Location in Non-Negative Pressure Rooms	Length of Time Non-Negative Pressure Room is Closed
Surgery	30 min
1N/S, MCH, Pavillion, East/West T~~t~~ower, Radiology/MRI/CT, ED	1 hour
PCU 3N/S	2 hours

3. **Staff may enter the room during this time (i.e. to clean) but must wear an N95 respirator until the time period has elapsed.**
4. **After the time period has ended, discontinue Airborne Precautions.**
5. **If the patient is no longer infectious or TB has been ruled out: No special precautions needed. The door may be immediately opened and the room cleaned as usual.**

~~Area~~	~~Length of Time Room is Closed~~
~~Orthopedics/Rehab (1N/S)~~	~~Two hours~~
~~Maternal/Child~~	~~Two Hours~~
~~South~~	~~Two hours~~
~~PCU3 N/S~~	~~Two hours~~
~~Pavilion (2P, 3P, 4P)~~	~~One hour~~
~~East/West Tower~~	~~One hour~~
~~Surgery~~	~~One hour~~
~~Radiology~~	~~One hour~~
~~Emergency Department~~	~~30 minutes~~
~~Bronchoscopy area~~	30 ~~30 minutes~~

~~c. If the patient is still infectious and was in a negative pressure room:~~
~~i. Keep the Airborne Precautions sign posted, leave the HEPA filter running and close the door for one more hour. Post a sign that specifies this time period. Staff may enter the room during this time (i.e. to clean) but must wear an N95 respirator until the time period has elapsed. After the one hour period has ended, discontinue Airborne Precautions.~~
~~d. If the patient is no longer infectious or TB has been ruled out:~~
~~i. No special precautions needed. The door may be immediately opened and the room cleaned as usual.~~

~~M.~~N. ANNUAL TUBERCULOSIS SCREENING:

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

~~N.~~O. AEROSOL TRANSMISSIBLE DISEASE CONTROL EXPOSURE DETERMINATION:

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

~~O.~~P. ISOLATION PRECAUTIONS:

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

~~P.~~Q. HIGH HAZARD PROCEDURES:

1. High hazard procedures include but not limited to
   a. Intubation and Extubation
   b. Sputum Induction
   c. Endotracheal & Tracheostomy Tube Care
   d. Bronchoscopy

e. Pulmonary Function Tests
f. Aerosolized administration of pentamidine or other medication
g. Autopsy

2. For patients with known or suspected Droplet infectious diseases staff must wear an N95 respirator.
3. For patients with known or suspected airborne infectious diseases staff must wear a N95 Respirator or Positive Air Purifying Respirator (PAPR) except in an operating room or procedure room during an invasive procedure where there is a sterile field wear a N95 mask.
   a. Order PAPRs from SPD (x7728)
4. Although Cal OSHA requires PAPRs for high hazard procedures on suspect/confirmed airborne disease patients, CDPH does allow the use of N95 Respirators instead of PAPRs if it interferes with the successful performance of the task or the procedure is performed with the patient in a ventilated enclosure.

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

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

c. Doors are kept closed.
d. Patients in Droplet precautions do not need AIIRs for routine care. However, high hazard and cough inducing procedures performed as part of the clinical care of patients in both Airborne and Droplet Precautions will be done in AIIR. See chart above for selection on type of respirator.
e. Portable HEPA filtration units can be used to facilitate AIIR. Engineering installs and maintains these devices. Place a work order for installation and monitoring.
f. AIIRs shall remain empty with Airborne Precautions sign posted and door closed for designated time when a patient with airborne transmissible disease has occupied the room. (See Room Shut Down Time)

4. Pulmonary Services
   a. Bronchoscopy for patients in Airborne or Droplet Precautions will be performed in an AIIR.
   b. N95 respirators or PAPRs are used during Bronchoscopy.
   c. In areas where AIIR is not available, aerosolized medications are administered using disposable nebulizer units with expiratory filters or multi-dose inhalers as clinically indicated.
   d. Aerosolized medications may be administered using traditional routes while the patient is in an AIIR. The staff should wear an N95 or PAPR during this treatment (see High Hazard Procedures).
   e. Bronchoscopy suite will remain closed for the designated time when procedure is performed on a patient with known or suspected ATD.
   f. Expiratory filters are used for intubated patients with known or suspected ATD during transport.
5. Maternal Child Health Services (MCH)
   a. Neonatal Intensive Care Unit (NICU)
      i. The NICU has a dedicated AIIR.
      ii. Neonates born to mothers with diseases known to be spread by airborne route are placed in the AIIR until the neonate is found to be non-infectious.
      iii. Prior to entering the unit, visitors are screened for signs of ADT and immunization history. Visitors are asked not to visit for duration of illness.
   b. Labor and Delivery and Maternal Child Health
      i. Labor rooms may have portable HEPA units installed for mothers who have suspected ATD.
      ii. Staff follow Standard and Transmission based Precautions as indicated using the appropriate N-95 respirators or PAPRs for Airborne Precautions.
      iii. Rooms 200 and 201 are an AIIR and are used for MCH patients who require Airborne Precautions or need high hazard procedures.

~~6. Behavioral Health~~
   ~~i. Patients who develop symptoms of ATD will be assessed by the physician to determine the need for medical intervention.~~
   ~~ii. Source control will be implemented including masking the patient, use of tissues and hand hygiene.~~
   ~~iii. If ATD illness is suspected (see list above) the patient will be asked to remain in their room and wear a surgical mask while awaiting admission to the hospital for further treatment.~~
   ~~iv. If the patient is unable to wear a mask and non-compliant with containing respiratory secretions with tissues. Staff will wear appropriate PPE based on the transmission of the suspected illness (Droplet or Airborne transmission).~~
   ~~v. If droplet precautions are indicated (see list above) and the patient is medically stable, the patient may remain on the BHU and Droplet precautions will be instituted and maintained for the duration of illness.~~
   ~~vi. Airborne Precautions cannot be implemented in the BHU. The need for admission to the hospital will be assessed on a case by case basis.~~
   ~~vii. Patients who are identified as needing and AIIR will be transferred within five~~

~~hours of identification.~~

~~7.~~**6.** Laboratory Services
- a. Methods of implementation for ATD exposure control in are found in the Laboratory Medicine Biosafety Plan.
- b. For respiratory protection in Laboratory Services: See Employee Health & Wellness Policy: Respiratory Protection Program Policy

~~8.~~**7.** Facilities Management Staff
- a. Facilities Management staff will wear N-95 respirators when entering an AIIR housing patient(s) with known or suspected ATD.
- b. N95 respirators are required when repairing, replacing, or maintaining air systems or equipment that may contain or generate aerosolized pathogens.

~~9.~~**8.** Personal Protective Equipment
- a. The respiratory protection program policy (Employee Health and Wellness Manual) describes requirements of PPE used for ATD protection in accordance with 29CFR1910.134 and CCR Title 8, section 5144.
- b. Respiratory Protection including N95 respirators or PAPRs is required in any hospital location in the following circumstances:
  - i. **Entering an Airborne Precaution Room that is occupied or has been recently occupied (refer to** Section M: **Room Shutdown** Time**) by a patient with suspected or known Airborne transmitted ATD.**
  - ii. **Attending high hazard procedure**
  - ~~i. Entering an AIIR occupied by a patient with an airborne transmitted ATD~~
  - ~~ii. Entering an Airborne Precautions room that is occupied or has been occupied within the past hour by a patient with active untreated airborne illness including pulmonary or laryngeal TB.~~
  - ~~iii. Entering a regular room where a patient with active or untreated pulmonary or laryngeal TB is undergoing or has undergone within the past 8 hours any high-hazard medical procedure.~~
  - ~~iv. Providing services that involve the need to be in close prolonged contact with a patient with active untreated airborne transmissible illness including pulmonary or laryngeal TB.~~
  - ~~v. Attending high-hazard procedures.~~
- c. Respirator Shortages
  - i. In the event of reported shortages of N95 respirators the following is recommended (notification received from supplier but still able to meet historic usage):
    1) TCHD will maintain a cache of N95 respirators in accordance with the disaster plan.
    2) Materials Distribution staff will perform in-house inventory to determine available stock and develop a timeline for inventory depletion.
    3) According to available stock, N95 respirators will be prioritized for distribution to Pulmonary Services, ICU, and Emergency Department for use in high hazard procedures.
    4) Re-use of N95 respirators for known or suspected Tuberculosis patients over a 12 hour shift unless the respirator is contaminated (e.g. visibly soiled) or the integrity of the respirator is disrupted (e.g. torn, cracked nose piece).
    5) Reuse of N95 respirators is acceptable during the care of patients with other ATD's under the following circumstances:
       a) A protective face shield (no surgical mask) is donned over the respirator to protect the respirator from contamination of ATD.
       b) The respirator integrity remains intact
       c) During the care of intubated and ventilated patients (closed circuit suction systems).
  - ii. In severe respirator shortages (less than 30 days of stock available in house,

when supplier cannot meet the demand or can only supply an alternative N95) the following steps may be considered:

1) Prioritize available N95 for high hazard procedures.
2) Provide surgical grade masks for employees who are not provided a respirator due to the implementation of prioritized respirator use.
3) Contact Local Public Health Officer for possible acquisition of N95 respirators from local or state stockpiles.
4) Alternate manufacturer's respirators may be used in cases of tuberculosis and other airborne illnesses. Fit testing will be waived in a declared state of emergency.
5) Except during high hazard procedures, surgical masks may be used for H1N1 influenza.
6) PAPRs may be used.
7) The Infection Control Officer, Infection Preventionist, and the Safety Officer will determine if Internal Disaster Code Orange is warranted based on patient surge, physical and staffing resources.
8) When there is no option for providing N95 respirators, surgical masks will be provided to the employee.

iii. Positive Air Purifying Respirators (PAPRs)

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

~~10.~~**9.** Admissions and transfers of patients with known or suspected airborne transmissible ATD:

a. Airborne transmissible ATD suspect cases shall be identified, and the individuals shall be given disposable tissues, hand hygiene materials and the patient will be masked until an AIIR is available. Transfer to an AIIR shall be facilitated within five (5) hours of identification.
b. If an AIIR is not available, patients shall be transferred to a facility with AIIR availability.
c. If the physician determines that transfer to another facility AIIR would be detrimental to the patient's condition the patient need not be transferred. In this case, employees will use N95 respirators when entering the room or area housing the individual. The patient's condition will be reassessed every 24 hours to determine if transfer is safe and the determination shall be documented.

~~11.~~**10.** Influenza Season

a. From November 1 to March 31, all employees, volunteers, contract workers or others covered under the ATD standard must wear a standard surgical mask while on duty in the hospital. This requirement does not apply to anyone who has received the current influenza vaccine as recommended by the County of San Diego Public Health and Centers for Disease Control and Prevention.
b. The enforcement dates are subject to change based on the recommendations of the hospital's Infection Control Committee.
c. Non-compliance with this requirement is subject to discipline as outlined in the hospital's Human Resources policy.

~~R.~~**S.** **MEDICAL SERVICES:**

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

~~S.~~T. **TRAINING:**

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

~~T.~~U. **REVIEW SCHEDULE:**

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

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

1. Active/Rule Out Tuberculosis (TB) Surgery Protocol
2. Criteria for Infectiousness and Placement In High Risk Setting Table (PCU Unit Only)
3. Employee Health and Wellness Policy: Immunization
4. Employee Health and Wellness Policy: Respiratory Protection
5. Infection Control Policy: Risk Assessment and Surveillance Plan
6. Infection Control Policy: Epidemiologic Investigation of a Suspected Outbreak
7. Infection Control Policy: Healthcare Associated Infections, Defined
~~7.~~8. **Infection Control Policy: Standard and Transmission-Based Precautions**
~~8.~~9. **Type and Duration of Precautions - Disease Specific**

~~V.~~W. **REFERENCE(S):**

1. Centers for Disease Control & Prevention, Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis In Health Care Settings, 2005. MMWR 2005; 54 (No RR-17). .
2. Centers for Disease Control & Prevention, Guideline for Environmental Infection Control in Health Care Facilities, 2003 (last updated 02/15/2017)
3. Centers for Disease Control & Prevention H1N1 guidance, Seasonal Influenza and vaccine Guidance **https://www.cdc.gov/flu/professionals/index.htm, Accessed 2/14/19** ~~www.cdc.gov~~
4. California Department of Public Health, Occupational Health Branch. (2015, August). Respirator Selection Guide for Aerosol Transmissible Disease. **https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/CDPH%20Document%20Library/HCResp-ATD-RespSelectGuide.pdf Accessed 2/14/19** ~~https://archive.cdph.ca.gov/programs/ohb/Documents/HCResp-ATD-RespSelectGuide.pdf~~
5. California Department of Public Health: January 20, 2015 Interim Guidance on Personal Protective Equipment (PPE) to be used by Healthcare Workers in the Inpatient Hospital Setting during Management of Patients with Suspected or Confirmed Ebola Virus Disease in California.
~~5.~~6. **https://www.calhospital.org/sites/main/files/file-attachments/cdph_-_ppe_guidance_for_management_of_ebola_patients_in_an_inpatient_setting_-final_1-20-2015_posted.pdf Accessed 2/14/19**
~~6.~~7. Respiratory Hygiene/Cough Etiquette in Healthcare Settings www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm **Accessed 2/14/19**
~~7.~~8. OSHA Directive CPL 02-02-078 dated June 30, 2015: Enforcement Procedures & Scheduling for Occupational Exposure to Tuberculosis. **https://www.osha.gov/sites/default/files/enforcement/directives/CPL_02-02-078.pdf Accessed 2/14/19**
~~8.~~9. CDPH: Cal-OSHA Aerosol Transmissible Diseases Standard, **Title 8 CCR Section 5199** August 5, 2009 **https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/Pages/ATDStd.aspx Accessed 2/14/19**
~~9.~~ ~~https://archive.cdph.ca.gov/programs/ohb/Pages/ATDStd.aspx~~

10. CDC: Tuberculin Skin Testing for TB dated May 11, 2016. https://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm **Accessed 2/14/19**
11. Cadena, J. (2014) Tuberculosis and other Mycobacteria. In P. Grota (Ed.), *APIC Text of Infection Control and Epidemiology 4th Ed.*, 95:1-20.
12. Hospital Respiratory Protection Program Toolkit: U.S. Dept of Labor/CDC/OSHA/NIOSH. Dated May 2015. https://www.osha.gov/Publications/OSHA3767.pdf **Accessed 2/14/19**
13. CDPH/CTCA: California Tuberculosis Risk Assessment: Adults June 2017 https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-TB-Risk-Assessment-and-Fact-Sheet.pdf **Accessed 2/14/19**
14. CDPH Respirator Toolkit August 2015 (CDC, OSHA, NIOSH May 2015) page 16 https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/CDPH%20Document%20Library/HCResp-CARPPGuide.pdf **Accessed 2/14/19**

ACTIVE/RULE OUT TUBERCULOSIS (TB)

Surgery Protocol

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

~~Refer to Infection Control Policy #IC.11 "Aerosol Transmissible Diseases and Tuberculosis Control Plan"~~

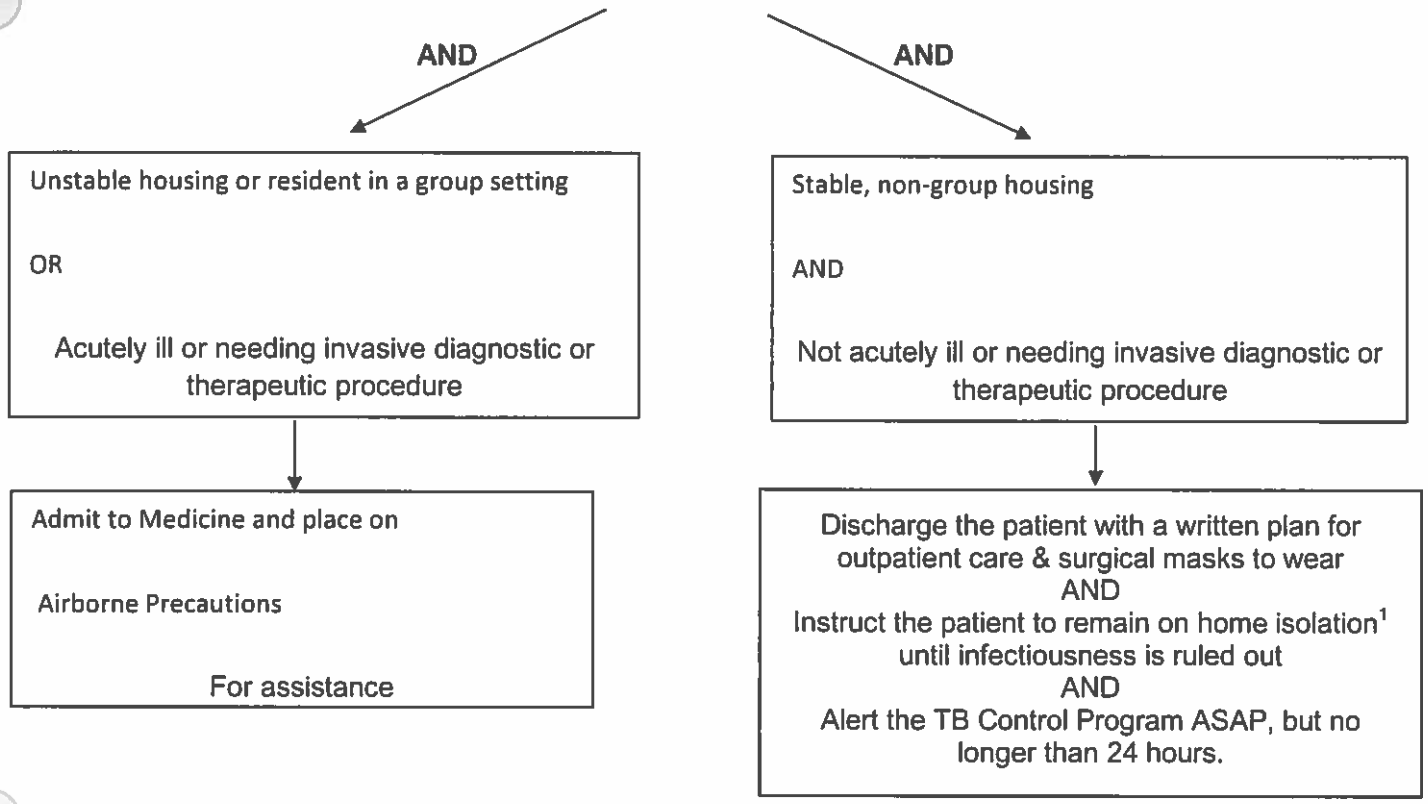
Criteria for Infectiousness and Placement In High Risk Setting Table (PCU Unit Only)

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

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

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

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



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

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

Tri-City Health Care District
Oceanside, California

INFECTION CONTROL ~~Policy Manual~~

ISSUE DATE: 01/92~~January 1992~~ **SUBJECT: Scabies and Lice**

REVISION DATE(S): 09/~~20~~04, 10/13~~, 5/19~~

Infection Control Department Approval ~~Date(s)~~:	~~07/16~~06/19
Infection Control Committee Approval ~~Date(s)~~:	~~07/16~~07/19
Pharmacy ~~and~~ &Therapeutics Committee Approval ~~Date(s)~~:	n/a
Medical Executive Committee Approval ~~Date(s)~~:	~~07/16~~07/19
Administration Approval:	08/19
Professional Affairs Committee Approval ~~Date(s)~~:	~~08/16~~ n/a
Board of Directors Approval ~~Date(s)~~:	08/16

A. **PURPOSE:**

1. Provide assistance in the management and identification of scabies and lice. To prevent transmission in the event of occupational exposure to scabies and or lice.

B. **INTRODUCTION:**

1. **Scabies** is a parasitic infestation of the skin caused by the human itch mite, *Sarcoptes scabiei.* The microscopic scabies mite burrows into the upper layer of skin where it lives and lays eggs. The typical presenting symptom in most patients with scabies is intense itching (pruritus), which is usually more severe at night, and a pimple like (papular) rash. In the immune-compromised, elderly, disabled, homeless or debilitated patients a generalized dermatitis more widely distributed is seen with extensive scaling, vesiculation and crusting. "Norwegian" or crusted scabies presents as a crusty, scaly dermatitis usually of the hands and feet. Persons with crusted scabies have thick crusts of skin that contain large number of scabies mites and eggs. Itching is remarkably minimal.
2. **Lice** are parasitic insects that can be found on people's heads and bodies including the pubic area which can result in severe itching. Lice are host specific and those of animals do not infest humans. Human lice survive by feeding on human blood. Lice move by crawling; they cannot hop or fly. Three types of lice are:
3. Head lice are 2.1-3.3mm in length. Head lice infest the head and neck and attach their eggs to the base of the hair shaft.
4. Body lice are 2.3-3.6mm in length. They are rarely found on the body except when feeding, they are usually found on clothing. They are known to spread disease.
5. Pubic (crab) lice are 1.1-1.8mm in length. Pubic lice are typically found attached to hair in the pubic area but sometimes are found on coarse hair elsewhere on the body (ie: eyebrows, eyelashes, beard, mustache, chest and armpits, etc)

C. **TRANSMISSION:**

1. **Scabies**:
   a. The scabies mite usually is spread by direct prolonged skin to skin contact with a person who has scabies. Scabies can be indirectly spread by sharing articles of clothing, towels or bedding with and infested person. On a person, scabies mites can live for as long as 1-2 months. Scabies mites generally do not survive more than 2-3 days away from human skin.
   b. Persons with "Norwegian" or crusted scabies are highly contagious to other persons due to the large number of mites present in the exfoliating scales. Infestation can spread easily by brief direct skin to skin contact and by contamination of items such as clothing, bedding or furniture.

2. **Lice:**
   a. Transmission requires direct contact with an infested person & objects used by them (ie: shared clothing and head wear) Lice crawl, but do not hop or fly. Eggs hatch within 7-10 days. Time of survival off host: Head lice: 2 days, Body lice: 4-7 days and Pubic (crab) lice 1 day.

D. **POLICY:**
1. Place patient in Contact Precautions upon realizing or suspecting the patient has scabies or lice.
2. Examination of the patient by nursing and medical staff to determine if scabies or lice are present.
   a. Bag up all personal clothing and belongings and seal the bag tightly. Send clothes and personal belongings with family if possible.
3. Provide topical treatment as prescribed per physician orders.
4. Continue Contact Precautions until 24 hours after **effective** treatment.
5. After patient is discharged and insects are visible in the room, place a work order for Building Engineering to contact Pest Control to inspect room.
6. Once room is cleared by inspection, have Environmental Services terminally clean room.

E. **OCCUPATIONAL EXPOSURE:**
1. Standard and Contact precautions should prevent the transmission of most cases of scabies and lice. If an exposure to a patient with scabies and or lice occur before Contact Precautions are applied and the patient is treated the employee should:
   a. Immediately report the exposure to their Supervisor, Charge Nurse or Manager as per Employee Health & Wellness policy: Guidelines for Reporting Exposure.
2. Employee Health Services will institute appropriate follow up as needed.

F. **RELATED DOCUMENT(S):**
1. Employee Health and Wellness Policy Manual: Injury & Illness Prevention Program
2. Employee Health and Wellness Policy Manual: Guidelines for Reporting Exposures policy
3. Infection Control **Policy**: Bloodborne Exposure Control Plan
4. Infection Control **Policy**: Philosophy
5. Infection Control **Policy**: Standard and Transmission Based Precautions
6. Infection Control **Policy**: Tuberculosis Exposure Control Plan

G. **REFERENCE(S) ~~LIST~~:**
1. APIC Text of Infection Control and Epidemiology, 4th edition, 2014
2. Control of Communicable Diseases Manual, D.L. Heymann, MD, Ed. 19th edition 2008
3. http://www.cdc.gov/parasites/scabies/index.html **(Accessed 5/2/19)**
4. http://www.cdc.gov/parasites/lice/ **(Accessed 5/2/19)**

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL

ISSUE DATE: 11/99

SUBJECT: Standard and Transmission-Based Precautions

REVISION DATE(S): 10/05, 01/11, 09/15, 01/17, 08/17~~, 5/19~~

Infection Control Department Approval:	~~04/18~~06/19
Infection Control Committee Approval:	~~04/18~~07/19
Pharmacy ~~and~~ & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~06/18~~07/19
Administration Approval:	08/19
Professional Affairs Committee Approval:	~~07/18~~ n/a
Board of Directors Approval:	07/18

A. **PURPOSE:**

1. The Centers for Disease Control and Prevention (CDC) and the Hospital Infection Control Advisory Council (HICPAC) published the Guidelines for Isolation Precautions in Hospitals in 2007. Changes were made to include respiratory hygiene/cough etiquette practices. Masking for spinal procedures and application of PPE prior to entering the room of a patient in Droplet or Contact Precautions
2. The current guidelines continue to support two levels of precautions, Standard Precautions and Transmission-based Precautions. Standard Precautions are the primary strategies to be used in the care of all patients to protect both healthcare workers and patients. Transmission-based Precautions are designed only for the care of specified patients, or patients known or suspected to be infected or colonized with epidemiologically important pathogens transmitted via airborne, droplet, or contact with dry skin or contaminated objects.

B. **POLICY:**

1. For immunocompromised patients see Patient Care Services: Neutropenic Precautions Policy.
   a. Use Standard Precautions, with emphasis on hand hygiene.
   b. Private room preferred. If semi-private room is used, select a roommate with no identified infection, including respiratory tract, urinary tract, or skin/wound infection.
   c. A patient is not required to wear a standard surgical mask when out of the room.
2. Physicians' role
   a. If a patient is known or suspected to be infected with a highly transmissible disease, or if a patient is infected or colonized with an epidemiologically important microorganism, appropriate isolation precautions should be ordered for the patient.
   b. In addition to hand washing before and after patient contact, wearing gloves before and discarding gloves and washing hands after touching any body substance, physicians need to evaluate their interaction with patients, and use barriers such as masks, eyewear and gown based upon anticipated contact with infectious materials.
   c. Physicians should be aware of their current vaccination status regarding (rubella, measles, varicella, hepatitis B) and participate in the Medical Center's annual tuberculosis screening program. All physicians who have frequent contact with blood and body fluids should be immunized against hepatitis B.
3. The role of nurses and other direct care providers is to:
   a. Assure that isolation orders are entered and proper isolation signage is posted outside of the patients' room.
   b. Perform hand hygiene before and after patient contact, wearing gloves before and discarding gloves and washing hands after touching any body substance. Direct care

providers need to evaluate their interaction with the patient and use barriers such as masks, eyewear, and gown based upon possible and anticipated contact with infectious aerosols, splashes, vomitus, etc. that may result during the contact.

c. If a patient has a disease that requires Transmission-based precautions, the nurse is responsible to triage persons wishing to enter the patient's room.

d. Any direct care provider who uses reusable equipment for a patient in contact precautions is responsible to disinfect that item before it is used for another patient.

e. The nurse and or caregiver is responsible to communicate to receiving departments the isolation status of a patient. This is accomplished by completing the Off Unit Transfer/Assessment: Type of Isolation/Precautions in the electronic medical record (EMR)

4. All direct care providers need to know their own hepatitis B, chicken pox, rubella and measles status and participate in the Medical Center's annual TB skin testing program. This participation is required by the hospital.

5. All direct care providers who have frequent contact with blood or body fluids should be immunized against hepatitis B. Free hepatitis vaccination is a benefit of employment at Tri-City Medical Center.

6. Specimen Labeling

~~a.~~ Standard Precautions tell us to consider all bodily fluids as potentially infectious regardless of the patients' diagnosis. Standard precautions need to be utilized while handling all specimens. (~~In 1990, the Clinical Laboratory established formal policies requiring that all specimens be handled as if potentially infectious. To place "blood and body fluid precautions" on specimen conveys the notion to others to treat this particular specimen with caution, but other specimen without the labeling need not be handled as carefully. If needed, it is permissible to note the patient's diagnosis on laboratory requests, pathology requests, radiology request, etc. Please note that it is illegal in the state of California to note a person's HIV status on requests).~~

7. Handling of soiled linen from patients' rooms

a. All linen must be handled in a consistent and identical manner because there are no "infectious linen" designations under Standard Precautions. All linen leaves the Medical Center in unmarked plastic bags. The contract laundry, also regulated by OSHA and the state, requires workers to wear protective barriers when handling soiled linen at all times. Linen should be handled minimally.

8. Dishware and eating utensils

a. The combination of hot water and detergents used in dishwashers is sufficient to decontaminate dishware and eating utensils. Therefore, no special precautions are needed for dishware (e.g., dishes, glasses, cups) or eating utensils; reusable dishware and utensils may be used for patients requiring Transmission-Based Precautions.

9. Disposal of waste from patients' rooms

a. All trash generated from individual patient rooms follow general hospital waste guidelines. If waste is saturated and/or dripping with blood place in the red "Biohazard" trash. See Infection Control Policy: Blood borne Pathogen Exposure Control Plan.

10. All closed system fluid filled containers (e.g., Pleur-evac, auto transfusion, etc.) are to be disposed of as follows:

a. Obtain a red "biohazardous" plastic bag from the soiled utility room.

b. Place the container into the bag and tie it securely by gathering the circumference and using a single knot to close the bag. Be sure to reinforce the bag if there is a leak or if leaking is anticipated.

c. If a patient's room does not have a "biohazard" waste receptacle, carry the red bag to the soiled utility room and place it into the labeled biohazard barrel.

d. All suction canister liners and tubing should be changed every 24 hours or when ¾ full, whichever comes first. Suction canisters liners may be emptied in the hopper or treated with a Liquid Treatment System (LTS). Once the contents solidify, the LTS, the canister liner and its contents are discarded in the regular trash.

11. Wound Dressings
    a. All wound dressings are to be disposed of in a manner as to confine and contain any body fluids that may be present. Wound dressings dripping with blood or bloody body fluids should be discarded in a red biohazard bag and placed into the biohazard barrel. Dressings with small amount of blood can be disposed of in the regular trash. Examples of these are IV dressings, trach site dressings, bandaids, gauze or cotton balls used in fingerstick glucose testing,
    b. Small dressings can be enclosed in a disposable glove used to remove the dressing. Pull the glove off inside out containing the dressing inside of it. The dressing and gloves can be discarded into the regular trash container in the patient's room.

C. **STANDARD PRECAUTIONS:**

1. Standard Precautions are designed to reduce risk of transmission of blood-borne pathogens transmission of pathogens to and from mucus membranes and non-intact skin.
    a. All blood, body fluids, secretions, excretions (except sweat) are handled as if potentially carrying bloodborne pathogens. Clean gloves are required when touching non-intact skin and mucus membranes.
2. Elements of Standard Precautions
    a. All personnel should implement Standard Precautions at all times regardless of the patient's diagnosis
    b. Hand Hygiene: See Infection Control Policy: Hand Hygiene
        i. Respiratory Hygiene/Cough Etiquette education of healthcare facility staff, patients, and visitors is accomplished through New Employee and Physician Orientation, the patient hand book and signage posted at cough etiquette stations provided throughout the hospital. Tissues are provided along with hand hygiene solution and adult and child sized masks in patient waiting areas throughout the hospital.
    c. Gloves
        i. Wear gloves when touching blood, body fluids, secretions, excretions, contaminated objects, mucous membranes and non-intact skin.
        ii. Change gloves between tasks and procedures on the same patient when moving from one body site to another.
        iii. Remove gloves after use, before touching uncontaminated items and environmental surfaces, and before going to another patient.
        iv. ~~Decontaminate~~ **Perform hand hygiene** ~~hands~~ immediately after removing gloves.
    d. Masks, Eye/Face Shields
        i. Wear a mask, eye protection or a face shield to protect mucous membranes of the eyes, nose, and mouth during procedures and activities that are likely to create splashes or sprays of blood, body fluids, secretions and excretions. (See Infection Control Policy: Blood borne Pathogen Exposure Control Plan, Appendix: Standard Precautions: Personal Precautions Equipment Table)
        ii. Wear a mask for insertion of catheters or injection of material into spinal or epidural spaces via lumbar puncture procedures (e.g., myelogram, spinal or epidural anesthesia).
    e. Gown
        i. Wear gown or plastic apron to protect the skin and prevent soiling of clothing during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions or excretions or cause soiling of clothing.
3. Flowers and Potted Plants
        i. Designate care and maintenance of flowers and potted plants to staff not directly involved with patient care
        ii. If plant or flower care by patient-care staff is unavoidable, instruct the staff to

wear gloves when handling the plants and flowers and perform hand hygiene after glove removal

4. Patient Care Equipment
   a. Handle used patient care equipment contaminated with blood, body fluids, secretions and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to other patients and the environment.
   b. Ensure that reusable equipment is properly cleaned and disinfected before it is used for the care of another patient.
   c. Single use items should be discarded.
5. Environmental Control
   a. Routine cleaning and disinfection of environmental surfaces, beds, bedrails, bedside equipment, and other frequently touched surfaces per protocol.
6. Safe injection practices – see Patient Care Services: Medication Administration policy. The following practices apply to the use of needles, cannulas that replace needles, and, where applicable intravenous delivery systems:
   a. Use aseptic technique to avoid contamination of sterile injection equipment.
   b. Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use.
   c. Multi-dose vials should be dedicated to a single patient whenever possible. If multidose vials must be used both the needle or cannula and syringe used to access the multidose vial must be sterile.
7. Do not keep multidose vials in the immediate patient treatment area and store in accordance with the manufacturer's recommendations; discard if sterility is compromised or questionable.

D. **TRANSMISSION-BASED PRECAUTIONS:**

1. Transmission-based Precautions are used in addition to Standard Precautions for diseases that require extra barriers to prevent transmission.
   a. Types of Transmission-based Precautions:
      i. Airborne Precautions
      ii. Droplet Precautions
      iii. Contact Precautions
   b. See Type and Duration of Precautions - Disease Specific (FKA Short Sheet - https://tcmc.ellucid.com/documents/view/4323).
   c. Communicate and notify receiving department/services if patient requires Transmission-based Precautions (i.e. Airborne, Contact or Droplet Precautions).
2. Airborne Precautions
   a. In addition to Standard Precautions, use Airborne Precautions for patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei.
   b. Place patient in an Airborne Infection Isolation room AIIR with at least 6-12 air exchanges per hour, HEPA filtration and negative pressure. If the AIIR rooms are not available Engineering can assist with a temporary set-up. Every effort must be made to place a patient in an AIIR within 5 hours of identification.
   c. Wear respiratory protection (N95 respirator or Powered Air Purifying Respirator) when entering the room. See the Infection Control Policy: ATD: Tuberculosis Control Plan for more information.
   d. Minimize patient dispersal of microorganisms by placing a surgical mask (not an N95 respirator) on the patient during transport.
3. Droplet Precautions
   a. In addition to Standard Precautions, use Droplet Precautions for a patient known or suspected to be infected with organisms that are transmitted by droplets
   b. Place the patient in a private room or cohort patients who have the same infection with the same microorganism.
   c. Wear masks when entering the patient room.

d. Mask patients during transport.

4. Contact Precautions
   a. In addition to Standard Precautions, use Contact Precautions for specified patients known or infected or colonized with epidemiologically important microorganism that can be transmitted via direct contact with the patient or equipment in the patients' environment such as MRSA and VRE. (See Infection Control Policy: Management of Patients with MDRO's)
   b. Place patient in a private room or cohort patients who are carrying the same microorganisms. When a private room is not available and cohorting is not achievable, consider the epidemiology of the microorganism and the patient population when determining patient placement. First try to select someone with no invasive lines (IV, central line, foley, trach, etc.) or open wound. If this is not possible, then select someone with an invasive line that carries a low risk of infection, such as a peripheral IV or NG tube. Consultation with **I**infection ~~control~~ **Prevention** staff is advised when there are questions about patient placement.
   c. Gloves
      i. Wear gloves whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient (e.g. medical equipment, bed rails) Don gloves upon entry into the room or cubicle **and continue to follow Standard Precautions.**~~.~~
   d. Gowns
      i. Wear a gown whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient. Don gown upon entry into the room or cubicle **and continue to follow Standard Precautions**.
      ii. Remove gown and gloves and **perform**~~observe~~ hand hygiene before leaving the patient-care **room or** environment
   e. Dedicate the use of non-critical equipment to a single patient, when possible
   f. Clean and disinfect commonly used items before use of another patient with hospital approved disinfectant
   g. Patient transport
      i. Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients on Contact Precautions. Don clean PPE to handle the patient at the transport destination.

E. **PREGNANT HEALTH CARE WORKERS:**

1. Pregnant healthcare workers are not more likely to contract infections from patients.
2. Unless a pregnant healthcare worker is susceptible to a patient's infection, the HCW will provide the same care as provided by non-pregnant worker.
3. Restricting pregnant HCW from caring for patients with potentially transmissible infections is considered only for patients with parvovirus B19 and for patients with respiratory syncytial virus infections who are receiving ribavirin aerosol.

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

~~1. Clinical Syndromes or Conditions Warranting Empiric Transmission- Based Precautions in Addition to Standard Precautions~~
~~2. Infection Control Considerations for High Priority (CDC Category A) Diseases that May Result from Bioterrorist Attacks or are Considered to be Bioterrorist Threats~~
~~3.~~**1.** Infection Control Policy: ATD: Tuberculosis Control Plan
~~4.~~**2.** Infection Control Policy: Blood borne Pathogen Exposure Control Plan
~~5.~~**3.** Infection Control Policy: Ebola Plan
~~6.~~**4.** Patient Care Services Policy: Medication Administration
~~7.~~**5.** Patient Care Services Policy: Neutropenic Precautions
~~8. Recommendations for Application of Standard Precautions for the Care of All Patients in All~~

~~Healthcare Settings~~

~~9.~~6. Type and Duration of Precautions - Disease Specific (~~F~~AKA Short Sheet)

G. **REFERENCE(S):**

1. Centers for Disease Control and Prevention (200~~1~~7). CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Setting. Retrieved from https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/index.html **Accessed 5-14-19**
2. Grota, P. (Ed.). (2014) APIC Text of Infection Control and Epidemiology (4th ed). Washington DC: Association for Professionals in Infection control and Epidemiology, Inc.
3. Sehulster LM, Chinn RYW, Arduino MJ, Carpenter J, Donlan R, Ashford D, Besser R, Fields B, McNeil MM, Whitney C, Wong S, Juranek D, Cleveland J. Guidelines for environmental infection control in health-care facilities. Recommendations from CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Chicago IL; American Society for Healthcare Engineering/American Hospital Association; 2004. **https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines.pdf Accessed 5-14-19**
4. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007 **https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf Accessed 5-14-19** ~~http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf~~

Type and Duration of Precautions - Disease Specific (~~FKA~~ **AKA** Short Sheet)

A. **CONTACT PRECAUTIONS:**

1. For illnesses easily passed by direct contact with the patient or equipment. Private room if available. Cohort with others with same organisms. Do not place with fresh post-op or patients with invasive tubes. HCW wear gloves in the room and add a gown if clothes might touch objects or the patient. Use a mask is to protect your face from sprays or splashes.

B. **DROPLET PRECAUTIONS:**

1. For illnesses passed in large droplets (wet drop to wet mucus membrane contact). Private room if available. Cohort with others with same organisms. HCW wear a mask when closer than 3 ft. to the patient. Surgical masks for visitors going closer than 3 ft. to the patient and for patients outside the isolation rooms.

C. **AIRBORNE PRECAUTIONS:**

1. For illnesses passed in the air. Place in a negative pressure room (C26, 143, 243, 443, 287, 387, 487, 200, 201, 301, 312 & 326) Keep the door closed at all times. HCW wear N95 respirators in the patient's room. Surgical masks for visitors going into the isolation room and for patients outside the isolation rooms.

Type and Duration of Precautions - Disease Specific (~~FKA~~ AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Abscess Draining, major	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	No dressing or containment of drainage; until drainage stops or can be contained by dressing
Abscess Draining, minor or limited	Standard		Dressing covers and contains drainage
Acquired human immunodeficiency syndrome (HIV)	Standard		Post-exposure chemoprophylaxis for some blood exposures [866].
Actinomycosis	Standard		Not transmitted from person to person
Adenovirus infection (see agent-specific guidance under gastroenteritis, conjunctivitis, pneumonia)			
Amebiasis	Standard		Person to person transmission is rare. Transmission in settings for the mentally challenged and in a family group has been reported [1045]. Use care when handling diapered infants and mentally challenged persons [1046].
Anthrax	Standard		Infected patients do not generally pose a transmission risk.
Anthrax Cutaneous	Standard		Transmission through non-intact skin contact with draining lesions possible, therefore use Contact Precautions if large amount of uncontained drainage. Handwashing with soap and water preferable to use of waterless alcohol based antiseptics since alcohol does not have sporicidal activity [983].
Anthrax Pulmonary	Standard		Not transmitted from person to person
Anthrax Environmental: aerosolizable spore-containing powder or other substance		Until environment completely decontaminated	Until decontamination of environment complete [203]. Wear respirator (N95 mask or PAPRs), protective clothing; decontaminate persons with powder on them (Occupational Health Guidelines for Remediation Workers at Bacillus anthracis-Contaminated Sites — United States, 2001--2002 (https://www.cdc.gov/mmwr/preview/mmwrhtml/mm513 5a3.htm)) Hand hygiene: Handwashing for 30-60 seconds with soap and water or 2% chlorhexidene gluconate after spore contact (alcohol handrubs inactive against spores [983]. Post-exposure prophylaxis following environmental exposure: 60 days of antimicrobials (either doxycycline, ciprofloxacin, or levofloxacin) and post-exposure vaccine under IND
Antibiotic-associated colitis (see *Clostridium difficile*)			
Arthropod-borne • viral encephalitides (eastern, western, Venezuelan equine encephalomyelitis; St Louis, California encephalitis; West Nile Virus) and	Standard		Not transmitted from person to person except rarely by transfusion, and for West Nile virus by organ transplant, breastmilk or transplacentally [530, 1047]. Install screens in windows and doors in endemic areas. Use DEET-containing mosquito repellants and

Type and Duration of Precautions - Disease Specific (~~FKA~~ **AKA** Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
viral fevers (dengue, yellow fever, Colorado tick fever)			clothing to cover extremities.
Ascariasis	Standard		Not transmitted from person to person
Aspergillosis	Standard		Contact Precautions and Airborne if massive soft tissue infection with copious drainage and repeated irrigations required [154].
Avian influenza (see influenza, avian below)			
Babesiosis	Standard		Not transmitted from person to person except rarely by transfusion.
Blastomycosis, North American, cutaneous or pulmonary	Standard		Not transmitted from person to person
Botulism	Standard		Not transmitted from person to person
Bronchiolitis (see respiratory infections in infants and young children)	Contact + Standard	Duration of illness	Use mask according to Standard Precautions.
Brucellosis (undulant, Malta, Mediterranean fever)	Standard		Not transmitted from person to person except rarely via banked spermatozoa and sexual contact [1048, 1049]. Provide antimicrobial prophylaxis following laboratory exposure [1050].
Campylobacter gastroenteritis (see gastroenteritis)			
Candidiasis, all forms including mucocutaneous	Standard		
Cat-scratch fever (benign inoculation lymphoreticulosis)	Standard		Not transmitted from person to person
Cellulitis	Standard		
Chancroid (soft chancre) (*H. ducreyi*)	Standard		Transmitted sexually from person to person
Chickenpox (see >varicella)			
Chlamydia trachomatis Conjunctivitis	Standard		
Chlamydia trachomatis Genital (lymphogranuloma venereum)	Standard		
Chlamydia trachomatis Pneumonia (infants ≤3 mos. of age)	Standard		
Chlamydia pneumoniae	Standard		Outbreaks in institutionalized populations reported, rarely [1051, 1052].
Cholera (see gastroenteritis)			
Closed-cavity infection Open drain in place; limited or minor drainage	Standard		Contact Precautions if there is copious uncontained drainage
Closed-cavity infection No drain or closed drainage system in place	Standard		
Clostridium botulinum	Standard		Not transmitted from person to person
Clostridium difficile (see gastroenteritis, *C. difficile*)	Contact + Standard	Duration of illness	
Clostridium perfringens Food poisoning	Standard		Not transmitted from person to person
Clostridium perfringens Gas gangrene	Standard		Transmission from person to person rare; one outbreak in a surgical setting reported [1053]. Use

Type and Duration of Precautions - Disease Specific (~~FKA~~ **AKA** Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			Contact Precautions if wound drainage is extensive.
Coccidioidomycosis (valley fever) Draining lesions	Standard		Not transmitted from person to person except under extraordinary circumstances because the infectious arthroconidial form of *Coccidioides immitis* is not produced in humans [1054].
Coccidioidomycosis (valley fever) Pneumonia	Standard		Not transmitted from person to person except under extraordinary circumstances, (e.g., inhalation of aerosolized tissue phase endospores during necropsy, transplantation of infected lung) because the infectious arthroconidial form of *Coccidioides immitis* is not produced in humans [1054, 1055].
Colorado tick fever	Standard		Not transmitted from person to person
Congenital rubella	Contact + Standard	Until 1 yr of age	Standard Precautions if nasopharyngeal and urine cultures repeatedly neg. after 3 mos. of age
Conjunctivitis Acute bacterial	Standard		
Conjunctivitis Acute bacterial *Chlamydia*	Standard		
Conjunctivitis Acute bacterial Gonococcal	Standard		
Conjunctivitis Acute viral (acute hemorrhagic)	Contact + Standard	Duration of illness	Adenovirus most common; enterovirus 70 [1056], Coxsackie virus A24 [1057] also associated with community outbreaks. Highly contagious; outbreaks in eye clinics, pediatric and neonatal settings, institutional settings reported. Eye clinics should follow Standard Precautions when handling patients with conjunctivitis. Routine use of infection control measures in the handling of instruments and equipment will prevent the occurrence of outbreaks in this and other settings. [460, 814, 1058, 1059 461, 1060].
Corona virus associated with SARS (SARS-CoV) (see severe acute respiratory syndrome)			
Coxsackie virus disease (see enteroviral infection)			
Creutzfeldt-Jakob disease (CJD, vCJD)	Standard		Use disposable instruments or special sterilization/disinfection for surfaces, objects contaminated with neural tissue if CJD or vCJD suspected and has not been R/O; No special burial procedures [1061]
Croup (see respiratory infections in infants and young children)			
Crimean-Congo Fever (see Viral Hemorrhagic Fever)	Standard		
Cryptococcosis	Standard		Not transmitted from person to person, except rarely via tissue and corneal transplant [1062, 1063]
Cryptosporidiosis (see gastroenteritis)			
Cysticercosis	Standard		Not transmitted from person to person
Cytomegalovirus infection, including neonates and immunosuppressed patients	Standard		No additional precautions for pregnant HCWs

Type and Duration of Precautions - Disease Specific (~~FKA~~ **AKA** Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
)ecubitus ulcer (see Pressure ulcer)			
Dengue fever	Standard		Not transmitted from person to person
Diarrhea, acute-infective etiology suspected (see gastroenteritis)			
Diphtheria Cutaneous	Contact + Standard	Until off antimicrobial treatment and culture-negative	Until 2 cultures taken 24 hours apart negative
Diphtheria Pharyngeal	Droplet + Standard	Until off antimicrobial treatment and culture-negative	Until 2 cultures taken 24 hours apart negative
Ebola virus (see viral hemorrhagic fevers)			⚠ Ebola Virus Disease for Healthcare Workers [2014]: Update: Updated recommendations for healthcare workers can be found at Ebola: U.S. Healthcare Workers and Settings (https://www.cdc.gov/vhf/ebola/healthcare-us/).
Echinococcosis (hydatidosis)	Standard		Not transmitted from person to person
Echovirus (see enteroviral infection)			
Encephalitis or encephalomyelitis (see specific etiologic agents)			
Endometritis (endomyometritis)	Standard		
Enterobiasis (pinworm disease, oxyuriasis)	Standard		
Enterococcus species (see multidrug-resistant organisms if epidemiologically significant or vancomycin resistant)			
Enterocolitis, *C. difficile* (see *C. difficile*, gastroenteritis)			
Enteroviral infections (i.e., Group A and B Coxsackie viruses and Echo viruses) (excludes polio virus)	Standard		Use Contact Precautions for diapered or incontinent children for duration of illness and to control institutional outbreaks
Epiglottitis, due to *Haemophilus influenzae* type b	Droplet + Standard	Until 24 hours after initiation of effective therapy	See specific disease agents for epiglottitis due to other etiologies)
Epstein-Barr virus infection, including infectious mononucleosis	Standard		
Erythema infectiosum (also see Parvovirus B19)			
Escherichia coli gastroenteritis (see gastroenteritis)			
Food poisoning Botulism	Standard		Not transmitted from person to person
Food poisoning C. *perfringens* or *welchii*	Standard		Not transmitted from person to person
Food poisoning Staphylococcal	Standard		Not transmitted from person to person
Furunculosis, staphylococcal	Standard		Contact if drainage not controlled. Follow

Type and Duration of Precautions - Disease Specific (~~FKA~~ **AKA** Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			institutional policies if MRSA
Furunculosis, staphylococcal Infants and young children	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	
Gangrene (gas gangrene)	Standard		Not transmitted from person to person
Gastroenteritis	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks for gastroenteritis caused by all of the agents below
Gastroenteritis Adenovirus	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis *Campylobacter* species	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis Cholera (*Vibrio cholerae*)	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis *C. difficile*	Contact + Standard	Duration of illness	Discontinue antibiotics if appropriate. Do not share electronic thermometers [853], 854; ensure consistent environmental cleaning and disinfection. Hypochlorite solutions may be required for cleaning if transmission continues [847]. Handwashing with soap and water preferred because of the absence of sporicidal activity of alcohol in waterless antiseptic handrubs [983].
Gastroenteritis *Cryptosporidium species*	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis *E. coli* Enteropathogenic O157:H7 and other shiga toxin- producing strains	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis *E. coli* Other species	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis *Giardia lamblia*	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis Noroviruses	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks. Persons who clean areas heavily contaminated with feces or vomitus may benefit from wearing masks since virus can be aerosolized from these body substances [142, 147 148]; ensure consistent environmental cleaning and disinfection with focus on restrooms even when apparently unsoiled [273, 1064]). Hypochlorite solutions may be required when there is continued transmission [290-292]. Alcohol is less active, but there is no evidence that alcohol antiseptic handrubs are not effective for hand decontamination [294]. Cohorting of affected patients to separate airspaces

Type and Duration of Precautions - Disease Specific (~~FKA~~ **AKA** Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			and toilet facilities may help interrupt transmission during outbreaks.
Gastroenteritis Rotavirus	Contact + Standard	Duration of illness	Ensure consistent environmental cleaning and disinfection and frequent removal of soiled diapers. Prolonged shedding may occur in both immunocompetent and immunocompromised children and the elderly [932, 933].
Gastroenteritis *Salmonella* species (including *S. typhi*)	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis *Shigella* species (Bacillary dysentery)	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis Vibrio parahaemolyticus	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis Viral (if not covered elsewhere)	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis *Yersinia enterocolitica*	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
German measles (see rubella; see congenital rubella)			
Giardiasis (see gastroenteritis)			
Gonococcal ophthalmia neonatorum (gonorrheal ophthalmia, acute conjunctivitis of newborn)	Standard		
Gonorrhea	Standard		
Granuloma inguinale (Donovanosis, granuloma venereum)	Standard		
Guillain-Barre' syndrome	Standard		Not an infectious condition
Haemophilus influenzae (see disease- specific recommendations)			
Hand, foot, and mouth disease (see enteroviral infection)			
Hansen's Disease (see Leprosy)			
Hantavirus pulmonary syndrome	Standard		Not transmitted from person to person
Helicobacter pylori	Standard		
Hepatitis, viral Type A	Standard		Provide hepatitis A vaccine post-exposure as recommended [1065]
Hepatitis, viral Type A-Diapered or incontinent patients	Contact + Standard		Maintain Contact Precautions in infants and children <3 years of age for duration of hospitalization; for children 3-14 yrs. of age for 2 weeks after onset of symptoms; >14 yrs. of age for 1 week after onset of symptoms [833, 1066, 1067].
Hepatitis, viral Type B-HBsAg positive; acute or chronic	Standard		See specific recommendations for care of patients in hemodialysis centers 778
Hepatitis, viral Type C and other unspecified non-A, non-B	Standard		See specific recommendations for care of patients in hemodialysis centers [778]
Hepatitis, viral	Standard		

Type and Duration of Precautions - Disease Specific (~~FKA~~ AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Type D (seen only with hepatitis B)			
Hepatitis, viral Type E	Standard		Use Contact Precautions for diapered or incontinent individuals for the duration of illness [1068]
Hepatitis, viral Type G	Standard		
Herpangina (see enteroviral infection)			
Hookworm	Standard		
Herpes simplex (*Herpesvirus hominis*) Encephalitis	Standard		
Herpes simplex (Herpesvirus hominis) Mucocutaneous, disseminated or primary, severe	Contact + Standard	Until lesions dry and crusted	
Herpes simplex (Herpesvirus hominis) Mucocutaneous, recurrent (skin, oral, genital)	Standard		
Herpes simplex (Herpesvirus hominis) Neonatal	Contact + Standard	Until lesions dry and crusted	Also, for asymptomatic, exposed infants delivered vaginally or by C-section and if mother has active infection and membranes have been ruptured for more than 4 to 6 hours until infant surface cultures obtained at 24-36 hours. of age negative after 48 hours incubation [1069, 1070]
Herpes zoster (varicella-zoster) (shingles) Disseminated disease in any patient Localized disease in immunocompromised patient until disseminated infection ruled out	Airborne + Contact + Standard	Duration of illness	Susceptible HCWs should not enter room if immune caregivers are available; no recommendation for protection of immune HCWs; no recommendation for type of protection, i.e. surgical mask or respirator; for susceptible HCWs.
Herpes zoster (varicella-zoster) (shingles) Localized in patient with intact immune system with lesions that can be contained/covered	Standard	Duration of illness (with wound lesions, until wounds stop draining)	Susceptible HCWs should not provide direct patient care when other immune caregivers are available.
Histoplasmosis	Standard		Not transmitted from person to person
Human immunodeficiency virus (HIV)	Standard		Post-exposure chemoprophylaxis for some blood exposures [866].
Human metapneumovirus	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	HAI reported [1071], but route of transmission not established [823]. Assumed to be Contact transmission as for RSV since the viruses are closely related and have similar clinical manifestations and epidemiology. Wear masks according to Standard Precautions.
Impetigo	Contact + Standard	Until 24 hours after initiation of effective therapy	
Infectious mononucleosis	Standard		
Influenza Human (seasonal Influenza)	-		See Prevention Strategies for Seasonal Influenza in Healthcare Settings (https://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm) for current seasonal influenza guidance.

Type and Duration of Precautions - Disease Specific (~~FKA~~ AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
nfluenza Avian (e.g., H5N1, H7, H9 strains)	-		See [This link is no longer active: www.cdc.gov/flu/avian/professional/infect-control.htm. Similar information may be found at Interim Guidance for Infection Control Within Healthcare Settings When Caring for Confirmed Cases, Probable Cases, and Cases Under Investigation for Infection with Novel Influenza A Viruses Associated with Severe Disease (https://www.cdc.gov/flu/avianflu/novel-flu-infection- control.htm), accessed May 2016.] for current avian Influenza guidance.
Influenza Pandemic Influenza (also a human Influenza virus)	Droplet		See [This link is no longer active: http://www.pandemicflu.gov. Similar information may be found at Interim Guidance for Infection Control Within Healthcare Settings When Caring for Confirmed Cases, Probable Cases, and Cases Under Investigation for Infection with Novel Influenza A Viruses Associated with Severe Disease (https://www.cdc.gov/flu/avianflu/novel-flu-infection-control.htm), accessed May 2016.] for current pandemic Influenza guidance.
Kawasaki syndrome	Standard		Not an infectious condition
Lassa fever (see viral hemorrhagic fevers)	-		
Legionnaires' disease	Standard		Not transmitted from person to person
Leprosy	Standard		
Leptospirosis	Standard		Not transmitted from person to person
ice Head (pediculosis)	Contact + Standard	Until 24 hours after initiation of effective therapy	See [This link is no longer active: http://www.cdc.gov/ ncidod/dpd/parasites/lice/default.htm.Similar information may be found at CDC's Parasites - Lice (https://www.cdc.gov/parasites/lice/index.html), accessed May 2016.]
Lice Body	Standard		Transmitted person to person through infested clothing. Wear gown and gloves when removing clothing; bag and wash clothes according to CDC guidance [This link is no longer active: http://www.cdc.gov/ncidod/dpd/ parasites/lice/default.htm. Similar information may be found at CDC's Parasites - Lice (https://www.cdc.gov/parasites/lice/index.html), accessed May 2016.]
Lice Pubic	Standard		Transmitted person to person through sexual contact. See CDC's [This link is no longer active: http://www.cdc.gov/ncidod/dpd/parasites/lice/default .ht m. Similar information may be found at CDC's Parasites - Lice (https://www.cdc.gov/parasites/lice/index.html), accessed May 2016.]
Listeriosis (listeria monocytogenes)	Standard		Person-to-person transmission rare; cross-transmission in neonatal settings reported [1072, 1073 1074, 1075]
yme disease	Standard		Not transmitted from person to person
ymphocytic choriomeningitis	Standard		Not transmitted from person to person

Type and Duration of Precautions - Disease Specific (~~FKA~~ **AKA** Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Lymphogranuloma venereum	Standard		
Malaria	Standard		Not transmitted from person to person except through transfusion rarely and through a failure to follow Standard Precautions during patient care 1076-1079. Install screens in windows and doors in endemic areas. Use DEET-containing mosquito repellants and clothing to cover extremities.
Marburg virus disease (see viral hemorrhagic fevers)	-		
Measles (rubeola)	Airborne + Standard	4 days after onset of rash; duration of illness (with wound lesions, until wounds stop draining) in immune compromised	⚠ Measles Update [November 2011]: Updated recommendations can be found at Immunization of Healthcare Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP) (https://www.cdc.gov/mmwr/pdf/rr/rr6007.pdf). Susceptible HCWs should not enter room if immune care providers are available; no recommendation for face protection for immune HCW; no recommendation for type of face protection for susceptible HCWs, i.e., mask or respirator [1027, 1028]. For exposed susceptibles, post-exposure vaccine within 72 hours or immune globulin within 6 days when available [17, 1032, 1034]. Place exposed susceptible patients on Airborne Precautions and exclude susceptible healthcare personnel.
Melioidosis, all forms	Standard		Not transmitted from person to person.
Meningitis Aseptic (nonbacterial or viral; also see enteroviral infections)	Standard		Contact for infants and young children.
Meningitis Bacterial, gram-negative enteric, in neonates	Standard		
Meningitis Fungal	Standard		
Meningitis *Haemophilus Influenzae*, type b known or suspected	Droplet + Standard	Until 24 hours after initiation of effective therapy	
Meningitis *Listeria monocytogenes* (See Listeriosis)	Standard		
Meningitis *Neisseria meningitidis* (meningococcal) known or suspected	Droplet + Standard	Until 24 hours after initiation of effective therapy	See meningococcal disease below.
Meningitis *Streptococcus pneumoniae*	Standard		
Meningitis *M. tuberculosis*	Standard		Concurrent, active pulmonary disease or draining cutaneous lesions may necessitate addition of Contact and/or Airborne; For children, Airborne Precautions until active tuberculosis ruled out in visiting family members (see tuberculosis below) 42

Type and Duration of Precautions - Disease Specific (~~FKA~~ AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
leningitis Other diagnosed bacterial	Standard		
Meningococcal disease: sepsis, pneumonia, Meningitis	Droplet + Standard	Until 24 hours after initiation of effective therapy	Postexposure chemoprophylaxis for household contacts, HCWs exposed to respiratory secretions; postexposure vaccine only to control outbreaks 15, 17.
Molluscum contagiosum	Standard		
Monkeypox	Airborne + Contact + Standard	Airborne-Until monkeypox confirmed and smallpox excluded Contact-Until lesions crusted	See CDC's Monkeypox website (https://www.cdc.gov/poxvirus/monkeypox/) [Current version of this document may differ from original.] for most current recommendations. Transmission in hospital settings unlikely [269]. Pre- and post-exposure smallpox vaccine recommended for exposed HCWs
Mucormycosis	Standard		
Multidrug-resistant organisms (MDROs), infection or colonization (e.g., MRSA, VRE, VISA/VRSA, ESBLs, resistant *S. pneumoniae*)	Contact + Standard		MDROs judged by the infection control program, based on local, state, regional, or national recommendations, to be of clinical and epidemiologic significance. Contact Precautions recommended in settings with evidence of ongoing transmission, acute care settings with increased risk for transmission or wounds that cannot be contained by dressings. See recommendations for management options in Management of Multidrug-Resistant Organisms In Healthcare Settings, 2006 (https://www.cdc.gov/infectioncontrol/guidelines/mdro/) [870]. Contact state health department for guidance regarding new or emerging MDRO.
Mumps (infectious parotitis)	Droplet + Standard	Until 9 days	After onset of swelling; susceptible HCWs should not provide care if immune caregivers are available. Note: (Recent assessment of outbreaks in healthy 18- 24 year olds has indicated that salivary viral shedding occurred early in the course of illness and that 5 days of isolation after onset of parotitis may be appropriate in community settings; however the implications for healthcare personnel and high-risk patient populations remain to be clarified.)
Mycobacteria, nontuberculosis (atypical)			Not transmitted person-to-person
Mycobacteria, nontuberculosis (atypical) Pulmonary	Standard		
Mycobacteria, nontuberculosis (atypical) Wound	Standard		
Mycoplasma pneumonia	Droplet + Standard	Duration of Illness	
Necrotizing enterocolitis	Standard		Contact Precautions when cases clustered temporally [1080-1083].
Nocardiosis, draining lesions, or other presentations	Standard		Not transmitted person-to-person
Norovirus (see gastroenteritis)			
Norwalk agent Gastroenteritis ee gastroenteritis)			
Orf	Standard		

Type and Duration of Precautions - Disease Specific (~~FKA~~ AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Parainfluenza virus infection, respiratory in infants and young children	Contact + Standard	Duration of illness	Viral shedding may be prolonged in immunosuppressed patients [1009, 1010]. Reliability of antigentesting to determine when to remove patients with prolonged hospitalizations from Contact Precautions uncertain.
Parvovirus B19 (Erythema infectiosum)	Droplet + Standard		Maintain precautions for duration of hospitalization when chronic disease occurs in an immunocompromised patient. For patients with transient aplastic crisis or red-cell crisis, maintain precautions for 7 days. Duration of precautions for immunosuppressed patients with persistently positive PCR not defined, but transmission has occurred [929].
Pediculosis (Lice)	Contact + Standard	Until 24 hours after initiation of effective therapy after treatment	
Pertussis (whooping cough)	Droplet + Standard	Until 5 days	Single patient room preferred. Cohorting an option. Post-exposure chemoprophylaxis for household contacts and HCWs with prolonged exposure to respiratory secretions [863]. Recommendations for Tdap vaccine in adults under development. ⚠ Tdap Vaccine Recommendations [2011] Update: Current recommendations can be found at Tdap / Td ACIP Vaccine Recommendations (www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/tdap-td.html).
Pinworm infection (Enterobiasis)	Standard		
Plague (*Yersinia pestis*) Bubonic	Standard		
Plague (*Yersinia pestis*) Pneumonic	Droplet + Standard	Until 48 hours	Antimicrobial prophylaxis for exposed HCW [207].
Pneumonia Adenovirus	Droplet + Contact + Standard	Duration of illness	Outbreaks in pediatric and institutional settings reported [376, 1084-1086]. In immunocompromised hosts, extend duration of Droplet and Contact Precautions due to prolonged shedding of virus [931]
Pneumonia Bacterial not listed elsewhere (including gram-negative bacterial)	Standard		
Pneumonia *B. cepacia* in patients with CF, including respiratory tract colonization	Contact + Standard	Unknown	Avoid exposure to other persons with CF; private room preferred. Criteria for D/C precautions not established. See CF Foundation guideline [20]
Pneumonia *B. cepacia* in patients without CF (see multidrug-resistant organisms)			
Pneumonia *Chlamydia*	Standard		
Pneumonia	Standard		

Type and Duration of Precautions - Disease Specific (~~FKA~~ **AKA** Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Fungal			
Pneumonia *Haemophilus influenzae*, type b Adults	Standard		
Pneumonia *Haemophilus influenzae*, type b Infants and children	Droplet + Standard	Until 24 hours after initiation of effective therapy	
Pneumonia *Legionella spp.*	Standard		
Pneumonia Meningococcal	Droplet + Standard	Until 24 hours after initiation of effective therapy	See meningococcal disease above
Pneumonia Multidrug-resistant bacterial (see multidrug-resistant organisms)			
Pneumonia *Mycoplasma* (primary atypical Pneumonia)	Droplet	Duration of illness	
Pneumonia Pneumococcal pneumonia	Standard		Use Droplet Precautions if evidence of transmission within a patient care unit or facility [196-198, 1087]
Pneumonia *Pneumocystis jiroveci* (*Pneumocystis carinii*)	Standard		Avoid placement in the same room with an immunocompromised patient.
neumonia *Staphylococcus aureus*	Standard		For MRSA, see MDROs
Pneumonia Streptococcus, group A Adults	Droplet + Standard	Until 24 hours after initiation of effective therapy	See streptococcal disease (group A streptococcus) below Contact precautions if skin lesions present
Pneumonia *Streptococcus*, group A Infants and young children	Droplet + Standard	Until 24 hours after initiation of effective therapy	Contact Precautions if skin lesions present
Pneumonia Varicella-zoster (See Varicella- Zoster)			
Pneumonia Viral Adults	Standard		
Pneumonia Viral Infants and young children (see respiratory infectious disease, acute, or specific viral agent)			
Poliomyelitis	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	
ressure ulcer (decubitus lcer, pressure sore) infected	Contact + Standard	Duration of illness (with	If no dressing or containment of drainage; until drainage stops or can be contained by dressing

Type and Duration of Precautions - Disease Specific (~~FKA~~ **AKA** Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Major		wound lesions, until wounds stop draining)	
Pressure ulcer (decubitus ulcer, pressure sore) infected Minor or limited	Standard		If dressing covers and contains drainage
Prion disease (See Creutzfeld-Jacob Disease)			
Psittacosis (ornithosis) (*Chlamydia psittaci*)	Standard		Not transmitted from person to person
Q fever	Standard		
Rabies	Standard		Person to person transmission rare; transmission via corneal, tissue and organ transplants has been reported [539, 1088]. If patient has bitten another individual or saliva has contaminated an open wound or mucous membrane, wash exposed area thoroughly and administer postexposure prophylaxis. [1089]
Rat-bite fever (*Streptobacillus moniliformis* disease, *Spirillum minus* disease)	Standard		Not transmitted from person to person
Relapsing fever	Standard		Not transmitted from person to person
Resistant bacterial infection or colonization (see multidrug-resistant organisms)			
Respiratory infectious disease, acute (if not covered elsewhere) Adults	Standard		
Respiratory infectious disease, acute (if not covered elsewhere) Infants and young children	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	Also see syndromes or conditions listed in Table 2
Respiratory syncytial virus infection, in infants, young children and immunocompromised adults	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	Wear mask according to Standard Precautions [24] CB [116, 117]. In immunocompromised patients, extend the duration of Contact Precautions due to prolonged shedding [928]). Reliability of antigen testing to determine when to remove patients with prolonged hospitalizations from Contact Precautions uncertain.
Reye's syndrome	Standard		Not an infectious condition
Rheumatic fever	Standard		Not an infectious condition
Rhinovirus	Droplet + Standard	Duration of illness (with wound lesions, until wounds stop draining)	Droplet most important route of transmission [104 1090]. Outbreaks have occurred in NICUs and LTCFs [413, 1091, 1092]. Add Contact Precautions if copious moist secretions and close contact likely to occur (e.g., young infants) [111, 833].
Rickettsial fevers, tickborne (Rocky Mountain spotted fever, tickborne Typhus fever)	Standard		Not transmitted from person to person except through transfusion, rarely
Rickettsialpox (vesicular rickettsiosis)	Standard		Not transmitted from person to person
Ringworm (dermatophytosis, dermatomycosis, tinea)	Standard		Rarely, outbreaks have occurred in healthcare settings, (e.g., NICU [1093], rehabilitation hospital [1094]. Use Contact Precautions for outbreak.
Ritter's disease Staphylococcal scalded skin	Contact + Standard	Duration of illness (with	See staphylococcal disease, scalded skin syndrome below

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
yndrome)		wound lesions, until wounds stop draining)	
Rocky Mountain spotted fever	Standard		Not transmitted from person to person except through transfusion, rarely
Roseola infantum (exanthem subitum; caused by HHV-6)	Standard		
Rotavirus infection (see gastroenteritis)			
Rubella (German measles) (also see congenital rubella)	Droplet + Standard	Until 7 days after onset of rash	Susceptible HCWs should not enter room if immune caregivers are available. No recommendation for wearing face protection (e.g., a surgical mask) if immune. Pregnant women who are not immune should not care for these patients [17, 33]. Administer vaccine within three days of exposure to non-pregnant susceptible individuals. Place exposed susceptible patients on Droplet Precautions; exclude susceptible healthcare personnel from duty from day 5 after first exposure to day 21 after last exposure, regardless of post-exposure vaccine.
Rubeola (see measles)			
Salmonellosis (see gastroenteritis)			
Scabies	Contact	Until 24	
Scalded skin syndrome, staphylococcal	Contact	Duration of illness (with wound lesions, until wounds stop draining)	See staphylococcal disease, scalded skin syndrome below)
Schistosomiasis (bilharziasis)	Standard		
Severe acute respiratory syndrome (SARS)	Airborne + Droplet + Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining) plus 10 days after resolution of fever, provided respiratory symptoms are absent or improving	Airborne preferred; D if AIIR unavailable. N95 or higher respiratory protection; surgical mask if N95 unavailable; eye protection (goggles, face shield); aerosol- generating procedures and "supershedders" highest risk for transmission via small droplet nuclei and large droplets [93, 94, 96]. Vigilant environmental disinfection (see [This link is no longer active: www.cdc.gov/ncidod/sars. Similar information may be found at CDC Severe Acute Respiratory Syndrome (SARS) (https://www.cdc.gov/sars/index.html), accessed May 2016.])
Shigellosis (see gastroenteritis)			
Smallpox (variola; see Vaccinia for management of vaccinated persons)	Airborne + Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	Until all scabs have crusted and separated (3-4 weeks). Non-vaccinated HCWs should not provide care when immune HCWs are available; N95 or higher respiratory protection for susceptible and successfully vaccinated individuals; postexposure vaccine within 4 days of exposure protective [108, 129, 1038-1040].
Sporotrichosis	Standard		
Spirillum minor disease (rat-bite fever)	Standard		Not transmitted from person to person
Staphylococcal disease (*S aureus*) Skin, wound, or burn	Contact	Duration of illness (with wound lesions,	No dressing or dressing does not contain drainage adequately

Type and Duration of Precautions - Disease Specific (~~FKA~~ **AKA** Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Major		until wounds stop draining)	
Staphylococcal disease (*S aureus*) Skin, wound, or burn Minor or limited	Standard		Dressing covers and contains drainage adequately
Staphylococcal disease (*S aureus*) Enterocolitis	Standard		Use Contact Precautions for diapered or incontinent children for duration of illness
Staphylococcal disease (*S aureus*) Multidrug-resistant (see multidrug-resistant organisms)			
Staphylococcal disease (*S aureus*) Pneumonia	Standard		
Staphylococcal disease (*S aureus*) Scalded skin syndrome	Contact	Duration of illness (with wound lesions, until wounds stop draining)	Consider healthcare personnel as potential source of nursery, NICU outbreak [1095].
Staphylococcal disease (*S aureus*) Toxic shock syndrome	Standard		
Streptobacillus moniliformis disease (rat-bite fever)	Standard		Not transmitted from person to person
Streptococcal disease (group A streptococcus) Skin, wound, or burn Major	Contact + Droplet + Standard	Until 24 hours after initiation of effective therapy	No dressing or dressing does not contain drainage adequately
Streptococcal disease (group A streptococcus) Skin, wound, or burn Minor or limited	Standard		Dressing covers and contains drainage adequately
Streptococcal disease (group A streptococcus) Endometritis (puerperal sepsis)	Standard		
Streptococcal disease (group A streptococcus) Pharyngitis in infants and young children	Droplet	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A streptococcus) Pneumonia	Droplet	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A streptococcus) Scarlet fever in infants and young children	Droplet	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A streptococcus) Serious invasive disease	Droplet	Until 24 hours after initiation of effective therapy	Outbreaks of serious invasive disease have occurred secondary to transmission among patients and healthcare personnel [162, 972, 1096-1098] Contact Precautions for draining wound as above; follow rec. for antimicrobial prophylaxis in selected conditions [160].
Streptococcal disease (group	Standard		

Type and Duration of Precautions - Disease Specific (~~FKA~~ AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
streptococcus), neonatal			
Streptococcal disease (not group A or B) unless covered elsewhere Multidrug-resistant (see multidrug-resistant organisms)			
Strongyloidiasis	Standard		
Syphilis Latent (tertiary) and seropositivity without lesions	Standard		
Syphilis Skin and mucous membrane, including congenital, primary, secondary	Standard		
Tapeworm disease *Hymenolepis nana*	Standard		Not transmitted from person to person
Tapeworm disease *Taenia solium* (pork)	Standard		
Tapeworm disease Other	Standard		
Tetanus	Standard		Not transmitted from person to person
Tinea (e.g., dermatophytosis, dermatomycosis, ringworm)	Standard		Rare episodes of person-to-person transmission
Toxoplasmosis	Standard		Transmission from person to person is rare; vertical transmission from mother to child, transmission through organs and blood transfusion rare
Toxic shock syndrome (staphylococcal disease, streptococcal disease)	Standard		Droplet Precautions for the first 24 hours after implementation of antibiotic therapy if Group A streptococcus is a likely etiology
Trachoma, acute	Standard		
Transmissible spongiform encephalopathy (see Creutzfeld-Jacob disease, CJD, vCJD)			
Trench mouth (Vincent's angina)	Standard		
Trichinosis	Standard		
Trichomoniasis	Standard		
Trichuriasis (whipworm disease)	Standard		
Tuberculosis (*M. tuberculosis*) Extrapulmonary, draining lesion	Airborne + Contact + Standard		Discontinue precautions only when patient is improving clinically, and drainage has ceased or there are three consecutive negative cultures of continued drainage [1025, 1026]. Examine for evidence of active pulmonary tuberculosis.
Tuberculosis (*M. tuberculosis*) Extrapulmonary, no draining lesion, Meningitis	Standard		Examine for evidence of pulmonary tuberculosis. For infants and children, use Airborne until active pulmonary tuberculosis in visiting family members ruled out [42]
Tuberculosis (*M. tuberculosis*) Pulmonary or laryngeal disease, confirmed	Airborne		Discontinue precautions only when patient on effective therapy is improving clinically and has three consecutive sputum smears negative for acid-fast bacilli collected on separate days (MMWR 2005; 54: RR-17 Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005 (https://www.cdc.gov/mmwr/preview/mmwrhtml/rr541

Type and Duration of Precautions - Disease Specific (~~FKA~~ AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			7a_1.htm?s_cid=rr5417a1_e)) [12].
Tuberculosis (*M. tuberculosis*) Pulmonary or laryngeal disease, suspected	Airborne		Discontinue precautions only when the likelihood of infectious TB disease is deemed negligible, and either 1. there is another diagnosis that explains the clinical syndrome or 2. the results of three sputum smears for AFB are negative. Each of the three sputum specimens should be collected 8-24 hours apart, and at least one should be an early morning specimen
Tuberculosis (*M. tuberculosis*) Skin-test positive with no evidence of current active disease	Standard		
Tularemia Draining lesion	Standard		Not transmitted from person to person
Tularemia Pulmonary	Standard		Not transmitted from person to person
Typhoid (*Salmonella typhi*) fever (see gastroenteritis)			
Typhus *Rickettsia prowazekii* (Epidemic or Louse-borne Typhus)	Standard		Transmitted from person to person through close personal or clothing contact
Typhus *Rickettsia typhi*	Standard		Not transmitted from person to person
Urinary tract infection (including pyelonephritis), with or without urinary catheter	Standard		
Vaccinia			Only vaccinated HCWs have contact with active vaccination sites and care for persons with adverse vaccinia events; if unvaccinated, only HCWs without contraindications to vaccine may provide care.
Vaccinia Vaccination site care (including autoinoculated areas)	Standard		Vaccination recommended for vaccinators; for newly vaccinated HCWs: semi-permeable dressing over gauze until scab separates, with dressing change as fluid accumulates, ~3-5 days; gloves, hand hygiene for dressing change; vaccinated HCW or HCW without contraindication to vaccine for dressing changes [205, 221, 225].
Vaccinia (adverse events following vaccination) Eczema vaccinatum	Contact	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material
Vaccinia (adverse events following vaccination) Fetal vaccinia	Contact	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material
Vaccinia (adverse events following vaccination) Generalized vaccinia	Contact	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material
Vaccinia (adverse events following vaccination)	Contact		For contact with virus-containing lesions and exudative material

Type and Duration of Precautions - Disease Specific (~~FKA~~ **AKA** Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Progressive vaccinia			
Vaccinia (adverse events following vaccination) PostVaccinia encephalitis	Standard		
Vaccinia (adverse events following vaccination) Blepharitis or conjunctivitis	Contact + Standard		Use Contact Precautions if there is copious drainage
Vaccinia (adverse events following vaccination) Iritis or keratitis	Standard		
Vaccinia (adverse events following vaccination) Vaccinia-associated erythema multiforme (Stevens Johnson Syndrome)	Standard		Not an infectious condition
Vaccinia (adverse events following vaccination) Secondary bacterial infection (e.g., *S. aureus*, group A beta hemolytic streptococcus)	Standard + Contact		Follow organism-specific (strep, staph most frequent) recommendations and consider magnitude of drainage
Varicella Zoster	Airborne + Contact + Standard	Until lesions dry and crusted	Susceptible HCWs should not enter room if immune caregivers are available; no recommendation for face protection of immune HCWs; no recommendation for type of protection, i.e., surgical mask or respirator for susceptible HCWs. In immunocompromised host with varicella Pneumonia, prolong duration of precautions for duration of illness. Post-exposure prophylaxis: provide post-exposure vaccine ASAP but within 120 hours; for susceptible exposed persons for whom vaccine is contraindicated (immunocompromised persons, pregnant women, newborns whose mother's varicella onset is <5days before delivery or within 48 hours after delivery) provide VZIG, when available, within 96 hours; if unavailable, use IVIG, Use Airborne for exposed susceptible persons and exclude exposed susceptible healthcare workers beginning 8 days after first exposure until 21 days after last exposure or 28 if received VZIG, regardless of postexposure vaccination. [1036].
Variola (see smallpox)			
Vibrio parahaemolyticus (see gastroenteritis)			
Vincent's angina (trench mouth)	Standard		
Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses	Standard + Droplet + Contact	Duration of illness (with wound lesions, until wounds stop draining)	⚠ Ebola Virus Disease Update [2014]: Updated recommendations for healthcare workers can be found at Ebola: U.S. Healthcare Workers and Settings (https://www.cdc.gov/vhf/ebola/healthcare-us/). Single-patient room preferred. Emphasize: 1. use of sharps safety devices and safe work practices,

Type and Duration of Precautions - Disease Specific (~~FKA~~ AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			2. hand hygiene; 3. barrier protection against blood and body fluids upon entry into room (single gloves and fluid-resistant or impermeable gown, face/eye protection with masks, goggles or face shields); and 4. appropriate waste handling. Use N95 or higher respirators when performing aerosol-generating procedures. Largest viral load in final stages of illness when hemorrhage may occur; additional PPE, including double gloves, leg and shoe coverings may be used, especially in resource-limited settings where options for cleaning and laundry are limited. Notify public health officials immediately if Ebola is suspected [212, 314, 740, 772]. Also see Table 3 for Ebola as a bioterrorism agent.
Viral respiratory diseases (not covered elsewhere) Adults	Standard		
Viral respiratory diseases (not covered elsewhere) Infants and young children (see respiratory infectious disease, acute)			
Whooping cough (see pertussis)			
Wound infections Major	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	No dressing or dressing does not contain drainage adequately
Wound infections Minor or limited	Standard		Dressing covers and contains drainage adequately
Yersinia enterocolitica Gastroenteritis (see gastroenteritis)			
Zoster (varicella-zoster) (see herpes zoster)			
Zygomycosis (phycomycosis, mucormycosis)	Standard		Not transmitted person-to-person

Type and Duration of Precautions - Disease Specific (~~FKA~~ **AKA** Short Sheet)

Clinical Syndromes or Conditions Warranting Empiric Transmission- Based Precautions in Addition to Standard Precautions

Disease	Clinical Syndrome or Condition†	Potential Pathogens‡	Empiric Precautions (Always Includes Standard Precautions)
Diarrhea	Acute diarrhea with a likely infectious cause in an incontinent or diapered patient	Enteric pathogens§	Contact Precautions (pediatrics and adult)
Meningitis	Meningitis	*Neisseria meningitidis*	Droplet Precautions for first 24 hours of antimicrobial therapy; mask and face protection for intubation
Meningitis	Meningitis	Enteroviruses	Contact Precautions for infants and children
Meningitis	Meningitis	*M. tuberculosis*	Airborne Precautions if pulmonary infiltrate Airborne Precautions plus Contact Precautions if potentially infectious draining body fluid present
Rash or Exanthems, Generalized, Etiology Unknown	Petechial/ecchymotic with fever (general)	*Neisseria meningitides*	Droplet Precautions for first 24 hours of antimicrobial therapy
Rash or Exanthems, Generalized, Etiology Unknown	Petechial/ecchymotic with fever (general) - If positive history of travel to an area with an ongoing outbreak of VHF in the 10 days before onset of fever	Ebola, Lassa, Marburg viruses	Droplet Precautions plus Contact Precautions, with face/eye protection, emphasizing safety sharps and barrier precautions when blood exposure likely. Use N95 or higher respiratory protection when aerosol-generating procedure performed. ⚠ Ebola Virus Disease Update [2014]: Updated recommendations for healthcare workers can be found at Ebola: U.S. Healthcare Workers and Settings (https://www.cdc.gov/vhf/ebola/health care-us/).
Rash or Exanthems, Generalized, Etiology Unknown	Vesicular	Varicella-zoster, *herpes simplex*, variola (smallpox), vaccinia viruses	Airborne plus Contact Precautions; Contact Precautions only if Herpes simplex, localized zoster in an immunocompetent host or vaccinia viruses most likely
Rash or Exanthems, Generalized, Etiology Unknown	Maculopapular with cough, coryza and fever	Rubeola (measles) virus	Airborne Precautions
Respiratory Infections	Cough/fever/upper lobe pulmonary infiltrate in an HIV- negative patient or a patient at low risk for human immunodeficiency virus (HIV) infection	*M. tuberculosis*, Respiratory viruses, *S. pneumoniae*, *S. aureus* (MSSA or MRSA)	Airborne Precautions plus Contact precautions
Respiratory Infections	Cough/fever/pulmonary infiltrate in any lung location in an HIV-infected patient or a patient at high risk for HIV	*M. tuberculosis*, Respiratory viruses, *S. pneumoniae*, *S. aureus* (MSSA or	Airborne Precautions plus Contact Precautions Use eye/face protection if aerosol-generating procedure performed or contact with respiratory secretions

Type and Duration of Precautions - Disease Specific (~~FKA~~ AKA Short Sheet)

Disease	Clinical Syndrome or Condition†	Potential Pathogens‡	Empiric Precautions (Always Includes Standard Precautions)
	infection	MRSA)	anticipated. If tuberculosis is unlikely and there are no AIIRs and/or respirators available, use Droplet Precautions instead of Airborne Precautions Tuberculosis more likely in HIV-infected individual than in HIV negative individual
Respiratory Infections	Cough/fever/pulmonary infiltrate in any lung location in a patient with a history of recent travel (10-21 days) to countries with active outbreaks of SARS, avian influenza	*M. tuberculosis*, severe acute respiratory syndrome virus (SARS- CoV), avian influenza	Airborne plus Contact Precautions plus eye protection. If SARS and tuberculosis unlikely, use Droplet Precautions instead of Airborne Precautions.
Respiratory Infections	Respiratory infections, particularly bronchiolitis and pneumonia, in infants and young children	Respiratory syncytial virus, parainfluenza virus, adenovirus, influenza virus, *Human metapneumovirus*	Contact plus Droplet Precautions; Droplet Precautions may be discontinued when adenovirus and influenza have been ruled out
Skin or Wound Infection	Abscess or draining wound that cannot be covered	*Staphylococcus aureus* (MSSA or MRSA), group A streptococcus	Contact Precautions Add Droplet Precautions for the first 24 hours of appropriate antimicrobial therapy if invasive Group A streptococcal disease is suspected

⚠ **Format Change [February 2017]:** The format of this section was changed to improve readability and accessibility. The content is unchanged.

* Infection control professionals should modify or adapt this table according to local conditions. To ensure that appropriate empiric precautions are implemented always, hospitals must have systems in place to evaluate patients routinely according to these criteria as part of their preadmission and admission care.
† Patients with the syndromes or conditions listed below may present with atypical signs or symptoms (e.g.neonates and adults with pertussis may not have paroxysmal or severe cough). The clinician's index of suspicion should be guided by the prevalence of specific conditions in the community, as well as clinical judgment.
‡ The organisms listed under the column "Potential Pathogens" are not intended to represent the complete, or even most likely, diagnoses, but rather possible etiologic agents that require additional precautions beyond Standard Precautions until they can be ruled out.
§ These pathogens include enterohemorrhagic *Escherichia coli* O157:H7, *Shigella spp*, hepatitis A virus, noroviruses, rotavirus, *C. difficile*.

Infection Control Considerations for High-Priority (CDC Category A) Diseases that May Result from Bioterrorist Attacks or are Considered to be Bioterrorist Threats

Table 3A. Anthrax

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode Cutaneous and inhalation disease have occurred in past bioterrorist incidents	Cutaneous (contact with spores); Respiratory Tract: (inhalation of spores); Gastrointestinal Tract (ingestion of spores - rare) Comment: Spores can be inhaled into the lower respiratory tract. The infectious dose of *B. anthracis* in humans by any route is not precisely known. In primates, the LD50 (i.e., the dose required to kill 50% of animals) for an aerosol challenge with *B. anthracis* is estimated to be 8,000–50,000 spores; the infectious dose may be as low as 1-3 spores
Incubation Period	Cutaneous: 1 to12 days; Respiratory Tract: Usually 1 to 7 days but up to 43 days reported; Gastrointestinal Tract: 15-72 hours
Clinical Features	Cutaneous: Painless, reddish papule, which develops a central vesicle or bulla in 1-2 days; over next 3-7 days lesion becomes pustular, and then necrotic, with black eschar; extensive surrounding edema. Respiratory Tract: initial flu-like illness for 1-3 days with headache, fever, malaise, cough; by day 4 severe dyspnea and shock, and is usually fatal (85%- 90% if untreated; meningitis in 50% of Respiratory Tract cases. Gastrointestinal Tract: if intestinal form, necrotic, ulcerated edematous lesions develop in intestines with fever, nausea and vomiting, progression to hematemesis and bloody diarrhea; 25-60% fatal
Diagnosis	Cutaneous: Swabs of lesion (under eschar) for immunohistochemistry, polymerase chain reaction and culture; punch biopsy for immunohistochemistry, polymerase chain reaction and culture; vesicular fluid aspirate for Gram stain and culture; blood culture if systemic symptoms; acute and convalescent sera for ELISA serology Respiratory Tract: Chest X-ray or CT scan demonstrating wide mediastinal widening and/or pleural effusion, hilar abnormalities; blood for culture and polymerase chain reaction; pleural effusion for culture, polymerase chain reaction and immunohistochemistry; cerebrospinal fluid if meningeal signs present for immunohistochemistry, polymerase chain reaction and culture; acute and convalescent sera for ELISA serology; pleural and/or bronchial biopsies immunohistochemistry. Gastrointestinal Tract: blood and ascites fluid, stool samples, rectal swabs, and swabs of oropharyngeal lesions if present for culture, polymerase chain reaction and immunohistochemistry.
Infectivity	Cutaneous: Person-to-person transmission from contact with lesion of untreated patient possible, but extremely rare. Respiratory Tract and Gastrointestinal Tract: Person-to-person transmission does not occur. Aerosolized powder, environmental exposures: Highly infectious if aerosolized
Recommended Precautions	Cutaneous: Standard Precautions; Contact Precautions if uncontained copious drainage. Respiratory Tract and Gastrointestinal Tract: Standard Precautions. Aerosolized powder, environmental exposures: Respirator (N95 mask or Powered Air Purifying Respirators), protective clothing; decontamination of persons with powder on them (Occupational Health Guidelines for Remediation Workers at Bacillus anthracis-Contaminated Sites --- United States, 2001--2002 (https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5135a3.htm)). Hand hygiene: Handwashing for 30-60 seconds with soap and water or 2% chlorhexidene gluconate after spore contact (alcohol handrubs inactive against spores [Weber DJ JAMA 2003; 289:1274]). Post-exposure prophylaxis following environmental exposure: 60 days of antimicrobials (either doxycycline, ciprofloxacin, or levofloxacin) and post- exposure vaccine under IND

Table 3B. Botulism

Characteristics	Infection Control Considerations
Site(s) of Infection;	Gastrointestinal Tract: Ingestion of toxin-containing food,

Type and Duration of Precautions - Disease Specific (~~EKA~~ **AKA** Short Sheet)

Characteristics	Infection Control Considerations
Transmission Mode	Respiratory Tract: Inhalation of toxin containing aerosol cause disease. Comment: Toxin ingested or potentially delivered by aerosol in bioterrorist incidents. LD50 (lethal dose for 50% of experimental animals) for type A is 0.001 µg/ml/kg.
Incubation Period	1-5 days.
Clinical Features	Ptosis, generalized weakness, dizziness, dry mouth and throat, blurred vision, diplopia, dysarthria, dysphonia, and dysphagia followed by symmetrical descending paralysis and respiratory failure.
Diagnosis	Clinical diagnosis; identification of toxin in stool, serology unless toxin-containing material available for toxin neutralization bioassays.
Infectivity	Not transmitted from person to person. Exposure to toxin necessary for disease.
Recommended Precautions	Standard Precautions.

Table 3C. Ebola Hemorrhagic Fever

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode	As a rule infection develops after exposure of mucous membranes or respiratory tract, or through broken skin or percutaneous injury.
Incubation Period	2-19 days, usually 5-10 days
Clinical Features	Febrile illnesses with malaise, myalgias, headache, vomiting and diarrhea that are rapidly complicated by hypotension, shock, and hemorrhagic features. Massive hemorrhage in < 50% pts.
Diagnosis	Etiologic diagnosis can be made using respiratory tract-polymerase chain reaction, serologic detection of antibody and antigen, pathologic assessment with immunohistochemistry and viral culture with EM confirmation of morphology,
Infectivity	Person-to-person transmission primarily occurs through unprotected contact with blood and body fluids; percutaneous injuries (e.g., needlestick) associated with a high rate of transmission; transmission in healthcare settings has been reported but is prevented by use of barrier precautions.
Recommended Precautions	Hemorrhagic fever specific barrier precautions: If disease is believed to be related to intentional release of a bioweapon, epidemiology of transmission is unpredictable pending observation of disease transmission. Until the nature of the pathogen is understood and its transmission pattern confirmed, Standard, Contact and Airborne Precautions should be used. Once the pathogen is characterized, if the epidemiology of transmission is consistent with natural disease, Droplet Precautions can be substituted for Airborne Precautions. Emphasize: 1. use of sharps safety devices and safe work practices, 2. hand hygiene; 3. barrier protection against blood and body fluids upon entry into room (single gloves and fluid- resistant or impermeable gown, face/eye protection with masks, goggles or face shields); and 4. appropriate waste handling. Use N95 or higher respirators when performing aerosol-generating procedures. In settings where AIIRs are unavailable or the large numbers of patients cannot be accommodated by existing AIIRs, observe Droplet Precautions (plus Standard Precautions and Contact Precautions) and segregate patients from those not suspected of VHF infection. Limit blooddraws to those essential to care. See text for discussion and Appendix A for recommendations for naturally occurring VHFs.

Plague

Pneumonic plague is not as contagious as is often thought. Historical accounts and contemporary evidence indicate that persons with plague usually transmit the infection only when the disease is in the end stage. These persons cough copious amounts of bloody sputum that contains many plague bacteria. Patients in the early stage of primary pneumonic plague (approximately the first 20–24 h) apparently pose little risk [1, 2]. Antibiotic medication rapidly clears the sputum of plague bacilli, so that a patient generally is not infective within hours after initiation of effective antibiotic treatment [3]. This means that in modern times many patients will never reach a stage where they pose a

significant risk to others. Even in the end stage of disease, transmission only occurs after close contact. Simple protective measures, such as wearing masks, good hygiene, and avoiding close contact, have been effective to interrupt transmission during many pneumonic plague outbreaks [2]. In the United States, the last known cases of person to person transmission of pneumonic plague occurred in 1925 [2].

Table 3D. Plague

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode	Respiratory Tract: Inhalation of respiratory droplets. Comment: Pneumonic plague most likely to occur if used as a biological weapon, but some cases of bubonic and primary septicemia may also occur. Infective dose 100 to 500 bacteria
Incubation Period	1 to 6, usually 2 to 3 days.
Clinical Features	Pneumonic: fever, chills, headache, cough, dyspnea, rapid progression of weakness, and in a later stage hemoptysis, circulatory collapse, and bleeding diathesis
Diagnosis	Presumptive diagnosis from Gram stain or Wayson stain of sputum, blood, or lymph node aspirate; definitive diagnosis from cultures of same material, or paired acute/convalescent serology.
Infectivity	Person-to-person transmission occurs via respiratory droplets risk of transmission is low during first 20-24 hours of illness and requires close contact. Respiratory secretions probably are not infectious within a few hours after initiation of appropriate therapy.
Recommended Precautions	Standard Precautions, Droplet Precautions until patients have received 48 hours of appropriate therapy. Chemoprophylaxis: Consider antibiotic prophylaxis for HCWs with close contact exposure.

1. Wu L-T. A treatise on pneumonic plague. Geneva: League of Nations, 1926. III. Health.
2. Kool JL. Risk of person to person transmission of pneumonic plague. Clinical Infectious Diseases, 2005; 40 (8): 1166-1172
3. Butler TC. Plague and other Yersinia infections. In: Greenough WB, ed. Current topics in infectious disease. New York: Plenum Medical Book Company, 1983.

Table 3E. Smallpox

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode	Respiratory Tract Inhalation of droplet or, rarely, aerosols; and skin lesions (contact with virus). Comment: If used as a biological weapon, natural disease, which has not occurred since 1977, will likely result.
Incubation Period	7 to 19 days (mean 12 days)
Clinical Features	Fever, malaise, backache, headache, and often vomiting for 2-3 days; then generalized papular or maculopapular rash (more on face and extremities), which becomes vesicular (on day 4 or 5) and then pustular; lesions all in same stage.
Diagnosis	Electron microscopy of vesicular fluid or culture of vesicular fluid by WHO approved laboratory (CDC); detection by polymerase chain reaction available only in select LRN labs, CDC and USAMRID
Infectivity	Secondary attack rates up to 50% in unvaccinated persons; infected persons may transmit disease from time rash appears until all lesions have crusted over (about 3 weeks); greatest infectivity during first 10 days of rash.
Recommended Precautions	Combined use of Standard, Contact, and Airborne Precautions until all scabs have separated (3-4 weeks). Transmission by the airborne route is a rare event; Airborne Precautions is recommended when possible, but in the event of mass exposures, barrier precautions and containment within a designated area are most important. [204, 212] Only immune HCWs to care for pts; post-exposure vaccine within 4 days. Vaccinia: HCWs cover vaccination site with gauze and semi-permeable dressing until scab separates (≥21 days). Observe hand hygiene. Adverse events with virus-containing lesions: Standard plus Contact Precautions until all lesions crusted. Vaccinia adverse events with lesions containing infectious virus include inadvertent autoinoculation, ocular lesions (blepharitis, conjunctivitis), generalized vaccinia,

Characteristics	Infection Control Considerations
	progressive vaccinia, eczema vaccinatum; bacterial superinfection also requires addition of contact precautions if exudates cannot be contained. [216, 217]

Table 3F. Tularemia

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode	Respiratory Tract: Inhalation of aerosolized bacteria. Gastrointestinal Tract: Ingestion of food or drink contaminated with aerosolized bacteria. Comment: Pneumonic or typhoidal disease likely to occur after bioterrorist event using aerosol delivery. Infective dose 10-50 bacteria
Incubation Period	2 to 10 days, usually 3 to 5 days
Clinical Features	Pneumonic: malaise, cough, sputum production, dyspnea; Typhoidal: fever, prostration, weight loss and frequently an associated pneumonia.
Diagnosis	Diagnosis usually made with serology on acute and convalescent serum specimens; bacterium can be detected by polymerase chain reaction (LRN) or isolated from blood and other body fluids on cysteine-enriched media or mouse inoculation.
Infectivity	Person-to-person spread is rare. Laboratory workers who encounter/handle cultures of this organism are at high risk for disease if exposed.
Recommended Precautions	Standard Precautions

Type and Duration of Precautions - Disease Specific (~~FKA~~ **AKA** Short Sheet)

Recommendations for Application of Standard Precautions for the Care of All Patients in All Healthcare Settings

Component	Recommendations
Hand hygiene	After touching blood, body fluids, secretions, excretions, contaminated items; immediately after removing gloves; between patient contacts.
Personal protective equipment (PPE) Gloves	For touching blood, body fluids, secretions, excretions, contaminated items; for touching mucous membranes and nonintact skin
Personal protective equipment (PPE) Gown	During procedures and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated.
Personal protective equipment (PPE) Mask, eye protection (goggles), face shield	During procedures and patient-care activities likely to generate splashes or sprays of blood, body fluids, secretions, especially suctioning, endotracheal intubation. During aerosol-generating procedures on patients with suspected or proven infections transmitted by respiratory aerosols wear a fit-tested N95 or higher respirator in addition to gloves, gown and face/eye protection.
Soiled patient-care equipment	Handle in a manner that prevents transfer of microorganisms to others and to the environment; wear gloves if visibly contaminated; perform hand hygiene.
Environmental control	Develop procedures for routine care, cleaning, and disinfection of environmental surfaces, especially frequently touched surfaces in patient-care areas.
Textiles and laundry	Handle in a manner that prevents transfer of microorganisms to others and to the environment
Needles and other sharps	Do not recap, bend, break, or hand-manipulate used needles; if recapping is required, use a one-handed scoop technique only; use safety features when available; place used sharps in puncture- resistant container
Patient resuscitation	Use mouthpiece, resuscitation bag, other ventilation devices to prevent contact with mouth and oral secretions
Patient placement	Prioritize for single-patient room if patient is at increased risk of transmission, is likely to contaminate the environment, does not maintain appropriate hygiene, or is at increased risk of acquiring infection or developing adverse outcome following infection.
Respiratory hygiene/cough etiquette (source containment of infectious respiratory secretions in symptomatic patients, beginning at initial point of encounter e.g., triage and reception areas in emergency departments and physician offices)	Instruct symptomatic persons to cover mouth/nose when sneezing/coughing; use tissues and dispose in no-touch receptacle; observe hand hygiene after soiling of hands with respiratory secretions; wear surgical mask if tolerated or maintain spatial separation, >3 feet if possible.

(See Sections II.D.-II.J. and III.A.1)

Tri-City Medical Center
Oceanside, California

INTENSIVE CARE UNIT

ISSUE DATE:	**NEW**	**SUBJECT:**	**Scope of Service for Intensive Care Unit**

REVISION DATE(S):

Intensive Care Unit Department Approval:	**03/19**
~~**Department of Anesthesiology Approval:**~~	
~~**Operating Room Committee Approval:**~~	
Critical Care Committee Approval:	**06/19**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**07/19**
Administration Approval:	**08/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**
1. To describe the Scope of Service for the Intensive Care Unit (ICU) department at Tri-City Medical Center.

B. **POLICY:**
1. Goals:
   a. To improve the general well-being of critically ill patients who requires comprehensive medical and surgical intensive nursing care.
   b. To provide the highest quality nursing care in the safest environment.
   c. To reduce and manage complications and unexpected outcomes.
   d. To continuously evaluate and improve the services provided.
2. Description of service :
   a. The Intensive care unit is a 26-bed inpatient unit serving critically ill patients from 14 years of age through adulthood. Care is provided 24 hours a day, 7 days a week.
   ~~a.~~**b.** **Direct patient service is provided by a multidisciplinary team, including Hospitalists, Intensivists, specialty physician consultants, critical care trained registered nurses (RNs), RN case managers, social workers, financial and spiritual care providers.**
   ~~b.~~**c.** Monitoring:
      i. Continuous cardiac monitoring
      ii. Invasive central venous, pulmonary artery, arterial, or Intracranial **pressure** (ICP) monitoring
      iii. Every 1-2 hours Vital signs, Urine Output, Neuro, vascular assessments by nursing **during times of instability, post-procedure, or high risk interventions.**
   ~~c.~~**d.** Medications:
      i. ~~Titration of~~ **Intravenous** (IV) vasoactive ~~drugs~~**, sedative, paralytic, analgesic, or inotropic medications, including frequent monitoring and titration of doses**
      ii. Barbiturates coma/neuro muscular blockade
      iii. Intrav ~~V~~enous anti-arrhythmias **medications**
      iv. Systemic thrombolytic therapy
      v. Fluid replacement
      ~~v.~~**vi.** **IV insulin infusions**
   ~~d.~~**e.** Advance Technologies:

i. Temporary/external pacemakers
ii. Mechanical ventilation **using high level of PEEP or alterations in I:E ratio**
iii. Intra-aortic balloon pump/ventricular assist device
iv. External ventriculostomy/ICP monitoring
v. Continuous Renal Replacement Therapy
vi. Balloon tamponade of varices
~~vi.~~**vii. Targeted temperatgure management following cardiac arrest**

~~e.~~**f.** Moderate Sedation procedure
i. Bronchoscopy
ii. **Esophogastroduodenoscopy** (EGD)/Colonoscopy/Flexible sigmoidoscopy
iii. Percutaneous tracheostomy
iv. Cardioversion
~~v.~~ ~~PEG Placement~~

~~f.~~**g.** Methods to assess patient's needs:
i. Admission, initial shift assessments, reassessments, and systemic specific assessments are performed by RNs per the Standards of Patient Care. Nurses utilize a variety of sources to gather pertinent information ~~i.e.~~, **including** physical assessment, data from the patient's medical record, patient, families or significant others, and other disciplines
ii. The professional nursing staff is responsible for the ongoing assessment, treatment and evaluation of: ineffective airway clearance and inadequate gas exchange; alterations in perfusion related to decrease cardiac output; alterations in fluid volume; infection and maintenance of asepsis during wound care and invasive procedures.
iii. In addition, the nursing staff is also responsible to assess alterations in nutritional needs; comfort related to pain; patient and significant other education; and spiritual, cultural, and emotional needs of patients and their families.

~~g.~~**h.** Scope~~s~~ of services:
i. The ICU scope of service encompasses a wide variety of medical and surgical diagnoses. The unit population includes but is not limited to patients with diagnoses of myocardial infarction, unstable angina, congestive heart failure, acute pulmonary edema, acute respiratory failure, sepsis and gastrointestinal bleed. Neuro**logical** ~~diagnosis to~~ **diagnoses** include ~~those~~ patients with positive or a suspected ~~diagnosis of~~ stroke, transient ischemic attack or seizures. Surgical diagnoses include but are not limited to nephrectomy, bowel resection, thoracotomy, and vascular surgery (includes coronary artery bypass grafting and abdominal aortic aneurysm repair).
ii. Care is individualized to the patient to elevate the level of care focusing on the patient's medical needs and based on best practice guidelines.
iii. Interdisciplinary Collaboration and Support:
~~iii.~~**1)** **The practice of daily multidisciplinary rounds (MDRs) supports the communication and goal development for achievement of best practice and outcomes management.**
~~1)~~**2)** The ICU has an ongoing working relationship with the following services in the hospital to provide the scope and quality of care necessary to safeguard the patient: Respiratory Therapy, Laboratory, Blood Bank, Social Services, Radiography, Clinical Engineering, Environmental Services, Pharmacy, Materials Management, Central Supply, Dietary Services, Infection Control, Volunteer Services, Pastoral Care and Physicians.

~~h.~~**i.** Staffing and availability of staff:
i. Sufficient staffing is maintained at all times in terms of number of personnel, skill mix, and competency to meet the needs of the patients in the ICU.
ii. Staffing is maintained in a nurse-to-patient ratio of 1:1 or 1:2 depending on patient acuity.

iii. Basic Life Support (BLS) certification is required for the **ICU Registered Nurses (RNs)** and **Lift Team Technicians (**LTTs). Advanced Cardiac Life Support (ACLS) certification and National Institute of Health Stoke Scale (NIHSS) certification is required for all RNs.

iv. The unit is staffed with a Director, Assistant Nurse Managers (ANM), Clinical Nurse Educator, RNs, break relief RNs, LTTs, and **Unit Secretary**; a relief charge RN is assigned when ANMs are not scheduled.

1) The Nursing Director has 24 hours accountability for the administration, organization and professional management of the unit.

2) The Assistant Nurse Managers have a 24 hour responsibility for the unit and are directly responsible to the Nursing Director. These responsibilities center in the following areas:
   a) Competent nurses to provide patient care.
   b) Staff development of competency validation and educational programs.
   c) Service excellence.
   d) Responsible for scheduling, staffing, hiring, counseling and evaluating staff performance.
   e) Planning and organization.
   f) Developing, revising, implementing, and reviewing policies and procedures.
   g) Contributing to the preparations and managing of the fiscal year budget.
   h) Maintaining structural and clinical standards.
   i) Participating in medical committees and management meetings.
   j) Allocating equipment and material resources.
   k) Communication to all interdisciplinary personnel.
   l) Directing and participating in performance-based quality improvement activities, quality control measurements and performance improvement teams.

3) **The** Clinical Nurse Educator has a 24 hours responsibility for the unit and is directly responsible to the Nursing Director. These responsibilities center in the following areas:
   a) Competent nurses to provide patient care.
   b) Staff development of competency validation and educational programs.
   c) Developing, revising, implementing, and reviewing policies and procedures
   d) Maintaining structural and clinical standards
   e) Communication to all interdisciplinary personnel.
   f) Directing and participating in performance-based quality improvement activities, quality control measurements and performance improvement teams.

4) **The** Relief Charge Nurse~~: the relief charge~~ nurse has shift responsibility for the unit and is directly responsible to the Assistant Nurse Manager. The Relief Charge Nurse serves as a role model and resource person for the assigned shift. The Relief Charge Nurse in concert with the Nursing Director, staffing Office, and House Supervisor/Administrative Coordinator is responsible for coordinating and ensuring appropriate allocation of nursing resource(s) every shift, considering patient classification needs, general staffing guidelines, and knowledge and skill level of personnel.

v. **ICU discharge criteria:**

1) **ICU discharge is indicated when physiologic status has stabilized such that ICU care is no longer needed, and the following are present:**

a) **No ICU specific intervention or monitoring currently needed or anticipated**
b) **Discontinuation of IV vasopressors and inotropic medications**
c) **Stabilized on anti-hypertensive, anti-anginal, and anti-arrhythmic agents for more than 4 hours with stable hemodynamics**
d) **Discontinuation of ICU assisted ventilation needs as indicated by any of the following:**
   i) **Stable chronic ventilator or long-term weaning needs**
   ii) **Extubation and discontinuation of assisted ventilation with stable respiratory status for at least 4 hours**
e) **Requirements for care with a staffing ratio of 1 nurse to 4 patients or more.**

~~i.~~**j.** Assessing department services:
   i. The unit is a 24-hour, 7-day-a-week service.
   ii. Medical Director is responsible for clinical direction and medical supervision of the unit. The director/designee will be responsible for making decisions, in consultation with the physician/designee for the patient, for the disposition of a patient when a patient load exceeds optimal operational capacity.

~~j.~~**k.** The extent to which the department's level of care/service meet patient needs:
   i. The level of care provided by the ICU unit meets the needs of inpatients through availability of staff that are competent to provide service for the current patient population and the coordination of nursing services with other disciplines.

~~k.~~**l.** Performance Improvement **(PI)**:
   i. The unit uses the Find Organize Clarify Understand Select - Plan Do Check Act (FOCUS-PDCA) and GEMBA methodologies for process improvement.
   ii. ICU PI data is posted in the department.

~~l.~~**m.** Standards used by the department in the care of patients:
   i. The nursing service abides by regulations in California Title XXII, Title 16, The Joint Commission, Board of Registered Nursing (BRN), and Centers for Medicare and Medicaid Services (CMS). Clinical Practice Guidelines for specific patient population i.e., Community Acquired Simple Pneumonia, Heart Failure
   ii. The following external standards of practice or clinical guidelines are utilized within the department or serve as underpinnings for the development of the department standards and/per policies and procedures.
      1) AACN Procedure Manual for Critical Care.
      2) The Lippincott Manual of Nursing Practice.

~~m.~~**n.** Medication administration standards related to care of the patient:
   i. Medications, general and narcotics, are dispensed via the Pyxis system. Intravenous maintenance solutions and normal saline flush solutions are stored in a supply Pyxis located near the medication Pyxis. Medications requiring refrigeration are stored at the appropriate temperatures. Medications that are not dispensed by the Pyxis system are stored in locked cabinets. Nurses assess and document the administration, effectiveness, and side effects of medication per the Medication Administration Policy.
   ii. All medications administered are documented on the electronic Medication Administration Record (eMAR) for inpatients.

Tri-City Medical Center	Women and Newborn Services Neonatal Intensive Care Unit (NICU)
PROCEDURE:	**CARDIO-RESPIRATORY MONITORING IN THE NICU**
Purpose:	To provide reliable and accurate monitoring of neonatal cardiac and respiratory activity.
Supportive Data:	Cardio-respiratory monitoring should be used in any patient who requires intensive or intermediate care and in any patient at risk for apnea or rhythm disturbances.
Equipment:	~~1.~~ Cardio-respiratory monitor ~~2.~~ Neonatal monitoring electrodes
Issue Date: ~~9/07~~	**09/07**

A. **POLICY:**

1. **In order to provide reliable and accurate monitoring of neonatal cardiac and respiratory activity,** ~~A~~all patients admitted to the NICU will be placed on a cardio-respiratory monitor and continuously monitored until discharged from the NICU, **unless alternate order placed by MD.**~~.~~

B. **PROCEDURE:**

1. Skin should be clean and dry prior to placement of electrodes.
2. Do not place electrodes to broken or bruised skin.
3. Avoid ~~placed~~ electrode **placement** s directly on the nipples.
~~3.~~**4. Select the smallest effective electrode in order to minimize skin exposure and limit potential complication of irritation from gel/adhesives.**
~~4.~~**5.** Basic three-lead configuration for electrode placement:
   a. White: Right lateral chest at level of the nipple line.
   b. Black: Left lateral chest at level of the nipple line.
   c. Red or green: Left lower rib cage.
~~5.~~**6.** Connect electrodes, matching color/corresponding electrode placement, to the ECG cable attached to the monitor.
7. Ensure that the monitor is turned on and in neo mode. Select the lead that provides the best signal and QRS size.
~~6.~~**8. If detection of respirations is ~~is~~ poor due to shallow breathing, move the right and left lateral chest electrodes up towards the axillary area.**
~~7.~~**9.** Alarm parameters will be audible and set per NICU Standards of Care or physician/allied health professional (AHP)'s order.
   a. ~~When alarms are silenced, they must be~~**All silenced alarms will be** reactivated before leaving the patient's bedside.
   ~~b.~~ Ensure that alarms and alarm limits are set **to the individual patient's diagnosis** and checked at the beginning of every shift.
   ~~c.~~**b.** Alarms should prompt immediate patient assessment.
      i. Note alarm indication (i.e. tachycardia, apnea)
      ii. Treat patient condition as necessary or correct the source of any false alarm.
      iii. Notify physician/allied health professional if indicated.
   ~~iii.~~**c. During use of high-frequency ventilation, the respiratory monitoring alarm may be turned off. ~~Because accurate assessment of respiratory rate is not possible during the use of high frequency ventilation, the respiratory monitoring may be turned off. It must be reinitiated u~~Upon ~~any change~~changes in ventilator mode, the respiratory alarm must be reinitiated and alarms verified.**
~~8.~~**10.** Electrodes will be changed as needed to provide an artifact free monitor tracing.

C. **DOCUMENTATION:**

Women and Newborn Services NICU ~~Department Review~~	Department of OB/GYN	Division of Neonatology/ Perinatal Collaborative Practice	Department of Pediatrics	Pharmacy ~~and~~ & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/09, 06/11, 08/12, 12/16, 06/19	n/a	01/17, 06/19	n/a	n/a	02/17, 07/19	08/19	03/17, n/a	03/17

The following is to be documented in the patient's **electronic** medical record:

1. Vital signs per NICU Standards of Care.
2. Episodes requiring intervention.
3. Intervention performed and patient's response to intervention.
4. Alarm limits every shift.
5. Physician/AHP notification ad hoc form as necessary.

D. **REFERENCE(S):**

1. **Gardner, S. L., Carter, B.S., Hines, M.E., & Hernandez, J.A.(2016). Merenstein &Gardner's handbook of neonatal intensive care (8th ed.). St. Louis, MO: Elsevier.**
~~1.~~**2.** Aehlert, B. (2009). ECGs Made Easy Pocket Reference, 4th Ed. Mosby: Elsevier.
~~2.~~**3.** Jacobson, C. (2003). Bedside cardiac monitoring. *Critical Care Nurse*, 21(6); 71-73.
~~3.~~**4.** Lippincott Manual of Nursing Procedures, 9th Ed. (2009). Lippincott, Williams & Wilkins.
~~4.~~**5.** MacDonald, M. G. & Ramasethu, J. (Eds.). (2013). *Atlas of procedures in Neonatology, 5th ed.* Lippincott Williams & Wilkins.
~~5.~~**6.** Smith-Temple, J. (2009). *Nurses Guide to Clinical Procedures*, 6th Ed. Lippincott, Williams & Wilkins.

Tri-City Medical Center	Women's & and Newborn Children's Services Manual — Neonatal Intensive Care Unit (NICU)
PROCEDURE:	**INTRAFACILITY TRANSPORT OF THE NICU PATIENT**
Purpose:	Establish a standard of care for transporting NICU patients to other departments within TCMC **(for Procedural Transports).**
Equipment:	1. Transport isolette 2. Manual resuscitator bag with reservoir 3. Neopuff resuscitator 4. Pulse oximeter 5. Cardiac monitor 6. Full oxygen cylinder 7. Gas source in the area to which patient is being transported
Issue Date:	**09/07**

A. **PROCEDUREPOLICY:**

1. Designated member of leadership team, relief charge nurse or unit secretary**Prior to transfer, NICU staff member** will call the receiving department prior to transfer to insure department's readiness for patient.
2. NICU patients will be transported in transport isolette with a NICU nurse.
3. **NICU nurse will remain with the patient throughout transport.**
2.4. Patients requiring mechanical ventilation will **also** be accompanied by the NICU RN and **Respiratory Care Practitioner** (RCP).
3.5. The interdisciplinary team (Physician, licensed independent practitioner (LIP**Allied Health Professional (AHP)**), RN, RCP) will determine if the acuity warrants additional personnel such as the RCP or the Physician/LIP..
4.6. Confirm patient identity **per hospital policy.**using two identifier system. Refer to Patient Care Services "Identification, Patient" policy
7. The RN is responsible for:
   5.a. **Obtaining Transport bag from NICU (for procedural transports.)**
   a.b. Overseeing the transport **for t.patient monitoring and safety.**
   b. Staying with the patient throughout the procedure.
   c. Ongoing patient monitoring and safety.
   d. Monitoring oxygen flow and oxygen saturation if not accompanied by a RCP.
   e. Documentation in the patient's medical record.
6.8. The RCP is responsible for:
   a. Attaching Neopuff resuscitator to the full oxygen cylinder. **Verification of transport isolette and equipment prior to transport.**
   b. Ensuring a mask is present.
   e.b. Managing oxygen flow and oxygen saturation.
   d.c. Maintaining airway security and patency.
   e.d. Monitoring ventilator for correct connections and proper function.
   f.e. Documentation in patient's medical record.
7.9. Family centered care: The parents are invited to accompany the patient on transport. If they are unable to attend, the Physician/LIP **AHP** and NICU RN will update the parents about the patient's clinical status.

B. **DOCUMENTATION:**

Women and Newborn Services NICU Department Review	Department of OB/GYN	Division of Neonatology/ Perinatal Collaborative Practice	Department of Pediatrics	Pharmacy and &Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
01/15, 05/19	n/a	01/15, 06/19	n/a	n/a	03/15, 07/19	08/19	4/15, n/a	06/09, 06/11, 608/12, 04/15

1. The transport will be documented in the patient's medical record: **including time of departure and arrival back on unit.** ~~.~~
2. The RCP will document the ventilator check for intubated patients.

C. **REFERENCE(S):**

1. ~~Riley, L. E~~**Kilpatrick, S. J.**, & ~~Stark, A. R~~**Papile, L.** (Eds.). (2017~~2~~). *Guidelines for Perinatal Care ~~8~~7th Edition*. American Academy of Pediatrics and The American College of Obstetricians and Gynecology.
~~2.~~ Ikuta, Linda M., and Sandra S. Beauman, eds. (2011). Policies, Procedures, and Competencies for Neonatal Nursing Care. Glenview, IL: National Association of Neonatal Nursing Care

Tri-City Medical Center	Women and Newborn Services -**Neonatal Intensive Care Unit** (NICU)
PROCEDURE:	**MEASURING INFANT LENGTH IN THE NEONATAL INTENSIVE CARE UNIT (NICU)**
Purpose:	A series of accurate weights and measurements of stature or length offer important information about a child's growth pattern.
Supportive Data:	The gold standard technique for measuring length for children less than 24 months involves a recumbent length measuring board.
Equipment:	~~Infant stadiometer~~~~Seca 210 Measure Mat~~ **Length board**
Issue Date:	10/08

A. **POLICY:**

1. The **infant** ~~**stadiometer (recumbent**~~ **length board)**~~Seca 210 Measure Mat~~ will be utilized for accurate measurement of infants in the NICU. **Two caregivers should be utilized during the measurement process for optimum accuracy.**

B. **PROCEDURE:**

1. **Place** ~~T~~**the** ~~**stadiometer**~~**length board on a stable, clean, flat** ~~**hard**~~ **surface.**~~Measure Mat will be spread out and smoothed by hand on a hard surface.~~
2. ~~The infant is laid on the mat with the top of the head touching the head stop. The body will be positioned perpendicular to the head stop and stretched out fully.~~
3. ~~The infant's knees will be held together and pressed down gently against the mat with one hand, and the foot stop brought up against baby's heels with the other hand.~~
4. ~~The foot stop should be parallel to the head stop by lining it up with the vertical length measuring lines. The measurement is read along the edge of the Measure Mat.~~
2. **Place the diapered infant on its back in the center of the** ~~**stadiometer**~~**length board.**
3. **One caregiver will gently hold the infant's head by cupping the ears so that the top of the head is against the stationary headpiece and looking straight forward.**
4. **The second caregiver will ensure that the infant is lying straight on the board with proper head positioning, then gently extend both legs by placing** ~~**left**~~ **one hand on the knees and moving the foot piece with the** ~~**right**~~ **other hand. Length is measured when feet (toes pointing upward) are flat against the movable foot piece.**
5. The measurement, **recorded to the nearest 0.1cm,** is documented in infant's medical record and plotted on the appropriate ~~fetal infant~~ growth chart based on the infant's gestational age.
6. Following use, ~~**wipe the stadiometer**~~**clean the length board** ~~clean~~ with hospital approved disinfectant wipes.~~Roll up mat and store away from excessive heat~~.

C. **REFERENCE(S):**

1. ~~Centers for Disease Control (2000) Use and Interpretation of CDC Growth Charts.~~
1. **National Center for Health Statistics. (2010, September 09). Retrieved from https://www.cdc.gov/growthcharts/**
2. Rifas-Shiman, S.L., et al. (2005) Misdiagnosis of Overweight and Underweight Children Younger than 2 Years of Age Due to Length Measurement Bias. Medscape General Medicine 7(4):56.
3. ~~Seca 210 Instruction Manual~~
4. **Verklan, M. T., & Walden, M. (2015).** ***Core curriculum for neonatal intensive care nursing.*** **Elsevier Saunders.**

~~3.~~**5. World Health Organization. Training Course on Child Growth Assessment. Geneva, WHO, 2008.**

Women and Newborn Services NICU ~~Department Review Revision~~	Department of OB/GYN	Division of Neonatology/ Perinatal Collaborative Practice	Department of Pediatrics	Pharmacy and & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
6/09, 8/12, 01/16, 04/19	n/a	10/15, 06/19	n/a	n/a	04/16, 07/19	08/19	05/16, n/a	08/12, 05/16

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE: 08/91	**SUBJECT:** Outpatient Medical Records
REVISION DATE(S): 02/94, 09/97, 10/99, 01/06	**POLICY NUMBER:** 1001

Rehabilitation Department Approval:	12/15
Department of Medicine Approval:	01/19
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	03/19
Administration Approval:	08/19
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~**ISSUE DATE: 8/91**~~	~~**SUBJECT: OUTPATIENT MEDICAL RECORDS**~~
~~**REVISION DATE: 2/94, 9/97, 10/99, 1/06**~~	~~**STANDARD NUMBER: 1001**~~
~~**REVIEW DATE: 1/03, 1/09, 4/12**~~	~~**CROSS REFERENCE:**~~
	~~**APPROVAL:**~~

~~A. PURPOSE~~

~~1. To ensure that outpatient medical records are completed and in compliance with regulatory guidelines.~~

A. **POLICY MANUAL:**

~~2.~~1. All outpatients accepted for treatment will have a completed medical record compiled and maintained.

B. **PROCEDURE:**

1. The Office Coordinator, Clerk Receptionist, or Rehabilitation Aide will be responsible for obtaining or creating the file and paperwork necessary for the medical record.
2. Each medical record will contain the following:
   a. Outpatient Admission Form: To include patient's name, address, medical record number, social security number, insurance information, age, sex, marital status, religion, date of admission, admitting physician, initial diagnostic impression, and diagnosis.
   b. Physician's Prescription/Referral Authorization~~,~~: which includes diagnosis, physician signature, and date signed.
   c. A signed Conditions of Admissions Form: If the patient is under 18 years of age, they must be accompanied by an adult who assumes responsibility for care during therapy sessions. This includes signature for authorization of treatment and completion of Medical History and Physical form.
   d. History and Physical **Intake** form.
   e. Discharge Summary from other facilities, if **available/** appropriate.
   ~~f. Admission Agreement for outpatient services.~~
   ~~g.~~**f.** Copy of insurance card(s) and authorization as appropriate.
   ~~h.~~**g.** **Signed** Cancellation/No-Show policy
   ~~i.~~**h.** HIPAA form and workers' compensation release of information form, if applicable.
   i. **Signature Log**
3. Once the patient has been seen, an evaluation will be documented and placed in the chart.

~~4.~~a. The initial evaluation will be faxed to the physician, and the original will be maintained in the chart.

~~5.~~4. Progress will be documented after every patient visit.

~~6.~~a. Progress summaries will be written by each appropriate therapist **every 30 days to** ~~on a monthly basis~~ or per authorization **as appropriate** ~~period for outpatient pediatric patients~~. A copy will be faxed to the referring physician, and the original will be maintained in the patient's chart.

5. A discharge summary including patient/family teaching and continuation of services referral.

~~7.~~a. A copy is to be faxed to the physician, with the original to remain in the outpatient record.

ALLERGIES: ☐ NKDA ☐ Allergic to: _____

DELETE- Request to retire this PPO per Mary Diamond.

MEDICATIONS TO BE DISPENSED:

IRRIGATION:

☐ 0.9% NaCl ☐ Sterile Water ☐ Simethicone drops, 0.6 mL mixed with 500mL Sterile Water
☐ Mucomyst (Acetylcysteine 20% 200 mg/mL) 4mL in 7mL H2O
☐ Other: _____

LOCAL ANESTHETICS:

☐ Lidocaine 2% oral topical (viscous) _____ mL POx _____
☐ Hurricane topical spray (Benzocaine 20%) ½ second spray x1
☐ Lidocaine 1% _____ mL injected locally to PEG site by physician
☐ Other: _____

OTHER MEDICATIONS:

☐ Atropine 0.4mg/mL _____ mg IVP
☐ Benadryl (Diphenhydramine 20mg/mL) _____ mg IVP
☐ Ethamolin (Ethanolamine Oleate Injetion, 5% 2mL/ampule) _____ mL injection via sclera needle
☐ Fentanyl (Sublimaze 50mcg/mL) _____ mcg IVP
☐ Glucagon (Glucagen 1 mg) _____ mg IVP
☐ Iodophor PVP ointment for PEG
☐ Narcan (Nalone HCL 0.4mg/mL) _____ mg IVP
☐ Demerol (Meperidine 50mg/mL) _____ mg IVP
☐ Phenergan (Promethazine 25mg/mL) _____ mg (VPB) 0.9% NaCl 25mL
☐ Romazicon (Flumazenil 0.5mg/5mL)
☐ Versed (1mg/mL) _____ mg
☐ Other: _____
☐ Other: _____
☐ Other: _____

CONTRAST:

☐ Conray _____ mL
☐ Isovue _____ mL
☐ Other: _____

DVT PROPHYLAXIS:

☐ Apply Sequential Compression Device (SCD)
☐ Apply TED stockings

MISCELLANEOUS:

☐ Apply abdominal counterpressure as directed by Endoscopist during colonoscopy

☐ Read Back all T.O./V.O. orders

Nurse's – Signature Date Time

Physician's – Signature Date

Affix Patient Label

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

Intraoperative Endoscopy Physician Orders
Page 1 of 1

8711- Revised (10/12)

Board Approved 01/13

Community Healthcare & Alliance Committee (No meeting held in July or August, 2019)

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
August 22, 2019

Members Present	Director Julie Nygaard, Director Rocky Chavez, Director Leigh Anne Grass, Dr. Marcus Contardo, Dr. Jeffrey Ferber, Dr. Cary Mells, Mr. Jack Cumming
Non-Voting Members Present:	Steve Dietlin, CEO, Ray Rivas, CFO, Scott Livingstone, COO, Dr. Gene Ma, CMO, Susan Bond, General Counsel, Barbara Vogelsang, CNE *(joined the meeting @ 9:30 a.m.)*
Others:	Steve Harrington, Eva England, Mark Albright, Monica Trudeau, Maria Carapia, Kristy Larkin, Thomas Moore, Sue Shrader, Jeremy Raimo, Lori Roach, Jane Dunmeyer, Debra Feller, Candice Parras, Barbara Hainsworth, Kathryn Fitzwilliam & Mick Midkiff *(joined the meeting @ 9:08 a.m.)*
Members Absent:	

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to Order	Director Nygaard called the meeting to order at 8:33 a.m.		Chair
2. Approval of Agenda	Director Nygaard announced that a revised version of the following write-up had been distributed to the members of the Committee, reflecting that this item has been budgeted: • 7.i. Network Hardware Proposal-Cerner She also stated that there was an additional item for consideration by the Committee: Scott Livingstone requested that the following item be added to the agenda: • 7.k. Physician Agreement for Hospitalist Services & Coverage - Coastal Hospitalists Medical Associates, Inc.	**MOTION** **It was moved by Director Grass, Dr. Contardo seconded, and it was unanimously approved to accept the agenda of August 22, 2019, as well as the addition to the agenda of item 7.k. Physician Agreement for Hospitalist Services & Coverage - Coastal Hospitalists Medical Associates, Inc.** **Members:** **AYES: Nygaard, Grass, Chavez, Contardo, Ferber, Mells, Cumming** **NOES: None** **ABSTAIN: None** **ABSENT: None**	Chair

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Nygaard read the paragraph regarding comments from members of the public.	No comments	Chair
4. Ratification of minutes of June 20, 2019		Minutes were ratified. **MOTION** **It was moved by Dr. Ferber, Director Grass seconded, and the minutes of June 20, 2019 were unanimously approved, with Dr. Mells abstaining from the vote.**	Chair
5. Old Business	None		
6. New Business			
a. Introduction – New Physician Committee Member • Dr. Cary Mells	Director Nygaard welcomed Dr. Cary Mells to the Finance, Operations and Planning committee. He will assume the role of a physician committee member.		Chair
b. Community Member Candidate Interviews • Lisa De Jesus • Kathryn Fitzwilliam • M.E. "Mick" Midkiff • Frank Pokrop	All community member applicants, Ms. Lisa DeJesus, Ms. Kathryn Fitzwilliam, Mr. Mick Midkiff and Mr. Frank Pokrop remained outside the assembly room, and were brought in individually for their respective interviews. Each candidate was given an opportunity to present a brief opening statement regarding their resumes, and committee members were permitted to ask questions. Upon conclusion of the interviews the candidates were asked to remain outside the assembly room while the vote was undertaken. The candidate who was selected by the voting members of the Committee will be confirmed at the next Board of		Chair

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Directors meeting, and will then be notified by mail of their selection and subsequent Board confirmation. Ms. Fitzwilliam and Mr. Midkiff joined the proceedings at 9:08 a.m., following completion of the vote.		
7. Consideration of Consent Calendar:	It has been requested that the following items be pulled for discussion: <u>Director Nygaard requested:</u> 7.h. Cox Metro-E Proposal • Cox Business 7.i. Network Hardware Proposal • Cerner 7.j. Video / Power Lease • Stryker	**<u>MOTION</u>** **It was moved by Dr. Contardo, Director Grass seconded, and it was unanimously approved to accept the Consent Calendar of August 22, 2019.** **<u>Members:</u>** **AYES: Nygaard, Grass, Chavez, Contardo, Mells, Cumming** **NOES: None** **ABSTAIN: Dr. Mells, Dr. Ferber** **ABSENT: None**	Chair
a. Physician Agreement for ED On-Call Coverage • Pulmonary & ICU		**Approved via Consent Calendar**	Sherry Miller
b. Medical Staff Leadership Agreement – Physician Well-Being Committee Chair • Cary Mells, M.D.		**Approved via Consent Calendar**	Sherry Miller
c. Medical Staff Leadership Agreement – Chief of Staff • Mark Yamanaka, M.D.		**Approved via Consent Calendar**	Sherry Miller
d. Physician Agreement for Specialty Care Clinic & Progressive Care Unit • Victor Souza, M.D.		**Approved via Consent Calendar**	Lori Roach

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
e. Physician Agreement for Home Health Director • Dr. John LaFata		**Approved via Consent Calendar**	Monica Trudeau
f. Fifth Lease Amendment Proposal • Oscar Matthews, M.D. (Cardiologist)		**Approved via Consent Calendar**	Jeremy Raimo
g. Carlsbad-Wellness Center MOB Lease Agreement Proposal • Dean Vayser, DPM, ILD Consulting ("Tenant")		**Approved via Consent Calendar**	Jeremy Raimo
h. Cox Metro-E Proposal • Cox Business	Mark Albright gave a brief overview, conveying the essential nature of upgrading the E-services and the bandwidth at the hospital, as well as the various TCMC affiliated off-site locations. Minor discussion ensued.	**MOTION** **It was moved by Mr. Cumming, Director Grass seconded, to authorize the agreement with COX for Metro-E services for TCMC for a term of 60 months for Tri-City Medical Center, and 36 for months for OSNC, Tri-City Primary Care, & Wellness, for a total cost for the term cost of $527,520** **Members:** **AYES: Nygaard, Grass, Chavez, Contardo, Ferber, Mells, Cumming** **NOES: None** **ABSTAIN: None** **ABSENT: None**	Mark Albright
i. Network Hardware Proposal • Cerner	Mark Albright detailed that this proposal was an essential upgrade to ensure the necessary technical sophistication, as well as robust network security in order to keep pace with the ever increasing advances in technology. Minor discussion ensued.	**MOTION** **It was moved by Director Grass, Mr. Cumming seconded, to authorize the agreement with Cerner for network hardware / software / licenses / professional services for a term of 36 months, beginning**	Mark Albright

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		September 1, 2019, and ending August 31, 2022 for a total cost for the term of $1,849,941.37. **Members:** **AYES: Nygaard, Grass, Chavez, Contardo, Ferber, Mells, Cumming** **NOES: None** **ABSTAIN: None** **ABSENT: None**	
j. Video / Power Lease Proposal • Stryker	Debra Feller gave a brief PowerPoint presentation, during which she conveyed that this equipment lease would bring the latest technology to the operating rooms of TCMC. She emphasized these equipment upgrades would enhance the proficiency & efficiency of the performance of instruments and providers. Greater efficiency enhances the potential for faster turnaround times of the surgical suites, thereby maximizing surgery scheduling opportunities. Brief discussion ensued.	**MOTION** **It was moved by Dr. Contardo, Dr. Ferber seconded, to authorize the agreement with Stryker for video / power for a term of 60 months, beginning October, 2019 and ending October, 2024 for an annual cost of $644,877.48 and a total cost for the term $3,224,387.40 (taxes included).** **Members:** **AYES: Nygaard, Grass, Chavez, Contardo, Ferber, Mells, Cumming** **NOES: None** **ABSTAIN: None** **ABSENT: None**	Debra Feller
8. Financials:	Ray Rivas presented the financials ending July 31, 2019 (dollars in thousands) **TCHD – Financial Summary** **Fiscal Year to Date** Operating Revenue $ 28,815 Operating Expense $ 29,864 EBITDA $ 686 EROE $ (476) **TCMC – Key Indicators** **Fiscal Year to Date** Avg. Daily Census 143		

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Adjusted Patient Days 8,242 Surgery Cases 517 ED Visits 4,788 **TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year** Net Patient A/R Avg. (in millions) $ 43.0 Days in Net A/R Avg. 52.8 **Graphs:** • TCMC-Net Days in Patient Accounts Receivable • TCMC-Average Daily Census, Total Hospital-Excluding Newborns • TCMC-Acute Average Length of Stay		
9. Work Plan:			
a. Wellness Center *(bi-monthly)*	Scott Livingstone gave a brief PowerPoint presentation detailing the Wellness Center's financial performance for fiscal year 2019, year-to-date.		Ray Rivas
b. Construction Report *(quarterly)*	Scott Livingstone conveyed that the only item currently on the Construction Report was the Pharmacy USP800 upgrade. He emphasized that the actual construction on this project had been completed, and they are currently awaiting the inspection by the State Board of Pharmacy.		
c. ED Throughput *(quarterly)*	Candice Parras gave a single slide PowerPoint presentation detailing that the implementation of Station "D" in the Emergency Department has had a very positive effect on wait times and overall patient satisfaction.		Jeremy Raimo

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
d. Dashboard	No discussion		Ray Rivas
10. Comments by committee members	None		
11. Date of next meeting	Thursday, September 19, 2019		Ray Rivas
12. Community Openings (1)	Upon confirmation by the Board of Directors of the community member candidate selected by the Finance, Operations & Planning committee, this opening will be filled.		
13. Adjournment	Meeting adjourned 10:09 a.m.		Chair

Kathryn E. Fitzwilliam

6041 Patmos Way, Oceanside, California 92056 **(760) 941 3288**

VOLUNTEER EXPERIENCE

Tri City Medical Center: Audit Committee Community Member	2014-2019
Ocean Hills Country club: Various Board Posistions	2003-2019

PROFESSIONAL EXPERIENCE

LifeTechnologies, Carlsbad, California — 2007 – 2014
Director, Accounting Systems & Compliance

Gateway, Irvine, California — 2003 – 2006
VP, Internal Audit

The Walt Disney Company, Burbank, California — 2000 - 2003
Director Management Audit

Kelly Services, Inc., Troy, Michigan — 1995 - 2000
Director Business Systems — 1998- 2000
Director Internal Audit — 1997 -1998
IT Audit Manager — 1996 -1997
Senior Information Systems Auditor — 1995 -1996

Deloitte & Touche LLP, Detroit, Michigan — 1992 - 1995
Systems Consulting Assignments
Accounting Assignments
Auditing Assignments

Amerisure, Southfield, Michigan — 1990 - 1991
Business Systems Analyst

Fanuc Robotics, Auburn Hills, Michigan — 1989 -1990
Interim Controller and MIS Director – UK subsidiary

EDUCATION, PROFESSIONAL QUALIFICATIONS AND HONORS

Walsh College of Accountancy and Business Administration, Troy, Michigan
Bachelor of Accountancy, GPA 3.96/4.0, Presidential Scholarship, President's Honor Roll
Oakland Community College, Farmington Hills, Michigan
Associate Degree in Computer Science, Summa Cum Laude, GPA 4.00/4.00, and Dean's Honor Roll
Certified Public Accountant, licensed expired
Certified Information Systems Auditor
AICPA Elijah Watts Sells Award with High Distinction for CPA examination achievement (top 100 in country, out of 70,000)
Financial Executive Institute Award - Walsh College recipient for academic achievement

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 22, 2019
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Pulmonary & ICU

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

Physician's Name: Frank Corona, M.D., Martin Nielsen, M.D., Mark Yamanaka, M.D., Safouh Malhis, M.D.

Area of Service: Emergency Department On-Call: Pulmonary & ICU

Term of Agreement: 24 months, Beginning, July 1, 2019 – Ending, June 30, 2021

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: Pulmonary & ICU

Rate/Day	Panel Days per Year	Panel Annual Cost
$1,500	FY2020: 366	$549,000
	FY2021: 365	$547,500
	Total Term Cost	**$1,096,500**

Position Responsibilities:

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

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

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

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Frank Corona, M.D., Martin Nielsen, M.D., Mark Yamanaka, M.D., Safouh Malhis, M.D., as the ED On-Call Coverage Physicians for Pulmonary & ICU for a term of 24 months, beginning July 1, 2019 and ending June 30, 2021 at a daily rate of $1,500 for total term cost of $1,096,500.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 22, 2019
Medical Staff Leadership Agreement-Physician Well-Being Committee Chair

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

Physician's Name: Cary Mells, M.D.

Area of Service: Medical Staff: Physician Well-Being Committee Chair

Term of Agreement: 24 months, Beginning, August 1, 2019 – Ending, July 31, 2021

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current Medical Staff Area of Service Coverage: Physician Well-Being

Rate/Month	Annual Term Cost	Total Term Cost
$3,000	$36,000	$72,000

Position Responsibilities:

- Perform the duties of Chair of the Physician Well-Being Committee as set forth in the Tri-City Healthcare District Medical Staff Bylaws.
- Be available as a resource to the Medical Staff and Hospital with respect to well-being issues.
- Liaise with Hospital Administration and Medical Staff on issues relating to physician well-being programs.

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

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

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Cary Mells, M.D. as the Medical Staff Leadership Chair of the Physician Well-Being Committee for a term of 24 months, beginning August 1, 2019 and ending July 31, 2021, not to exceed an annual amount of $36,000 per year, and a total of $72,000 for the term.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 22, 2019
PHYSICIAN AGREEMENT FOR CHIEF OF STAFF
MEDICAL STAFF LEADERSHIP AGREEMENT – CHIEF OF STAFF

Type of Agreement		Medical Director		Panel		Other:
Status of Agreement	X	New Agreement		New Rates	X	Same Rates

Physicians Name: Mark Yamanaka, M.D.

Area of Service: Chief of Staff, Medical Staff Leadership

Term of Agreement: 24 months, Beginning, July 1, 2019 – Ending, June 30, 2021

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

Est. Rate/Hour	Hours per Month	Hours per Year	Monthly Stipend (TCHD)	Annual Stipend (TCHD)	Education Expense (TCHD) for Term	Cost for 24 Month Term (TCHD)
$148.75	40	480	$5,950	$71,400	$10,000	$152,800

Position Responsibilities:

- Previous monthly stipend amount: $5,950
- Perform the duties of Chief of Staff as set for the in the Tri-City Healthcare District Medical Staff Bylaws
- Attend meetings of the Board of Directors and such Board Committees as may be requested from time-to-time, including the Professional Affairs Committee.
- Liaise with Hospital Administration, including reporting on the status of activities of the Medical Staff.
- Attend Education training, including Greeley training regarding Credentialing and Peer Review

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

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

Motion: I move that the Finance, Operations and Planning Committee recommend the TCHD Board of Directors approve the Medical Staff Leadership Agreement for Chief of Staff, Mark Yamanaka, M.D. for a term of 24 months, beginning July 1, 2019 and ending on June 30, 2021, for a TCHD stipend of $5,950 per month, $71,400 annually and $142,800 for 24 months; plus an educational allowance up to $10,000 for a total not to exceed $152,800 for the term, paid by TCHD.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 22, 2019
Physician Agreement for Specialty Care Clinic & Progressive Care Unit

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

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

Area of Service: Specialty Care Clinic and Progressive Care Unit

Term of Agreement: 24 months, Beginning, September 1, 2019 – Ending, August 31, 2021

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	24 month (Term) Cost
$163	20	240	$3,260	$39,120	$78,240

Position Responsibilities:

- Participates in daily UR on the inpatient unit with the CDCR patients as needed.
- Participates in risk management investigation and evaluation of events.
- Establishes and reviews policies and procedures for medical care.
- Participates in quarterly or more frequent meetings with the CDCR and Sheriff Departments.
- Communicates as needed with attending and referring physicians; provides oversight of chart audits, peer review and delinquencies in documentation.
- Assists in introducing new services/programs requested by the vendors.

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

Person responsible for oversight of agreement: Lori Roach, R.N. Manager, Specialty Care Clinic & Progressive Care Unit / Barbara Vogelsang, Chief Nurse Executive

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Victor Souza as the Medical Director/Covering Physician for a term of 24 months beginning September 1, 2019, and ending August 31, 2021. Not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $163, for an annual cost of $39,120 and a total cost for the term of $78,240.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 22, 2019
PHYSICIAN AGREEMENT for Home Health Medical Director

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

Physician's Name: Dr. John LaFata

Area of Service: Home Health

Term of Agreement: 24 months, Beginning, September 1, 2019 – Ending, August 31, 2021

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

Rate / Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	24 month (Term) Cost
$169	10	120	$1,690	$20,280	$40,560

Position Responsibilities:

- Monitors and assures the delivery of quality, efficient, medically needed, safe home health services.
- Provides professional guidance and oversight for Tri-City Home Health Services. Attends case conference and department meetings.
- Conducts in-service training on (discipline/home health) specific issues and/or topics for physicians and home health staff.
- Participate in development and implementation of Home Care quality assurance program and risk management program as directed by Hospital, and shall assist Department in establishing, implementing, and maintaining procedures to maintain the quality of Medical Services provided.
- Develop and maintain ongoing dialogue with members of Hospital's Medical Staff concerning Department services.

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

Person responsible for oversight of agreement: Monica Trudeau, Director-Home Health / Barbara Vogelsang, Chief Nurse Executive

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize John LaFata as the Coverage Physician for a term of 24 months beginning September 1, 2019 and ending August 31, 2021. Not to exceed an average of 10 hours per month or 120 hours annually, at an hourly rate of $169 for an annual cost of $20,280, and a total cost for the term of $40,560.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 22, 2019
Fifth Lease Amendment Proposal – Oscar Matthews, M.D.

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

Physician Name: Oscar Matthews, M.D. (Cardiologist)

Premises: 2095 Vista Way, Suite 107, Vista, CA 92083 (1,450 sq. ft.)

Term of Agreement: 12 months, Beginning, August 1, 2019 - Ending July 31, 2020
Extends the existing lease agreement for 12 months / 1 year

Within Fair Market Value: YES (FMV was determined by Lease Comparables)

Rental Rate from Dr. Oscar Matthews:	**Revenue per Month**
Rental Rate of $2.14 per square foot, per month, (1,450 rentable sq. ft.)	$3,114.40
Total Term Revenue Amount:	**$37,373**

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

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

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the Fifth Amendment Lease Renewal with Dr. Oscar Matthews for an additional one-year term, beginning August 1, 2019, ending July 31, 2020. This proposal remains within the current fair market value rental rate of $2.14 per square foot, for a monthly revenue of $3,114.40, for a total revenue for the term of $37,373.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 22, 2019
Carlsbad-Wellness Center MOB Lease Agreement Proposal

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

Tenant Name: Dean Vayser, DPM, ILD Consulting ("Tenant")

Term: 24 Months, beginning at commencement date of August 1, 2019; Option for (1), one-year extensions at FMV

Premises: 6260 El Camino Real, Suite 100, Carlsbad, CA 92009 (245 sq. ft., inside Tri-City Medical Center Wound Care Center)

Within Fair Market Value: YES (FMV was determined by Lease Comparables)

Rental Rate from Dean Vayser, DPM:	**Revenue per Month**
Gross Rental Rate of $3.50 per square foot, per month, (245 rentable sq. ft.)	$857.50
Total Revenue Amount:	**$20,580**

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

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

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the Lease Agreement for office space inside Suite 100 in the Carlsbad Wellness Center MOB located at 6260 El Camino Real, Carlsbad, CA 92009, with Dean Vayser, DPM, for a 24 month term, at the rate of $857.50 per month, for a total revenue for the term of $20,580.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 22, 2019
COX Metro-E Proposal

Type of Agreement		Medical Directors		Panel	X	Other: Increase Bandwidth / Services
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Vendor's Name: COX Business

Area of Service: 3-Orthopaedic Specialists of North County Clinics, Tri-City Primary Care, Tri-City Medical Center, Wellness Center

Term of Agreement: 36 months – Orthopaedic Specialists of North County Clinics (3), Tri-City Primary Care, Wellness Center
60 months - Tri-City Medical Center

Maximum Totals:

Current Term Cost	Additions	Total Term Cost
$328,440	$199,080	$527,520

scription of Services/Supplies:
he following is necessary to implement Cerner Community Works & have off-site backups:

- Increasing TCMC Metro-E bandwidth to 2 GB from 1 GB
- Increasing Wellness Ctr. Metro-E Bandwidth to 1 GB from 500 MB
- Adding 500 MB Metro-E at TCPC
- Adding 500 MB at OSNC Oceanside
- Adding 500 MB Metro-E at OSNC Carlsbad
- Adding 500 MB Metro-E at OSNC Vista

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

Person responsible for oversight of agreement: Mark Albright, VP of Information Technology / Scott Livingstone, Chief Operating Officer

Motion:
ove that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize he agreement with COX for Metro-E services for TCMC for a term of 60 months for Tri-City Medical Center, and 36 for months for OSNC, Tri-City Primary Care, & Wellness, for a total cost for the term cost of $527,520.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 22, 2019
Network Hardware Proposal

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

Vendor's Name: Cerner

Area of Service: Entire Hospital

Term of Agreement: 36 months, Beginning, September 1, 2019 – Ending, August 31, 2022

Fee Description:	Financial Terms:	Amount Totals:
Monthly Subscription Fees:	$15,150.00 x 36 mo.	$545,400.00
Annual License Fees:	$54,403.99 x 3 yrs.	$163,211.97
One-Time Hardware Fees:	Quarterly Payments $142,666.18 x 8	$1,141,329.44
	Total Contracted Amount:	**$1,849,941.41**

Description of Services/Supplies:

- Cisco Hardware (wired & wireless) to build new wired / wireless TCMC networks
- Required software & licenses for the hardware
- 2 months Microsoft Active Directory Professional Services

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

Person responsible for oversight of agreement: Mark Albright, VP of Information Technology / Scott Livingstone, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Cerner for network hardware / software / licenses / professional services for a term of 36 months, beginning September 1, 2019, and ending August 31, 2022 for a total cost for the term of $1,849,941.37.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 22, 2019
Video / Power Lease Proposal

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

Vendor's Name: Stryker
Area of Service: Surgical Services
Term of Agreement: 60 Month Term, Commencing 10 Days Post-Delivery & Installation
October 2019 - October 2024

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$53,739.79	$644,877.48	$3,224,387.40

Description of Services/Supplies:

- Provides service for all specialties
- Enhances physician recruitment/retention
- Maintains state of art equipment
- Smoke evacuation compliance, visual image capture, ease of optics, CA Law
- Budgeted payment consistent with future upgrades eliminating capital dollars
- Repair & replace obsolete equipment
- Standardized equipment reducing errors with users
- Advanced image modalities for prevention of complications
- Efficiencies in staffing & time management
- Immediate clinical data integration to EMR, enhancing HIPPA compliance
- Clinical support for trouble shooting
- Contract compliance with equipment Capitus

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

Person responsible for oversight of agreement: Debra Feller, Clinical Director-Surgery / Barbara Vogelsang, Chief Nurse Executive

ion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Stryker for video/Power for a term of 60 months, beginning October, 2019 and ending October, 2024 for an annual cost of $644,877.48 and a total cost for the term $3,224,387.40 (taxes included).

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 22, 2019
PHYSICIAN AGREEMENT for HOSPITALIST SERVICES & COVERAGE

Type of Agreement		Medical Director		Panel		Other:
Status of Agreement	X	New Agreement	X	New Rates		Extension – Same Rates

Physicians Name: Coastal Hospitalists Medical Associates, Inc.

Area of Service: On-Site Coverage to Unassigned Patients

New Agreement Term: 24 Months – Beginning, September 1, 2019 – Ending, August 31, 2021

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

Monthly Cost Not to Exceed	Annual Cost Not to Exceed	Education Expense (TCHD) per Year (included)	Total NTE for 24 Month Term
$266,667	$3,210,000	$10,000	$6,420,000

The new agreement keeps the Hospitalist program at Fair Market Value. Annual cost includes Monthly Stipend, Medical Directorship Coverage, and Performance Incentives/Standards including Clinical Documentation, "Get with the Guidelines" stroke & cardiac measures, Patient Throughput, Customer Service, Utilization Management and Quality Governance.

Position Responsibilities/Scope: Coastal Hospitalists shall provide on-site coverage for all TCMC unassigned patients, as follows:

- Provide care for patients presenting through Emergency Department who require post-ED observation care and/or inpatient admission.
- Coverage by hospitalists will ensure that there are sufficient physicians available as needed for coverage seven days per week; 24 hours per day; 365/366 days per year.
- Each physician who provides services shall be licensed and qualified to practice medicine in California and be a member of TCHD's Medical Staff

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

Person responsible for oversight of agreement: Scott Livingstone, Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors approve the new Hospitalist Services & On-Site Coverage Services Agreement with Coastal Hospitalists Medical Associates, Inc. beginning September 1, 2019 and ending August 31, 2019 at a monthly cost not to exceed $266,667, an annual cost not to exceed $3,210,000, which includes an educational allowance up to $10,000 per year, and a total cost not to exceed $6,420,000 for the term.

Finance, Operations & Planning Committee
(No meeting held in July, 2019)

Professional Affairs Committee
(No meeting held in
July or August, 2019)

Audit, Compliance & Ethics Committee
(No meeting held in August, 2019)

Tri-City Medical Center
Audit, Compliance & Ethics Committee
July 16, 2019
Assembly Room 1
8:30 a.m-10:30 a. m.

Members Present:	Director Larry W. Schallock(Chair); Director George W. Coulter; Director Tracy M. Younger; Kathryn Fitzwilliam, Subject Matter Expert
Non-Voting Members:	Steve Dietlin (CEO); Scott Livingstone, COO; Ray Rivas, CFO
Others Present:	Teri Donnellan, Executive Assistant; Kristy Larkin, Director of Compliance, Audit & Monitoring; Maria Carapia, Compliance Specialist; Stacy Stelzriede, Engagement Partner (Moss Adams); Kyle Rogers, Audit Manager; Stanley J. Dale, MA, JD, CCEP; Carl Marcuzzi, CPA
Absent:	Leslie Schwartz, Community Member; Cary Mells, M.D.; Physician Member

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to Order	The meeting was called to order at 8:30 a.m. in Assembly Room 1 at Tri-City Medical Center by Chairman Schallock. Chairman Schallock reported Chief Compliance Officer Carlos Cruz recently left the organization to accept an offer on the east coast. Mr. Dietlin is in the process conducting a search for a new Compliance Officer. Chairman Schallock introduced Committee applicants Stanley Dale and Carl Marcuzzi. He explained the interview process which will take place later on in the agenda.		
2. Approval of Agenda	**It was moved by Director Coulter and seconded by Director Younger to approve the agenda as presented. The motion passed unanimously.**	**Agenda approved.**	
3. Comments by members of the public and committee members on any item of interest to the public before Committee's consideration of the item	There were no public comments.		

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
4. Ratification of minutes – April 16, 2019	**It was moved by Director Younger and seconded by Director Coulter to approve the minutes of April 16, 2019, as presented. The motion passed unanimously.**	**Minutes ratified.**	
4. Old Business - None			
5. New Business a) Fiscal 2019 Financial Statement Audit Entrance – Moss Adams	Ms. Stelzriede, Engagement Partner with Moss Adams introduced Kyle Rogers, Audit Manager. The team also includes Annie Norviel, Audit Senior Manager, Brian Conner, Concurring Reviewer and Matt Parsons, Audit Senior Manager who is in charge of the Single Audit. She noted Moss Adams always follows best practice with staff rotation every few years. Ms. Stelzriede presented information on the following: ➢ Required Communications to those Charged with Governance ➢ Our Responsibility Under US Generally Accepted Auditing Standards and Government Auditing Standards. Ms. Stelzriede explained the Auditor's role is to plan and perform the audit in accordance with generally accepted auditing standards and to design the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. Ms. Stelzriede emphasized that the audit of the financial statements does not relieve the Board or management of their responsibilities. ➢ Audit Process • Internal Controls • Analytical Procedures • Substantive Procedures Ms. Stelzriede explained that the auditors take a "controls" approach over revenue procurement and disbursements and if any significant issues were to arise between now and the audit, the Auditors would reach out to the Chair of the Committee.	**Information only.**	

	Discussion	Action Recommendations/ Conclusions	erson(s) Responsible
	Ms. Stelzriede commented that materiality is never the same number year to year. It may or may not adjust for qualitative factors. She stated that the auditors are not aware of anything this year however they do perform a "look back" analysis from the prior year. ➢ Significant Audit Areas • Revenue Recognition and Valuation of Patient Revenue/Receivables and Third Party Settlements • Self-Insured Liabilities • Line of Credit and Long-Term Debt (HUD Financing, Covenant Compliance and Single Audit) • Commitments and Contingencies, including status of MOB Legal Matter. MOB Legal Proceedings ➢ Consideration of Fraud Ms. Stelzriede explained how the auditors will gather information to identify fraud-related risks of material misstatement and the procedures to be performed which will include but not be limited to testing and analyzing significant accounting estimates or biases. ➢ Deliverables ➢ Audit TimeLine – Ms. Stelzriede expects to present the audit results to the committee and the Board at their September meetings. Ms. Stelzriede also provided an update of New Standards which included GASB 85 that addresses a variety of topics including issues related to blending component unit, goodwill, fair value measurement and application and postemployment benefits. Lastly, Ms. Stelzriede commented on the 2019 Health Care Conference entitled Preparing for the Future of Healthcare which is scheduled on November 7-8, 2019. Committee members asked questions of the auditors		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	throughout the presentation. *Ms. Stelzriede and Mr. Rogers left the meeting at 9:05 a.m.*		
b) Community Member Interviews: 1) Stanley J. Dale, MA, JD, CCEP	Mr. Stanley Dale provided a brief update of his background and experience. Mr. Dale has spent a great deal of time as an Educator in various Universities. He also has served as a Consultant, Mediator, worked in governmental services and has a JD as well as a certificate in Corporate Compliance and Ethics. Mr. Dale was very interested in Tri-City's Compliance department and its organization. Committee members asked questions of Mr. Dale as well. *Mr. Dale exited the meeting and Mr. Marcuzzi joined the meeting.*		
2) Carl Marcuzzi, CPA	Mr. Carl Marcuzzi provided a brief update of his background and experience. Mr. Marcuzzi is a CPA and is currently working independently after extensive work with a Dutch accounting firm in New York and moved on to Arthur Young. Mr. Marcuzzi served on the Audit Committee previously for a four-year term commencing 2012 through 2015 and also served on the Finance, Operations & Planning Committee from 2015-2017. Mr. Marcuzzi stated it has been two years since serving on one of our Board Committees and he is very interested in serving once again. Committee members asked questions of Mr. Marcuzzi as well. *Mr. Marcuzzi left the meeting at 9:15 a.m.* The committee discussed the qualifications of each candidate and it was their opinion that the committee could benefit from both Mr. Dale and Mr. Marcuzzi's experience. **It was moved by Director Coulter and seconded by Director Younger to recommend Mr. Stanley Dale to a two-year term on the Audit, Compliance & Ethics Committee. The motion passed unanimously.**		

	Discussion	Action Recommendations/ Conclusions	erson(s) Responsible
	It was moved by Director Younger and seconded by Director Coulter to recommend Carl Marcuzzi to a two-year term on the Audit, Compliance & Ethics Committee. The motion passed unanimously. *Mr. Dale and Mr. Marcuzzi rejoined the meeting at 9:20 a.m.* Chairman Schallock reported the committee believes both Mr. Dale and Mr. Marcuzzi bring value and insight to the committee. The committee unanimously recommended both individuals be appointed to a two-year term on the Committee.	**Recommendation to be sent to the Board of Directors to recommend Stanley Dale and Carl Marcuzzi to a two-year term on the Audit, Compliance & Ethics Committee; item to be placed on Board agenda and included in agenda packet.**	Ms. Donnellan
6. Comments from Committee Members	Chairman Schallock reported Leslie Schwartz's second two-year term will expire next month. He expressed his appreciation for Mr. Schwartz's service.		
7. Committee Openings	There are currently three committee openings, pending approval by the Board of two appointments, Mr. Dale and Mr. Marcuzzi.	**Mr. Dale and Mr. Marcuzzi will be contacted and confirm appointment following the August Board meeting.**	Ms. Donnellan
8. Date of Next Meeting	The Committee's next meeting is scheduled for September 17, 2019.		
9. Adjournment	Chairman Schallock adjourned the meeting at 9:25 a.m.		

MOSSADAMS

Audit Entrance: Tri-City Healthcare District

July 16, 2019

Audit Committee

Tri-City Healthcare District

Thank you for your continued engagement of Moss Adams LLP, the provider of choice for health care organizations. We are pleased to present our audit plan for Tri-City Healthcare District for the year ending June 30, 2019. We would also like to discuss current-year developments and auditing standard changes that will affect our audit.

We welcome any questions or input you may have regarding our audit plan and we look forward to working with you.

Your Dedicated Team

Stacy Stelzriede
Engagement Partner

Annie Norviel
Audit Senior Manager

Kyle Rogers
Audit Manager

Brian Conner
Concurring Reviewer

Matt Parsons
Audit Senior Manager (Single Audit)

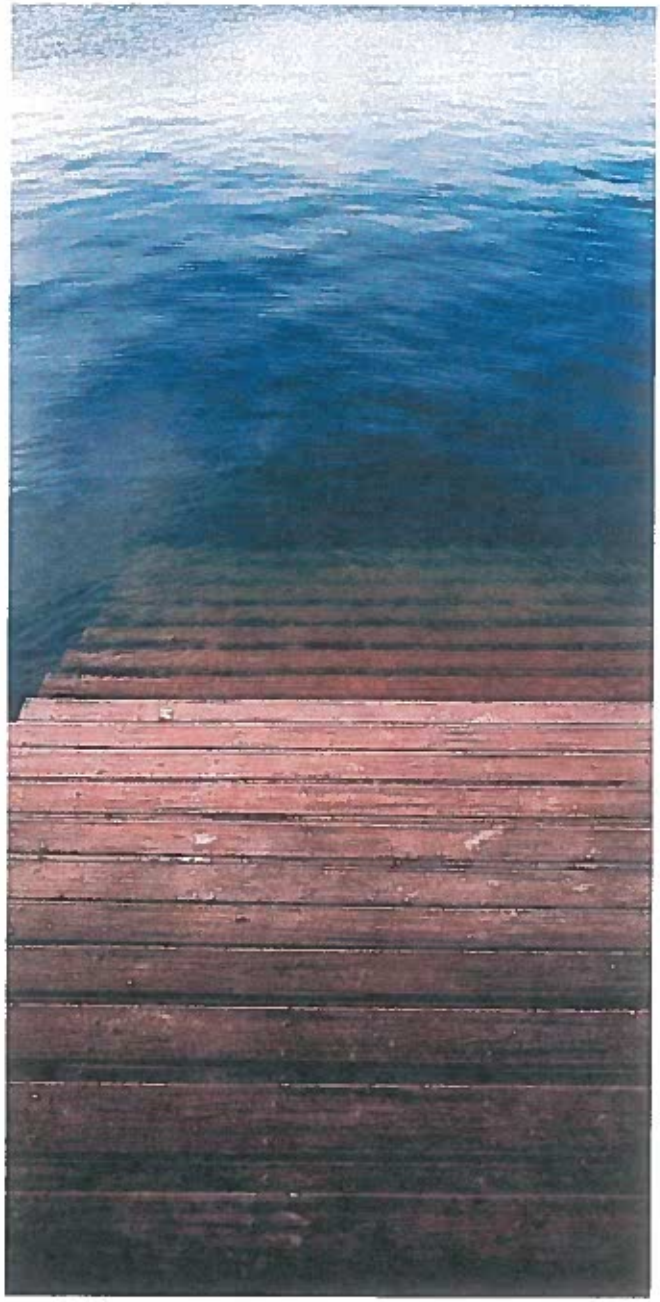
Required Communications to Those Charged with Governance

Now

- Auditor's responsibility under U.S. and government auditing standards
- Planned scope and timing of audit

Later

- Significant audit findings
- Qualitative aspects of accounting practices
- Difficulties encountered in performing the audit
- Corrected and uncorrected misstatements
- Management representations
- Management consultations with other independent accountants
- Other audit findings or issues



Our Responsibility

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

1

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

2

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

3

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

4

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

Audit Process

Internal Controls

Includes information technology

Analytical Procedures

Revenues and expenses

Trends, comparisons, and expectations

Substantive Procedures

Confirmation of account balances

Vouching to supporting documentation

Representations from attorneys and management

Examining objective evidence

What is Materiality?

The amount of a misstatement that could influence the economic decisions of users, taken on the basis of the financial statements.

How It's Calculated:

- Using certain quantitative (e.g., total assets) and qualitative factors (e.g., covenants, expectations, or industry factors)

It's Used To Identify:

- Significant risk areas
- Nature, timing, extent, and scope of test work
- Findings or misstatements

Significant Audit Areas

Revenue Recognition and Valuation of Patient Receivables and Third Party Settlements

Self-Insured Liabilities

Line of Credit and Long-Term Debt (HUD Financing, Covenant Compliance and Single Audit)

Commitments and Contingencies, including status of MOB Legal Matter

Consideration of Fraud

Auditors must consider fraud to "improve the likelihood that auditors will detect material misstatements due to fraud in a financial statement audit."

How we gather information to identify fraud-related risks of material misstatement:

- Brainstorm with team
- Conduct personnel interviews
- Document understanding of internal control
- Consider unusual or unexpected relationships identified in planning and performing the audit

Procedures to be performed:

- Examine general journal entries for nonstandard transactions
- Evaluate policies and accounting for revenue recognition
- Test and analyze significant accounting estimates for biases
- Evaluate the business rationale for significant unusual transactions

Deliverables

We will issue the following reports:

- Audit report on the financial statements of Tri-City Healthcare District as of and for the years ended June 30, 2019 and 2018
- GAGAS Report on Internal Control over Financial Reporting and on Compliance and Other Matters
- Report on Compliance for Each Major Program and Report on Internal Control over Compliance Required by Uniform Guidance
- Report to those charged with governance
  - Communicating required matters and other matters of interest
- Report to management and the audit committee
  - Communicating required internal control related matters identified during the audit

Nonattest services:

- Assist in drafting of the Data Collection Form as of and for the year ended June 30, 2019

Timeline

2019

July 8 - 12	July 8	July 16	Aug 5-23	Sept 2019	Sept 17, 2019	Sept 26, 2019
Interim audit procedures *(including test of implementation of internal controls)* for financial statements	Planning meeting with management	Entrance meeting with audit committee	Final fieldwork procedures	Discuss draft financial statements and auditor's reports with management	Audit committee approval of statements and exit meeting	Presentation of audit results to Board of Directors

MOSSADAMS

Accounting Update

New Standards

GASB 85 | Omnibus 2017

- This Statement addresses a variety of topics including issues related to blending component units, goodwill, fair value measurement and application, and postemployment benefits (pensions and other postemployment benefits [OPEB]).
- This Statement addresses the following topics (and others):
  1. Blending a component unit in circumstances in which the primary government is a business-type activity that reports in a single column for financial statement presentation
  2. Reporting amounts previously reported as goodwill and "negative" goodwill
  3. Timing of the measurement of pension or OPEB liabilities and expenditures recognized in financial statements prepared using the current financial resources measurement focus
  4. Recognizing on-behalf payments for pensions or OPEB in employer financial statements
- Effective for reporting periods beginning after December 15, 2017. Earlier application is encouraged.

New Standards

GASB 84 | Fiduciary Activities

Clarifies fiduciary activities as having the following characteristics:

1. Government controls the assets of the activity.
2. Those assets are not derived solely from the government's own source revenue.
3. One of the following:
   - The assets result from a pass-through grant or trust agreement.
   - Assets are used to benefit individuals not typical recipients of the government's goods and services (i.e. employees receive the benefit instead of patients.)
   - Assets are to be used to benefit other organizations or governments.

- Would require stand alone business-type entities (i.e. hospitals) with pension and OPEB trusts or patient custodial accounts to report separate fiduciary fund financial statements within the financial statements.
- Effective for reporting periods beginning after June 15, 2018. Earlier application is encouraged.

New Standards

GASB 90 | Majority Equity Interests (an amendment of GASB Statement No. 14 and No. 61)

- Governments that acquire a majority interest in a separate organization as an investment (i.e. has the ability to generate its own cash flow and was acquired for the primary purpose of generating income/profit) should measure the investment using the equity method.
- Special-purpose governments engaged only in fiduciary activities (i.e. a benefit or pension plan) should measure the investment at fair value.
- Governments that acquire a majority interest that does not meet the definition of investment should report the separate organization as a component unit.
- Governments that acquire 100% equity interest that meets the criteria of a component unit should follow guidance of a government combination in GASB 69.
- Effective for reporting periods beginning after December 15, 2018. Earlier application is encouraged. Should be applied retroactively with the exception of bullets 3 and 4 above that should be applied prospectively.

New Standards

GASB 87 | Leases

- Would treat all leases as financings (no classification of capital v. operating) similar to FASB ASU 2016-02.
- Includes non-cancellable period + periods covered by options to renew if reasonably certain to be exercised.
- Lessee would record an intangible asset (amortized over the shorter of its useful life or lease term) and present value of future lease payments as a liability.
- Lessor would record a lease receivable and deferred inflow of resources for cash received up front + future payments (revenue recognized over lease term in a systematic and rational basis).
- Effective for reporting periods beginning after December 15, 2019. Earlier application is encouraged.

New Standards

GASB 89 | Interest Cost Incurred before the End of a Construction Period

- Interest incurred during construction of an asset that was once eligible for capitalization must now be expensed as a period cost. The only exception applies to regulated entities (rate setting agencies such as utilities).
- The objective was to enhance comparability for the cost of borrowing and simplify the accounting.
- Respondents to the Exposure Draft argued that stand-alone business type entities (like hospitals) would no long be comparable to non-governmental counterparts; however, GASB decided not to establish separate objectives for general government vs. business-type activities.
- Effective for reporting periods beginning after December 15, 2019. Earlier application is encouraged. The Statement should be applied prospectively.

On the Horizon – Exposure Drafts and Preliminary Views

- **Financial Reporting Model Improvements** – Proposes defining "operating" vs. "non-operating" activities; proposes requiring combining financial statements as supplementary information for blended component units; proposes classification of government-wide expenses by function or program.
- **Revenue and Expense Recognition** – Better differentiates exchange from non-exchange transactions; proposes a uniform revenue recognition standard with 3 models to be evaluated.

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About Moss Adams

You're Invited

Vision 2020

Preparing for the Future of Health Care

2019 HEALTH CARE CONFERENCE

Click here to register

WHEN

November 7-8, 2019

WHERE

Red Rock Casino, Resort & Spa

Las Vegas, Nevada

WHO

Executives and members of the C-suite in health care, life sciences, technology, and venture capital

James Carville

Famed liberal campaign consultant, political author and commentator

Jeff Flake

Former U S Senator from AZ

Susan Dentzer

Senior health care policy expert, author, and journalist

Karl Rove

Former Deputy Chief of Staff, Pres George W Bush; political strategist, pundit, and op-ed contributor for The Wall Street Journal

John Kitzhaber, M.D.

Former Governor of Oregon

Named one of Modern Healthcare's 100 Most Influential People in Healthcare

Donald Crane

President and CEO

America's Physician Groups

Our Expertise

D E E P

104
years in business

2,900+
professionals

30+
industries served

Crater Lake—
A monument to perseverance, North America's deepest lake filled to 1,949 feet over ~20 years.

Data as of November 2017

Our Reach

W I D E

25+
locations west of the Mississippi

100+
countries served through Praxity, AISBL

$527M
in revenue earned

Grand Canyon—
At 277 miles long and up to 18 miles wide, this icon serves as a testament to determination and time.

Data as of November 2017

Health Care Industry Experience

Our health care professionals dedicate their careers to serving the industry.

We cover the full spectrum of health care including:

- Hospitals and heath systems
- Independent practice associations
- Medical groups
- Community health centers
- Behavioral health organizations
- Long-term care
- Surgery centers
- Knox Keene licensed health plans
- Health care ancillary services

D E E P

2,200+
clients across the nation

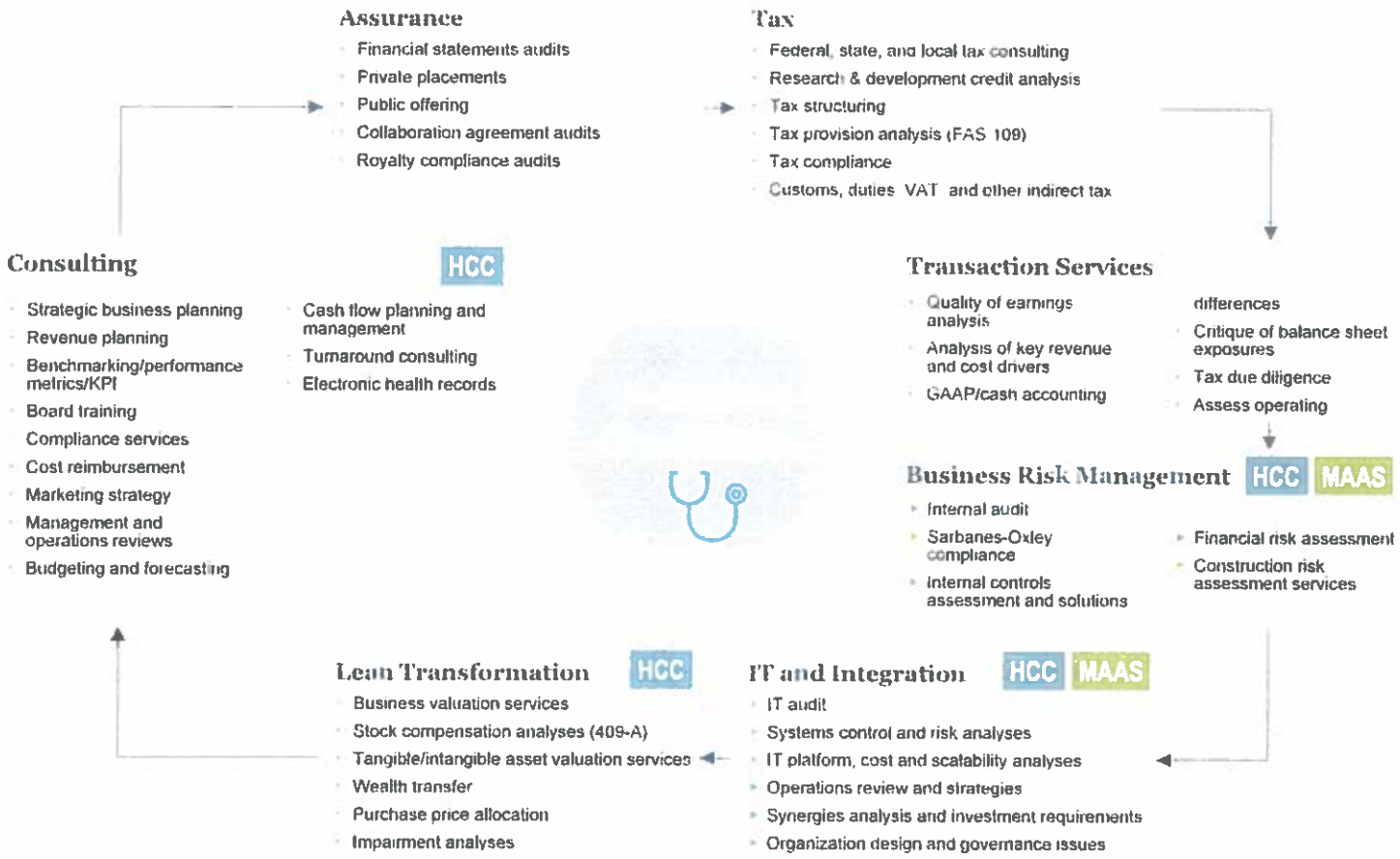
32
practice partners

270+
professionals

Crater Lake—
A monument to perseverance, North America's deepest lake filled to 1,949 feet over 720 years.

Data as of November 2017

Services Overview: How This All Fits Together



Services

We offer a full range of services and specializations that span accounting, consulting, and wealth management to suit your specific needs.

Accounting

ASSURANCE

- Financial Statement Audits
- Employee Benefit Plans
- Public Company & SEC
- Internal Audit
- Outsourced Accounting
- Contract Compliance
- Sustainability

TAX

- Accounting for Income Taxes (ASC 740)
- Accounting Methods
- Compensation & Benefits
- Credits & Incentives
- International
- State & Local
- Controversy & Dispute Resolution
- Tax Structuring
- Transfer Pricing

Consulting

IT

- Compliance
- Cybersecurity
- Assessment & Planning
- Development & Integration

STRATEGY & OPERATIONS

- Business Planning
- Performance Audits
- Succession Planning

TRANSACTIONS

- Due Diligence
- Investment Banking
- M&A Tax
- Restructuring
- Valuations

Wealth Management

INDIVIDUAL

- Tax
- Financial Planning
- Investments
- Family Office

INSTITUTIONAL

- Investments
- Insurance

Insights and Resources

In today's fast-paced world, we know how precious your time is. We also know that knowledge is key.
These resources offer what you need to know, when you need to know it, and is presented in the format that fits your life.

We'll keep you informed to help you stay abreast of critical industry issues.

Moss Adams closely monitors regulatory agencies, participates in industry and technical forums, and writes about a wide range of relevant accounting, tax, and business issues to keep you informed.

We also offer CPE webinars and events which are archived and available on demand, allowing you to watch them on your schedule.

Connect With Us

In today's fast-paced world, we know how precious your time is. We also know that knowledge is key. These resources offer what you need to know, when you need to know it, and is presented in the format that fits your life.

LinkedIn: www.linkedin.com/company/moss-adams-llp

Twitter: @Moss_Adams

Subscribe to our emails: www.mossadams.com/subscribe

RSS feeds: www.mossadams.com/RSS

YouTube: http://www.youtube.com/mossadamsllp

Stacy Stelzriede, Partner

(310) 295-3772

Annie Norviel, Senior Manager

(858) 627-1484

Kyle Rogers, Manager

(858) 627-1449

THANK YOU

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Oceanside, California 92057
E :stanleyjdale@gamail.com
P: (213) 446-4460 GV: (562) 600-0060 C: (630) 363-0000

EDUCATOR

University of LaVerne-LaVerne. CA and other locations

Adjunct 1/2013 through present
Instructor: Ethics. Human Resources. Business Law

University of Redlands-Redlands. CA and other locations

Visiting Assistant Professor and
Assistant Director- Banta Center for Business. Ethics and Society
Adjunct 1/2012 through 5/2015

Full Time 6/2015 through 7/2018

Instructor: Ethics. Human Resources, Business Law

Member:
ACBSP Accreditation Committee
School of Business Strategic Planning Committee
Keypath On-line Course Development Committee

Director: Teaching Ethics in High School Business classes in collaboration with
Corona-Norco Unified School District through a grant funded by Town & Gown

DeVry University-Chicago, IL and Pomona. CA Metropolitan Areas

Visiting Professor (over 14 years): Law. Communications. Business, Customer Service. Ethics and Career Development

Full Time Faculty Recruiter (2001-2004) Located. hired. observed and developed adjunct faculty. interfaced with academic and corporate management. Deans and Human Resources Department in employment matters and delivery of on-site and on-line courses

Keller Graduate School of Management-Chicago Metropolitan Area

Visiting Faculty: Law, and Political and Ethical Dimensions of Business

North Central College- Naperville, IL

Visiting Lecturer: US and International Conflict Resolution Courses

California Intercontinental University- Diamond Bar, CA: Business and Law Professor and Criminal Justice Curriculum Designer and Consultant

Platt College-Riverside, CA: Adjunct Professor of Paralegal and Criminal Justice Studies

CONSULTANT

Dale and Associates

Develop educational programs for start-up and existing schools with on-line and on-site schools-emphasis on paralegal and criminal justice programs-advisor to police agencies on as-need basis

Assist schools with ABA accreditation issues

Advisor to police agencies on as-need basis

BarExamDoctor.com-Tutor and coach future and past bar examinees, grade practice bar exams

Leyden Family Service and Mental Health Center: Former manager of Resource Development for large regional behavioral health center in suburban Chicago

United Way: Former Campaign Manager-Increased donations by 300% through employee workplace campaigns: Trained and managed volunteers: built consensus with diverse groups: Designed and implemented new data gathering and reporting systems

Rancho Cucamonga Police Department (SBCSD): Member Citizen Advisory Board

ATTORNEY
Court Admissions:

- U.S. Supreme Court
- U.S. Court of Appeals (7th Circuit)
- U.S. District Court (Northern District of IL, Eastern Division)
- Supreme Court of Texas
- Supreme Court of Illinois

General Counsel: Corporate Business Cards, Ltd: Advise senior management on matters such as commercial, real estate and labor law; monitor all outside counsel relationships; participate in management-level decision making and negotiations

Of Counsel: Law Offices of John T. Clery, P.C.-Business, Employment, Law Enforcement Training and Consulting

Circuit Court Arbitrator: Chair-qualified - Trial Courts of Cook and surrounding counties in IL

Dale, Stanek & Associates: Co-founder of a medium-sized law firm dealing with the real estate, business, commercial and immigration law
Borg-Warner Corporation: Advised all levels of management on commercial and financial matters; hired, monitored and supported local counsel, primarily in California

Illinois Secretary of State: Hearing Officer for the Securities Department-heard administrative law cases involving state blue skies law violations
State Bar Section Memberships:

- Illinois State Bar Association:
- Privacy and Information Security Law Section Council 2017-2019.
- ADR Section Council
- Past officer of numerous other ISBA Councils and Sections
- State Bar of Texas - ADR Section Council

Local Bar Association / Section Memberships:

- Illinois State Bar Association-Privacy and Information Security Law Section
- Texas Bar Association
- Chicago (IL) Bar Association- Former Chair: Mental Health Law Committee
- Los Angeles County (CA) Bar Association – Family Law; Labor/Employment Law
- Orange County (CA) Bar Association – ADR Section
- Western San Bernardino County (CA) Bar Association- ADR Section

MEDIATOR

California Area Mediation Associates: Founder of private consulting practice providing mediation, arbitration and conflict resolution services to the public- based in West Hollywood, CA

GOVERNMENT SERVICE

Formerly:

County of DuPage, Illinois
Chair: Community Service Block Grant Advisory Board

City of Naperville, IL
Co-founder: Police Community Radio Watch Program
Secretary: Nichols Library Board
Member: Transportation Advisory Board

Village of Schaumburg, IL

Chair, Olde Schaumburg Centre Commission (Zoning/Preservation)

EDUCATION

Northern Illinois University - J.D., Law- (top 15% of class)
Governors State University - M.A., Human Relations
Northeastern Illinois University - B.A., English (with Honors)
Pepperdine University School of Law - Certificate in California Court-Based Mediation of Family Law Matters
Los Angeles County Bar Association/Center for Civic Mediation-Trained Mediator
Society of Corporate Compliance and Ethics-Certified Compliance and Ethics Professional

ADDITIONAL CERTIFICATIONS, LICENSES and SKILLS

CCEP: Corporate Compliance and Ethics Professional-Society of Corporate Compliance and Ethics

Illinois State Board of Education: Certificated K-12 Teacher

Online course delivery proficiencies: BlackBoard, eCollege, Moodle

CIVIC and other ORGANIZATIONS / ACTIVITIES

- The Center for American and International Law
- Cook County (IL) Circuit Court Family Violence Coordinating Council
- Society of Corporate Compliance and Ethics
- Society for Human Resource Management (SHRM)

- Institute for Law Enforcement Administration / Center for Law Enforcement Ethics
- National Law Enforcement Officers Memorial Fund-supporting member
- Alliance for Illinois Manufacturing
- Illinois Association of Historic Preservation Commissions
- Monterey Bay International Trade Association
- Illinois Bar Foundation – Fellow
- American Mock Trial Association –Judge of Intercollegiate Mediation Tournaments
- DuPage County (IL) Community Service Block Grant Advisory Board: Former Chair
- International Academy of Dispute Resolution: Director
- Franklin Park/Schiller Park Chamber of Commerce: Director
- Schaumburg (IL) Zoning / Advisory Commission: Chair (2000-2015)
- Chicagoland Restaurant Brokers Association: Former Chair of Ethics Committee
- Knights of Columbus: 4th Degree Member-Title of Sir Knight: Officer Post: Advocate
- *Inside Counsel*: Member of Ad and Editorial Advisory Panel of legal publisher
- Volunteer: Fundraiser- Guerin Prep High, River Grove, IL
- Former Board Member: Mercedes Benz Club of America-Orange County (CA) Section
- Scoring Attorney- Riverside County, CA Mock Trial Competitions
- Contributor: Harris Survey Polls
- San Diego Union-Tribune Reader Panel
- Former President- JTPA / Private Industry Council of DuPage County, IL
- Former Member and Secretary: Nichols Public Library Board, Naperville, IL
- Former Member: Naperville (IL) Transportation Advisory Board
- Author: book reviews and articles for legal and ADR communities
- Actor: Appeared in TV commercials and on stage
- Bi-lingual: English / Spanish

CARL MARCUZZI, CPA

5159 Via Castilla • Oceanside, CA 92057 • (619) 987-8565 or (760) 721-7492 • Email: carlcpa@cox.net

July 3, 2019

Teri Donnellan
Executive Assistant
Tri-City Medial Center
4002 Vista Way
Oceanside, California 92056

Dear Ms. Donnellan,

I hereby submit my application for the open community seat on the Tri-City Medical Center audit committee. I have been an Oceanside resident since 2001. I previously served on the audit committee for a four year period commencing 2012 through 2015. In addition, I have also served as a community member on the financing, operations, and planning committee for the two year period of 2015 through 2017.

My qualifications and background for serving on the audit committee are summarized on the attached page. Please forward my application for the open community seat to the appropriate members of the Board of Directors who presently sit on the audit committee. Thank you for your time and consideration in this matter.

Respectfully submitted,

Carl Marcuzzi, CPA

Carl Marcuzzi, CPA
(619) 987-8565

A versatile CPA with skills in public, private and non-profit audit, tax planning and preparation, and

Experience

2011	Owner, Carl Marcuzzi, CPA , San Diego California
	Sole proprietor providing general accounting, tax planning and audit services to individual, corporate and non-profit clients.
1991 – 2011	Managing CPA, small CPA firms in San Diego and Vista California
	Imibimbo and Marcuzzi, 2007 – 2011 Griffiths and Associates, 2003 – 2007 Cossolias and Company, 1991 – 2003
	Provided full-service public accounting services including: compilations, financial statements, tax planning and preparation, audits of various entities, client incorporations, payroll, benefits planning
Earlier Experience	Staff CPA in New York-based global accounting firms

Education JD, Western Sierra Law School, San Diego, California

BA, Accounting, Rutgers University, Newark, New Jersey

Community 2015 – 2017 Finance, Operations and Planning Committee, TCMC

2012 – 2015 Audit Committee, TCMC

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #~~14~~-19-017 (FOP)

POLICY TITLE: Principal Investment Policy

I. It is the policy of Tri-City Medical Center to invest excess cash in short-term investments earning a market rate of interest with minimum risk to principal. The objectives of the Tri-City Healthcare District Principal Investment Policy shall be in the following priority:

A. Safety
B. Liquidity
C. Yield

The Treasurer of the Board of Directors or Vice President of Finance/Chief Financial Officer shall annually review and present to the Board of Directors a Statement of Investment Policy which the Board of Directors shall consider at a public meeting.

II. REPORTING REQUIREMENTS

The Treasurer of the Board of Directors or ~~Vice President o~~Chief Financial shall render a quarterly report to the Board of Directors and the CEO. The quarterly report shall be so submitted within 30 days following the end of the period covered by the report. The report shall include the type of investment, issuer, date of maturity, par and dollar amount invested on all securities, investments and moneys held by the District and shall additionally include a description of any of the District's funds, investments, or programs that are under the management of contracted parties, including lending programs. The report shall also include statements, information and items as described in Section 53646 of the Government Code of the State of California and any amendments thereto.

III. PRUDENT INVESTOR STANDARD AND OBJECTIVES

All investments of Tri-City Healthcare District shall comply with the prudent investor standard and objectives described in Government Code section 53600 et seq. and any amendments thereto.

IV. TYPES OF INVESTMENTS AND SAFEKEEPING

As far as possible all money belonging to Tri-City Healthcare District shall be deposited for safekeeping in accordance with Section 53635 and 53601, *et seq.* of the Government Code, and any amendments thereto, and any other applicable law.

Reviewed by the FO & P Committee: 7/19/05
Approved by the Board of Directors: 7/28/05
Reviewed by the FO & P Committee: 7/7/06
Approved by the Board of Directors: 7/27/06
Reviewed by the FO & P Committee: 10/16/07

Approved by the Board of Directors: 12/13/07
Reviewed by the FO&P Committee: 10/19/10
Approved by the Board of Directors: 11/04/10
Approved by the FO&P Committee: 6/17/14
Approved by the Board of Directors: 6/26/14
Reviewed by Ad Hoc Bylaw & Policies Committee: 7/2019
Approved by Board of Directors:

TRI-CITY HEALTHCARE DISTRICT
INVESTMENT POLICY STATEMENT

I. Purpose of This Statement of Investment Policy

A. This statement of Investment Policy outlines the objectives, goals and guidelines for the invested funds (Fund) and is set forth in order that:

1. There be a clear understanding on the part of the Board of Directors and Investment Manager(s) of the investment objectives and policies of the Fund so as to minimize the chance of the Board of Directors being surprised by results from what could be expected to occur during various stages of market cycle.

2. The Investment Manager(s) is given guidance and limitations in the investment of the Fund's assets.

3. The Board of Directors has a meaningful basis for the evaluation of the portfolio management by the Investment Manager(s) in order that the Board of Directors meets their fiduciary responsibility to prudently monitor the investment of the Fund.

4. The Board of Directors and Investment Advisors recognize that the Fund is limited in its investment options by Government Code section 53601 and shall be bound by the rules contained therein.

B. The investment of the Fund's assets shall be for the exclusive purpose of providing benefits for the Healthcare District maintaining the objective outlines in the "Investment Objectives" section.

C. It is the intent of this document to state general attitudes, guidelines, and a philosophy which will guide the Investment Manager(s) toward the performance desired. It is intended that the investment policies be sufficiently specific to be meaningful but adequately flexible to be practicable.

D. This Annual Statement of Investment Policy applies to all invested funds for Tri-City Healthcare District accounted for in the annual audit including general fund and restricted funds. Assets not included in this Policy include retirement plans and deferred savings plan assets held by fiduciaries, and funds held in restricted accounts as security for outstanding bonds per Government Code § 53631.

II. RESPONSIBILITIES OF THE BOARD OF DIRECTORS

A. The specific responsibilities of the Board of Directors in the investment process include and are not limited to:

1. Delegation to the Vice President of Finance the responsibility of overseeing the Investment Policy, and the following specific criteria:

   a. Determining the Fund's projected financial needs and communicating such to the Investment Manager(s) on a timely basis.

   b. Expressing the Fund's risk tolerance level.

   c. Developing sound and consistent investment policy guidelines, which the Investment Manager(s) can use in formulating corresponding investment decisions.

   d. Establishing reasonable investment objectives.

   e. Selecting qualified Investment Manager(s).

   f. Communicating clearly the major duties and responsibilities of the Investment Manager(s).

   g. Monitoring and evaluating performance results to assure that the policy guidelines are being adhered to and those objectives are being met.

   h. Taking appropriate action to replace Investment Manager(s) for failure to perform as expected.

   I. Periodically reporting Fund and Investment Manager's performance.

B. The Board of Directors recognize that their role is to establish general policy as to investment strategy and policy. ~~, but the~~The determination and selection of specific investments and securities must be delegated to the Investment Manager(s).

C. The investment policy objectives, goals, and guidelines that follow should represent the current consensus of the Board of Director's philosophy regarding the investment of the Fund's assets. The Statement of Investment Policy will need to be reviewed annually to ensure that the Statement continues to reflect the Board of Director's attitudes, expectations, and objectives.

III. RESPONSIBILITIES OF THE INVESTMENT MANAGER(S)

A. Adherence to All Applicable California Governmental Code Sections:

1. The Investment Manager(s) is responsible to insure all applicable Government Code sections are followed in a lawful manner. This includes but is not limited to; asset allocation restrictions, type of investments

allowed, credit worthiness of issuers, rating requirements for individual investments, length of maturities, qualifications of financial institutions, brokers/dealers utilized, etc.

2. Ensure that all District funds invested are insured or collateralized to the extent required by law.

B. Adherence to Statement of Investment Policy:

1. The Investment Manager(s) is expected to respect and observe the specific limitations, guidelines, attitudes, and philosophies stated herein, or as expressed in any written amendments of instructions.

2. The Investment Manager's acceptance of the responsibility to manage assets of the Fund will constitute a ratification of this Statement of Investment Policy, affirming the belief that they are realistically capable of achieving the Fund's objectives within the guidelines and limitations stated herein.

3. Prior to engagement as Investment Manager(s), submit a signed certification form attesting that the individual responsible for the Tri-City Healthcare District account with their firm, has reviewed the current investment policy and that the firm understands the policy and intends to abide by it, and all applicable California Government Code sections.

4. Ensure that funds maturing are placed in interest bearing accounts while awaiting reinvestment.

5. Provide reasonable portfolio diversification as to invested securities and financial institutions.

C. Discretionary Authority:

1. Investment Manager(s) will be responsible for making all investment decisions on a discretionary basis regarding all assets placed under its jurisdiction and ~~will~~ shall be held accountable for achieving the investment objectives indicated herein. Such discretion shall include decisions to buy, hold, and sell securities in amounts and proportions that are reflective of the Investment Manager's current investment strategy and compatible with the Fund's investment guidelines.

D. Communication:

1. Investment Manager(s) will keep management informed on a timely basis of major changes in its investment outlook, investment strategy, asset allocation, and other matters affecting their investment policies or philosophy.

2. Management also expects to be informed of any significant changes in the ownership, organizational structure, financial condition, or senior staffing of Investment Manager's firm.

3. Whenever Investment Manager(s) believes that any particular guideline should be altered or deleted, ~~it will~~ shall be the Investment Manager's responsibility to initiate written communications with management expressing its views and recommendations.

E. Reporting:

1. Management expects to receive timely notices of transaction activities as well as quarterly performance reports.

2. Management expects to receive quarterly performance monitors.

IV. INVESTMENT OBJECTIVES

The Fund is a fixed income portfolio.

A. Preservation of Capital – Over the investment time horizon, capital gains are to be protected. A positive return must be experienced over the investment time horizon.

B. Preservation of Purchasing Power – Asset growth, exclusive of contributions and withdrawals, US Treasury rates and money market rates should exceed the rate of inflation in order to preserve purchasing power of the participants' assets.

C. Safety – Investments must be consistent with State law and Tri-City Healthcare District's investment guidelines.

D. Liquidity – Insure availability of needed funds.

V. INVESTMENT GUIDELINES

Summary of Authorized Investments – Tri-City Healthcare District is subject to the limitations of Government Code section 53601 in making investments of surplus funds. Funds to be invested must be money in a sinking fund of, or surplus money in, the Tri-City Healthcare District treasury not required for immediate operations necessities. The term or maturity of any investment ~~may~~shall have a maximum remaining maturity of five years or less ~~not exceed 5 years~~ with the exception of securities underlying a repurchase or reverse repurchase agreements or securities lending agreement authorized by Section 53601 as it may be revised from time to time without prior authorization of the Tri-City Healthcare District Board, which approval must be made no less than 3 months prior to the investment so approved.

1. Summary of Government Code section 53601 – Summarized and outlined below are the corresponding paragraphs from California Government Code section 53601, as it may be amended from time to time.

a. Tri-City Healthcare District Local Agency Bonds

Revenue bonds issued by the local agency

b. United States Treasury Securities

Full faith and credit bills, notes and bonds issued by the United States Treasury

c. Registered State Securities

Revenue notes, bonds and warrants issued by the State or its agencies

d. Local Agency Securities

Revenue notes, bonds and warrants issued by Local agencies within the State

e. United States Government Agency Securities

U. S. Government Agency – GNMA, FHLB, FFCB, FNMA
U. S. Government-sponsored enterprise – FHLMC, SLMA

Banks for Cooperatives, Federal Land Banks, Federal Intermediate Credit Banks, Tennessee Valley Authority, Small Business Administration

f. Bankers Acceptances

Commercial bank time drafts
180 day maturity limit or
40% portfolio limit for investment category and 30% limit per issuing bank

g. Commercial Paper

Highest rating by Standard & Poor's or Moody's rating agencies

United States issuing corporations with assets exceeding $500 million and "A" debt rating by Standard & Poor's or Moody's

180 day maturity limit

10% limit of issuers outstanding commercial paper

15% portfolio limit for investment category

h. Negotiable Certificates of Deposit

Nationally or state-chartered bank, a savings or federal association (Financial Code section 5102), a state or federal credit union, or state-licensed branch of foreign bank. This shall remain in effect until January 1, 2021.

30% portfolio limit for investment category

i. Repurchase Agreements and Reverse Repurchase Agreements

1 year maturity limit, however, if the Agreement will exceed a term of 92 days, a written codicil must be obtained in accordance with Government Code section 53601(j))(3)(c).

Market value of 102% or greater of the funds borrowed against those securities

Security to be sold on reverse repurchase agreement fully paid for by District for at least 30 days prior to sale.

20% portfolio limit

j. Medium Term Notes

United States organized and operating corporations

Operating depository institutions licensed by the United States or any state

Debt rating, by nationally recognized rating service, in the "A" category, its equivalent or better

~~5 year maturity limit~~ The term shall have a maximum remaining maturity of five years or less.

30% portfolio limit for investment category

k. Share of Beneficial Interest

Diversified management companies defined in Section 53601(l)(l) of the California Government Code

Highest letter or numerical rating by not less than two national rating services, or having a registered investment advisor, registered with the SEC, with at least 5 years experience in securities authorized by Section 53601 subdivision (a)-(j) inclusive

and subdivisions (m) and (n) and assets under management exceeding $500 million

l. Pledged Money

Certificates of participation in bonds, indebtedness, or lease installment sale or other agreements

m. Secured Securities

First priority security interest in securities listed in Government Code section 53651 perfected through UCC

n. Mortgage Securities

Mortgage pass-through, collateralized mortgage obligation, mortgage backed or pay-through, equipment lease-backed, consumer receivable pass-through or receivable-backed bond

~~5 year maximum final maturity~~

"AA" issue rating by a nationally recognized rating agency and issuer with "A" rating by a nationally recognized rating agency

20% portfolio limit for investment category

o. JPA Beneficial Interest

Shares of beneficial interest issued by a joint powers authority organized pursuant to Government Code section 6509.7 that invests in the securities and obligations authorized under Subsections (a)-(n) above.

B. Additional Guidelines

1. Derivative Securities

Derivative securities will not be utilized in the portfolio.

2. Income Tax Considerations

Tri-City Healthcare District is a nontaxable entity, consequently, portfolio management decisions will be made without regard to income tax consequences.

3. Benchmark

I. Portfolio rate of return will be expected to outperform the return of, at least two, industry leading indices consistent with the duration of the Tri-City Healthcare District portfolio.

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #~~14~~19-026

POLICY TITLE: Requests for Inspection of Public Records

I. PURPOSE

This Policy sets forth the District policies and procedures regarding requests for inspection of public records. It is designed to be in compliance with existing law, specifically Government Code section 6250 et seq. If any provision of this Policy conflicts with the law, the law shall take precedence.

II. DEFINITIONS

As used in this Policy, the following terms shall have the following meanings:

A. "District" shall mean the TRI-CITY HEALTHCARE DISTRICT.

B. "Person" shall mean any natural person, corporation, partnership, limited liability company, firm, or association.

C. "Writing" means handwriting, typewriting, printing, ~~photostatting~~Photostatting, photographing, photocopying, electronic mail, facsimile, and every other means of recording upon any form of communication or representation, including letters, words, pictures, sounds, or symbols, or combination thereof and any record thereby created, regardless of the manner in which the record has been stored.

D. "Public records" shall mean any writing containing information relating to the conduct of the District's business prepared, owned, used, or retained by the District regardless of physical form or characteristics that are open to public inspection by law.

E. "Requestor" shall mean a person, or representative of a person, who has correctly filled out the request form, attached as Exhibit "A" to this Policy.

III. RIGHT TO INSPECT

To the extent required by law, and except as otherwise provided herein, all public records of the District are open to inspection by any person at all times during the office hours of the District (pursuant to Section V herein). Copies of public records may be obtained by any person, subject to compliance with the procedures set forth in this Policy. Any reasonably segregable portion of a record shall be available for inspection by any person requesting the record after deletion of the portions that are exempted by law.

IV. RECORDS EXEMPT FROM DISCLOSURE

Records which are exempt from disclosure under applicable law include but are not limited to the following:

A. Preliminary drafts, notes, interagency, or intra-agency memoranda which are not retained by the District in the ordinary course of business, provided that the public interest in withholding such records clearly outweighs the public interest in disclosure.

B. Records pertaining to pending litigation to which the District is a party, or to claims made pursuant to Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, until such pending litigation or claim has been finally adjudicated or otherwise settled.

C. Personnel, medical, or similar files, the disclosure of which would constitute an unwarranted invasion of personal privacy.

D. Contained in or related to:

1. Applications filed with any state agency responsible for the regulation or supervision of the issuance of securities or of financial institutions, including, but not limited to, banks, savings and loan associations, industrial loan companies, credit unions, and insurance companies.

2. Examination, operating, or condition reports prepared by, on behalf of, or for the use of, any state agency referred to in Section (1) above.

E. Geological and geophysical data, plant production data, and similar information relating to utility systems development, or market or crop reports, which are obtained in confidence from any person.

F. Test questions, scoring keys, and other examination data used to administer a licensing examination, examination for employment, or academic examination, except as provided for in Chapter 3 (commencing with Section 99150) of Part 65 of the Education Code.

G. The contents of real estate appraisals, engineering or feasibility estimates, and evaluations made for or by the District relative to the acquisition of property, or to prospective public supply and construction contracts, until all of the property has been acquired or all of the contract agreements are obtained; provided that the law of eminent domain shall not be affected by this provision.

H. Information required from any taxpayer in connection with the collection of local taxes which is received in confidence and the disclosure of the information to other persons would result in unfair competitive disadvantage to the person supplying such information.

I. Library circulation records kept for the purpose of identifying the borrower of items available in libraries, and library materials acquired solely for reference purposes. This exemption does not apply to records of the fines imposed on the borrowers.

J. Statements of personal worth or personal financial data required by a licensing agency and filed by an applicant with such licensing agency to establish his or her personal qualification for the license, certificate, or permit for which the applicant applied.

K. A final accreditation report of the Joint Commission on Accreditation of Hospitals that has been transmitted to the State Department of Health Services pursuant to subdivision (b) of Section 1282 of the Health and Safety Code.

L. Records of the District that relate to any contract with an insurer or nonprofit hospital service plan for inpatient or outpatient services for alternative rates pursuant to Section 10133 or 11512 of the Insurance Code. However, the record shall be open to inspection within one year after the contract is fully executed.

M. Computer software developed by a state or local agency is not itself a public record under this chapter. The agency may sell, lease, or license the software for commercial or noncommercial use. Computer software includes computer mapping systems, computer programs, and computer graphic systems.

N. The records made, if any, of closed sessions, pursuant to Government Code section 54957.2, are not public records subject to inspection.

O. Confidential information obtained for eligibility of public services or programs pursuant to Welfare and Institutions Code section 17852.

P. Records the disclosure of which is exempted or prohibited pursuant to federal or state law.

This partial list of exemptions is subject to applicable law, and any changes in law are automatically incorporated herein.

V. REQUEST TO INSPECT AND/OR MAKE COPIES

Any person desiring to inspect records, including electronic records that require data compilation, extraction, or programming and tapes of the meetings of the Board of Directors, of the District shall submit the request form attached as Exhibit "A" to the District's General Council or Office of the President/CEO. The requestor shall, in writing, specify the records to be inspected with sufficient detail to enable the District to identify the particular records and shall specify the number of person to attend such inspection. If the request is ambiguous or unfocused, the District shall make a reasonable effort to elicit additional clarifying information from the requester that will help identify

the record or records. Pursuant to Government Code section 6253.1, the District shall do all of the following, to the extent reasonable under the circumstances:

- Assist the member of the public to identify records and information that are responsive to the request or to the purpose of the request, if stated;
- Describe the information technology and physical location in which the records exist; and
- Provide suggestions for overcoming any practical basis for denying access to the records or information sought.
- The District shall not be obligated to create new records.
- These requirements are deemed to have been satisfied if the District is unable to identify the requested information after making a reasonable effort to elicit additional clarifying information from the requestor that will help identify the record or records.

The District, upon a request for inspection or for a copy of records, shall, within ten (10) days from receipt of the request, determine whether the request, in whole or in part, seeks inspection of or copies of disclosable public records in the possession of the District and shall promptly notify the person making the request of the determination and the reasons therefore. In unusual circumstances, the time limit prescribed in this Section may be extended by written notice by the District's General Council or President/CEO of the District or his/her designee to the person making the request, setting forth the reasons for the extension and the date on which a determination is expected to be dispatched. No notice shall specify a date that would result in an extension for more than fourteen (14) days. A response to a written request for inspection or copies of public records that includes a determination that the request is denied, in whole or in part, shall be in writing. As used in this Section, "unusual circumstances" means the following, but only to the extent reasonably necessary to the proper processing of the particular request:

1. The need to search for and collect the requested records from field facilities or other establishments that are separate from the office processing the request.

2. The need to search for, collect, and appropriately examine a voluminous amount of separate and distinct records that are demanded in a single request.

3. The need for consultation, which shall be conducted with all practicable speed, with another agency having substantial interest in the determination of the request or among two or more components of the District having substantial subject matter interest therein.

4. The need to compile data, to write programming language or a computer program, or to construct a computer report to extract data.

B. Procedures for Approved Requests for Inspection and/or Copies.

Approved requests for inspection and/or copies will be handled as follows:

1. Mail Request – The District's General Council or the Office of the President/CEO will notify the requestor of the fees to be paid to the District for copies of such records. Upon receipt of such fees, the Records Clerk shall prepare and mail copies of such records to the person requesting them.

2. In-Person Request – Copies of requested documents will be provided after receipt of a completed request form (Exhibit "A") and payment of fees in accordance with the established fee schedule (Exhibit "B").

3. Telephone Request – In response to a telephone request for copies of District records, the District's General Council or Office of the President/CEO will explain the records request procedure (including established fees) as outlined in subsections (1) and (2) above. Payment of fees is required before copies may be prepared.

4. Fax Requests – In response to a fax request for copies of District records, the Distrct's General Council or Office of the President/CEO will transmit to the Requestor an explanation of the procedures (including established fees) as outlined in subsections (1) and (2) above, and transmit Exhibits "A" and "B" to the Requestor. Payment of fees is required before copies may be prepared.

5. E-Mail Requests – In response to an E-Mail request for copies of District records, the Office of the President/CEO will transmit to the Requestor and explanation of the procedures (including established fees) as outlined in subsections (1) and (2) above, and transmit Exhibits "A" and "B" to the Requestor. Payment of fees is required before copies may be prepared.

C. Any person in attendance at an inspection of District records may request a copy of any record being inspected. Upon completion of the written request and payment of the fee set forth herein, the District's General Council or Office of the President/CEO will prepare the copies of such records for the requestor.

D. Should a member of the public desire to obtain a duplicate the audio or video tape of the Board of Directors meetings, the member of the public must follow the procedures set forth above for obtaining copies of public records.

VI. FEES FOR COPIES

The District shall charge a reasonable fee (not to exceed the direct cost of reproduction) for copies or of identifiable public records or information produced there from as set forth in Exhibit "B," attached hereto, which provides a complete schedule of photocopying, information reproduction, and transmission. Fees for producing records in response to requests that require data compilation, extraction, or programing shall be invoiced and paid in advance.

VII. AGENDAS AND AGENDA PACKETS, CHARGES FOR MAILING PACKETS

A. Any person may request that a copy of the Agenda, or a copy of all the documents constitutes the agenda packet, of any meeting of the Board or one or more of its Committees be mailed to that person. In accordance with Government Code 54952.2, Agendas and Agenda packets are retrievable, down loadable, indexable, and electronically searchable to the public free of charge and without any restrictions that would impede the reuse or redistribution of the agenda. If requested, the Agenda and documents in the agenda packet shall be made available in appropriate alternative formats to persons with a disability, as required by Section 202 of the Americans with Disabilities Act of 1990 (42 U.S.C. § 12132.), and the federal rules and regulations adopted in implementation thereof. Upon receipt of the written request, the Office of the President/CEO shall cause the requested materials to be mailed at the time the agenda is posted pursuant to Government Code section 54954.2 and 54956 or upon distribution to all, or a majority of all, of the members of the Board, whichever occurs first. Any request for mailed copies of Agendas or Agenda packets shall be valid for the calendar year in which it is filed, and must be renewed following January 1 of each year.

B. There is no fee for a request for mailing the Agenda of meetings of the Board or its Committees without the packet. The Board hereby establishes a fee for mailing the Agenda packet of meetings of the Board and its Committees. The fee shall not exceed the cost of providing the service. The fee for receiving the agenda packets shall be the actual cost incurred by the District, based on the previous year costs, payable in advance. If the requesting person requests mailing of the Agenda or Agenda packet for a specified period less than a year, the annual fee shall be pro-rated based upon the number of months and any parts thereof which fall within the period for which the request is made, but shall still be paid in advance. The fee amount applies regardless of whether the request is for agenda packets of the Board or one or more of its Committees, and the requestor shall be entitled to receive all of the packets. Failure of the requesting person to receive the Agenda or Agenda packet pursuant to this Section shall not constitute grounds for invalidation of the actions of the legislative body taken at the meeting for which the Agenda or Agenda packet was not received.

VIII. WAIVER OF REQUIRED FEES

As a means of facilitating and expediting efficient business relationships, the fees for copies of Agenda packets and approved minutes of Board of Directors meetings and Board of Directors Committee meetings may be waived for other local and state agencies, regulatory agencies and news organizations, at the discretion of the President/CEO. In addition, should any member of the public desire a public document such as minutes to a single meeting of the Board or a standing Committee of the Board, or the budget, the Office of the President/CEO may waive the fees. Any request for a waiver of required fees must be made in writing to the Office of the President/CEO at the time copies are requested, and the President/CEO shall keep a record of all fee waivers under this section. Should any public record request involve significant reproduction costs, in the judgment of the Office of the President/CEO, such costs shall not be waived. Additionally, should a public agency not reciprocate with a similar waiver of fees for Agenda packets and approved minutes of the meetings of their governing body, the District will require that the fees set forth in Exhibit "B" attached hereto shall be paid by that agency prior to receiving copies of District documents. Fees for the entities listed on Exhibit "C" attached hereto will be automatically waived except those agencies that do not reciprocate with a similar waiver.

Reviewed by the Gov/Leg Committee: 6/8/05
Approved by the Board of Directors: 6/23/05
Reviewed by the Gov/Leg Committee: 8/10/05
Approved by the Board of Directors: 9/22/05
Reviewed by the Gov/Leg Committee: 11/8/06
Approved by the Board of Directors: 12/14/06
Reviewed by the Gov/Leg Committee: 10/10/07
Approved by the Board of Directors: 12/13/07
Reviewed by the Gov/Leg Committee: 12/01/10
Approved by the Board of Directors: 12/16/10
Reviewed by the Gov/Leg Committee: 9/14/11
Approved by the Board of Directors: 9/29/11
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14

Reviewed by Ad Hoc Bylaw & Policies Committee: 7/2019
Approved by Board of Directors:

EXHIBIT "A"

TRI-CITY HEALTHCARE DISTRICT

PUBLIC RECORD REQUEST FORM

Date:_____

In accordance with Government Code section 6253(b) of the California Public Records Act, I am requesting to inspect the following documents:

_____

_____

_____

_____

I understand that the District will respond to all Public Records Requests in compliance with State law.

I am also seeking _____ copies of the documents listed above.

If I seek copies of the non-exclusive, above-listed documents, I understand that in accordance with Board Policy #026, the following non-exclusive fee schedule will apply: $.25 per page for 8 ½" x 11" copies; $.25 per page for 8½ x 14" copies; $0.25 per page for color copies; $.05 for standard business size envelope; $.10 for 9 x 12 or 10 x 13 manila envelope; postage is based on actual cost to the District, or as otherwise provided by law. Payment is required in advance of delivery of any requested records. If more than fifty (50) pages are requested, the District may require a deposit before making actual copies.

Name/Signature of Requestor: _____

Address:

_____

_____

Phone/Fax/E-Mail: _____

Refund/Additional Payment: _____

EXHIBIT "B"
TRI-CITY HEALTHCARE DISTRICT
PUBLIC RECORDS REQUEST
SCHEDULE OF FEES

Description	**Price**
Copy Price per Page (including electronic records) - Standard Letter Size (8 1/2" x 11")	$0.25
Copy Price per Page (including electronic records) - Legal Size (8 1/2" X 14")	$0.25
Color Copies	$0.25
Price for Mailing Letter Size Envelope (includes envelope only) Postage is Additional and will be payable based on actual cost to the District	$0.05
Price for Mailing 9 x 12 or 12 x 13 size Envelope (includes envelope only) Postage is Additional and will be payable based on actual cost to the District	$0.10
Price for Public Records in electronic format, including ~~video and/or~~ audio tapes of Board of Directors meetings, when requested in electronic format, shall be calculated by the District's General Counsel or President/CEO in accordance with Government Code section 6253.9, as it may be amended from time to time.	Per Gov. Code § 6253.9
Note: Payment is required in advance of delivery of any requested records.	

EXHIBIT "C"
TRI-CITY HEALTHCARE DISTRICT
REQUESTS FOR INSPECTION OF PUBLIC RECORDS
WAIVER OF REQUIRED FEES

As a means of facilitating and expediting efficient business relationships with other local and state agencies and regulatory agencies, customary fees shall automatically be waived for the following agencies, except those agencies that do not reciprocate with a similar waiver:

City of Oceanside
City of Vista
City of Carlsbad
County of San Diego
State of California
Hospital Districts within the State of California
San Diego County LAFCO
American Hospital Association
California Hospital Association
Association of California Hospital Districts
Hospital Association of San Diego and Imperial Counties
BETA Healthcare
The Governance Institute
Special Districts Institute
California Special Districts Association

Using prudent business judgment, the President/CEO has the authority to waive fees for additional agencies, news organizations and/or individuals that are not listed above.

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #~~17~~19-~~-~~040

POLICY TITLE: Activities for Which Board Compensation Is Available

When compensation has been authorized by Board Resolution, pursuant to Health & Safety Code section 32103, such compensation may be paid in accordance with Article III, section 4 of the Bylaws of the District and this policy. Compensation is limited to one hundred dollars ($100) per meeting (except as noted below), not to exceed ~~five~~ six meetings per month. The following are compensable activities:

1. Attendance at a regular, special or emergency meeting of the Board of Directors shall be compensable, provided the meeting is at least 30 minutes in length, and the Director seeking compensation is present during the meeting for not less than 30 minutes.

2. Attendance at any meeting of a standing or ~~ad~~-Ad ~~h~~Hoc ~~e~~Committee of the Board of Directors shall be compensable, provided that the meeting is at least 30 minutes in length, the Director is a member of the committee and is present during the meeting for not less than 30 minutes.

3. Attendance at meetings of the Tri-City Hospital Auxiliary and Tri-City Hospital Foundation at the request of the Chair of the Board shall be compensation, provided that the meeting is at least 30 minutes in length, the Director is physically present during the meeting for not less than 30 minutes, and further provided that compensation is limited to fifty ($50) per meeting.

~~4.~~ Attendance at the above listed compensable activities ~~may~~ shall require Board members to be present at more than five meetings per month. The Board of Directors finds that it will serve the best interests of the District for Board members to attend these meetings and be eligible for compensation for up to six meetings per calendar month.

No compensation shall be available, however:

1. For attendance via teleconference from a location which is not a location open to the public per the Brown Act and within the jurisdiction.

2. For attendance at a committee meeting in which the Board member is not a member of the committee.

3. Unless the minutes of the meeting or other written evidence reflects a Director's attendance in compliance with this policy.

4. If compensation is limited under any other Board policy, including, but not limited to Board Policy #01019-020. and #010-038.

5. If the Director does not request compensation in writing within 180 days of attending the meeting for which compensation may be paid.

Reviewed by the Gov/Leg Committee: 8/10/05
Approved by the Board of Directors: 9/22/05
Approved by the Board of Directors: 3/25/10
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14
Reviewed by the Gov/Leg Committee: 6/07/16
Approved by the Board of Directors: 6/30/16
Reviewed by the Gov/Leg Committee: 1/3/17
Approved by the Board of Directors: 1/26/17
Reviewed by Ad Hoc Bylaw & Policy Committee: 7/2019
Approved by the Board of Directors:

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #~~14~~19-041

POLICY TITLE: Board Policy On Public Information

A. General Operations: The release of public information, except records requested under the Public Records Act, in situations relating to the general operations of the hospital are the responsibility of the Chief Executive Officer/President of TriCity Health Care District. Board members and staff shall forward all media and other public requests for information regarding operations of the District, except records requested under the Public Records Act, to the CEO or to the ~~Public Affairs and Marketing Department~~Chief Government & External Affairs Officer.~~.~~

Notwithstanding the foregoing, Board members may respond independently to any request for public information, providing they make clear that they are **speaking only as individuals and not on behalf of the Board of Directors or the organization.**

Whenever feasible, the CEO shall ensure that press releases to be issued to the public are disseminated to the members of the Board prior to their public release, together with the expected date and time of the release (including any embargo conditions).

Contact information for the ~~Vice President of Public Affairs and Marketing~~Chief Government & External Affairs Officer, other members of the Marketing Department, and members of the Executive Management team (including but not limited to the Chief Operating Officer, Chief Compliance Officer, Chief Nursing Officer and Chief Financial Officer), and a brief description of their areas of responsibility and availability for public comment, will be distributed at least annually to Board members.

B. Emergencies: The Board recognizes that emergencies may arise from time to time making advanced release of press releases to the Board impracticable. In such instances, every effort shall be made to release statements to the Board concurrently with their release to the public.

In addition, at least annually the CEO, Public Safety Officer, or other designee will provide the Board with a briefing on the Hospital Incident Control System, including the protocols for emergency communications regarding District operations.

C. Confidentiality and Privacy: Every attempt will be made to assist the public in obtaining requested information in a timely and efficient manner, however, under HIPAA, the District is required to protect patient privacy, and may be required to obtain patient or family member consent before allowing public access to patients or any portion of the District's licensed facilities, or to provide information regarding current or former patients. Areas within the hospital facility which are located outside of the Board or Board committee meeting rooms, while such rooms are in active use for publicly-noticed meetings, are not open to the public or considered to be public forums for any purpose.

Reviewed by the Gov/Leg Committee: 9/08/10
Approved by the Board of Directors: /30/10
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14
Reviewed by Ad Hoc Bylaw & Policy Committee: 7/2019
Approved by Board of Directors:

TRICITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY ~~18~~19-042

POLICY TITLE: Duties of the Board of Directors

The purpose of this policy is to define the primary responsibilities of the Board of Directors as the governing body ultimately responsible for leadership of the organization.

Brief Job Description

The Board establishes the mission, vision, and goals for the organization. The Board is ultimately accountable for the quality of care rendered to its patients by both its medical and professional staffs, for its financial soundness and success, and for strategically planning its future. The Board hires the Chief Executive Officer, and approves the plans and budgets by which the CEO will accomplish the quality, financial and strategic goals of the Board. However, the Board has delegated to the CEO responsibility to run the day-to-day operations of all of the District's business enterprises; hence, the Board does not direct operations. Rather, the Board is responsible for ensuring that strategies developed by management will accomplish key goals, achieve the mission and fulfill the vision, and holding the CEO accountable for implementation of those strategies.

Primary Duties and Responsibilities

Financial.

1. Set objectives. It is the role of the Board of Directors, in cooperation with the Chief Executive Office, to specify key financial objectives which are aligned with Board-determined goals, mission and vision for the organization.

2. Oversee attainment of objectives. Through annual approval of the budget, and the ongoing activities of the Financial Operations and Planning Committee, the Board ensures that necessary financial planning activities are undertaken so that the organization's resources are effectively allocated across competing uses. The Board monitors and assesses the financial performance of the organization on an ongoing basis through review of periodic financial statements and other reports prepared and presented by the Chief Financial Officer.

3. Ensure transparency and accountability. Through the selection of independent auditors and acceptance of the annual financial audit report, together with targeted supplemental auditing activities of billing and collection activities for compliance with legal requirements, the Board ensures that appropriate accounting controls are in place and updated, as needed.

Community needs assessment and outreach.

The Board helps keep the organization informed about and sensitive to, community needs and perceptions. Conversely, the Board plays a key role in keeping the community informed regarding the services, activities, and plans of the organization.

Promote quality medical care.

1. Under its Bylaws and those of the Medical Staff, the Board appoints, reappoints and determine privileges of physicians who practice in the institution.

2. The Board hears periodic reports on indicators of quality, utilization and outcomes, as well as quality improvement implementation plans, for each area or department of the organization. The Board holds management accountable to ensure that effective risk management systems are in place and functioning effectively. In this manner, the Board takes responsibility for ensuring the quality of nursing and medical care rendered in the hospital.

3. The Board provides opportunities for members of the medical staff to participate in governance through membership on Board-appointed committees. The Board provides the Chief of the Medical Staff an opportunity to participate in Board meetings, including providing an agenda item at each regular meeting for reports from the Medical Staff.

4. The Board identifies the nurse executive function at the senior leadership level to provide effective leadership and to coordinate leaders to deliver nursing care, treatment, and services.

Compliance oversight.

The Board ensures compliance with requirements of regulatory and accrediting bodies by: (a) promoting an ethical, self-governing culture throughout the organization through Board and employment policies; (b) overseeing the effectiveness of the compliance program; and (c) providing the resources required to implement effective system.

Responsibilities Defined Elsewhere:

Bylaws.

The Bylaws of the Tri-City Healthcare District Board of Directors set forth, in Article III, the legal powers and duties of the board of directors, as provided under the Healthcare District law. The Board's oversight of compliance activities is reflected in Article VI, §2 (establishing a Compliance and Audit Committee) and Article VII, §3, describing its reporting relationship with the Chief Compliance Officer. Article VIII describes the Board's relationship with the Medical Staff. Article IX, §5 requires the Board to maintain a policy regarding annual self-evaluations.

Board Policies.

Some of the responsibilities of the Board, including those specifically identified by the Joint Commission, are addressed by board policies. The Medical Staff provides input on equipment and services to be provided at the hospital under Policy ~~17~~19-001. Minimum liability insurance requirements required for medical staff membership are described in a policy jointly-adopted by the Medical Staff. (Policy No. ~~15~~19-038.) The Board oversees the prudent investment of excess funds under Policy No. ~~14~~19-017, which is reviewed annually. Self-evaluations are conducted by the Board annually under Policy ~~14~~19-012. Board member orientation and training are provided for in Policies ~~16~~19-020 and ~~17~~19-039. Board responsibilities for decision making on legal matters, including hiring Board Counsel. is described in Policy ~~17~~19-023. Other policies establish a Code of Conduct for the Board (Policy No. ~~17~~19-039) and committee members (Policy No. ~~15~~19-031), and conflict of interest rules (by resolution in accordance with the Political Reform Act). These are merely examples and are not intended to be a comprehensive list of policies describing Board responsibilities.

Reviewed by Gov/Leg Committee: 1/12/2011
Approved by the Board of Directors: 1/27/2011
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14
Reviewed by Gov/Leg Committee: 10/6/2015
Approved by the Board of Directors: 10/30/15
Reviewed by the Gov/Leg Committee: 11/7/17
Approved by the Board of Directors: 12/14/17
Approved by the Board of Directors: 3/29/18
Reviewed by Bylaw Policy & Adhoc Committee: 8/2019
Approved by Board of Directors:

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #~~17~~19-043

POLICY TITLE: External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms

I. PURPOSE

To set forth limitations, requirements and guidelines for public rental/usage of Tri City Medical Center and other District facilities, including assembly rooms, classrooms, and conference rooms by those external and affiliated organizations, groups and persons which support the public purposes of the District.

II. POLICY

A. **Permitted Uses.** Tri City Medical Center assembly rooms, classrooms, and conference rooms shall be available to those public agencies, nonprofit organizations, associations and other groups, which further the health care needs of the public within the boundaries of the Tri-City Healthcare District, and those directly related to programs and operations which are supported, sponsored by, or affiliated with the District, including meetings of the Medical Staff, and charitable organizations primarily engaged in providing financial or other support to the District.

Although it is a public agency, the use of hospital and other district facilities is dedicated to the provision of health care to the community. By enacting this policy, the District does not intend to create a public forum in its facilities, but only to promote community health and improve health care services delivery within the District.

B. **Compatible Uses.** Public use authorized by this policy shall be solely for meetings and activities which are compatible with the safe, quiet and secure conduct of hospital and health care facility operations, and with the District's status as a public agency of the State of California. For example, several laws prohibit the use of public resources, such as office equipment, staff time, etc., for campaign or personal purposes (e.g., Gov. Code sections 8314, 85300; Penal Code section 426.) Government Code section 54964 restricts an officer or employee of a local agency from expending or authorizing the expenditure of any local agency funds to support or oppose a ballot measure or a candidate. In addition, the following are prohibited:

1. Tobacco use
2. Alcoholic beverages
3. Political or religious activities

4. Amplified sound which can be heard outside of the room being used

5. Commercial uses

6. Personal use by district employees

7. Animals, other than those needed by disabled persons.

C. **Priority of District Use**. The medical, governance, operational, business and emergency needs of the District shall take precedence over other uses of District property in the scheduling and allocation of space under this policy. Scheduled public uses under this policy are subject to cancellation at the discretion of the District. The District will endeavor to provide as much notice as possible..

D. **Liability for Damages/Insurance Coverages**. Groups or persons using District facilities under this policy shall agree to be liable for any personal injury, property damage or liabilities arising out of the conduct of the activity or conduct of the participants. The District may charge the amount necessary to repair damages and/or clean the facility, and may deny the responsible group or person further use of District facilities. Groups engaged in activities posing significant risks to the District may be required to provide evidence of liability, property and professional liability insurance. ~~The Chief Nurse Executive may establish such requirements on a case- by-case basis.~~ Examples of activities which may require evidence of insurance include: professional liability insurance for groups offering free medical screening or other medical services; groups exceeding 100 persons. For activities involving more than 100 persons, the District may require evidence of liability and property insurance.

E. **Rules for Use**

1. No signage or placards will be allowed on District premises without the prior written approval of the District. The District provides standard signage to direct participants to the activity location.

2. Halls, entrances, elevators and stairways will not be obstructed or used for any purpose other than ingress/egress under any circumstances.

3. No furniture, freight or equipment shall be brought in without prior notice, and approval by District.

4. No self-provided food services will be permitted without prior notice and approval by District.

5. Unless otherwise specifically approved, hours of usage will be limited to the hours of 7 a.m. through to 8:30 p.m. Monday through Friday, excluding District holidays. Saturdays may be available at additional cost.

F. **Cause for Denial.** The ~~Chief Nurse Executive (CNE)~~ District Appointed Representative will review all requests by external and affiliated organizations for meeting room space under this policy. Request for space use may be denied for any of the following reasons:

1. The space requested is not available.

2. The applicant is not among those described in paragraph 1.

3. The applicant has not fully complied with this policy.

4. The use proposed will disrupt the provision of medical care or normal hospital or facility operations, or is otherwise incompatible or prohibited under this policy.

5. The applicant has not provided the evidence of insurance required.

6. The applicant has previously failed to comply with this policy.

III. PROCEDURE

A. Applications for usage of assembly rooms, classrooms, and conference rooms are processed via the applicable room scheduler/event coordinator. The room request form must be completed in full and submitted before applications will be reviewed for compliance with this policy.

B. Unusual room requests will be forwarded to the ~~CNE~~ District Appointed Representative appointed by the Chief Operating Officer (COO) for review and denial or approval.

C. The room applicable scheduler/event coordinator will communicate results of request with the applicant.

D. A deposit may be required for any food services or other special services, facilities, setup or equipment to be provided by the District.

E. The District shall be given 48 hours advance notice of cancellation by a successful applicant. A cancellation fee will be charged for any costs incurred by the District prior to the cancelation

F. If the District's needs require cancellation of the planned use by an applicant, advance notice shall be given promptly and the deposit refunded.

G. If an application is denied, an applicant may appeal to the Chief ~~Executive~~ Operations Officer (COO).

H. The Chief Financial Officer of the District shall establish a schedule of fees and charges, ~~from time to time~~ based on market value and, based upon the District's

reasonably estimated costs for providing services, including but not limited to: Custodial services; room setup; food services; equipment rental. Supplemental charges may also be incurred to cover any unusual staff time or legal expenses which may be incurred in reviewing, processing or accommodating a request. The ~~CNE~~ COO may request supplemental charges, in addition to the payment of scheduled fees and charges. A copy of the Fee schedule ~~and the Meeting Room Request Form~~ shall be provided and appended to this policy as Exhibit~~s~~ A ~~and B~~.

I. Other than the hourly room rental fee, groups not charging any fee for participation and those not requiring any special services shall not be charged a fee solely for room use.

J. Applicant shall be invoiced by the District on a monthly basis for room rental fees incurred.

IV. ATTACHMENT(S)

A. Exhibit A: Fee Schedule

~~B. Exhibit B: Meeting Room Request Form~~

Reviewed by the Gov/Leg Committee: 4/11
Approved by the Board of Directors: 4/11
Reviewed by the Gov/Leg Committee: 4/14
Approved by the Board of Directors: 4/14
Reviewed by the Gov/Leg Committee: 7/15
Approved by the Board of Directors: 7/15
Reviewed by the Gov/Leg Committee: 10/17
Reviewed by the Gov/Leg Committee: 11/17
Approved by the Board of Directors: 12/17
Reviewed by the Bylaw & Policies Ad Hoc Committee: 7/19
Approved by the Board of Directors:

EXHIBIT A

FEE SCHEDULE

Organizations/groups ~~will~~ may not be charged room rental fees if they are 1) a non profit with proper proof of such status; and 2) a health-related program intended to further the healthcare needs of the community; and 3) a service fee of $25 per use to cover basic setup, utilities, custodial services, etc., is paid in advance. Any organizations/groups that do not meet all three of these criteria will be charged the below room rental rates in addition to catering, equipment, and any other fees for additional requests.

ROOM TYPE	*HOURLY RATE*
Classroom	*$30*
French Room	*$30*
Assembly Room	*$50*

These fees are for room rental only and are based on total time utilization for the hours reserved. Should the event exceed the hours requested, the user will be billed for the additional time used in hourly increments. Should an event end earlier than reserved, user will not be entitled to a refund of fees paid. Separate charges will be incurred for custom set-up and break-down, catering, equipment, etc. TCHD retains the right to adjust the rental charges when assessing fees for unusual situations or requests.

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #~~16~~19-044

POLICY TITLE: Distribution of Tickets and Passes to District-Sponsored or Controlled Events and Donated Tickets and Passes

This Policy provides a framework for the District's distribution of tickets or passes to District officials and others to attend District-sponsored or controlled events, as well as distribution of tickets or passes which are donated to the District. This Policy is authorized by 2 Cal. Code Regs. § 18944.1. This Policy is intended to be consistent with the Fair Political Practices Commission's regulations regarding gifts and behested payments, but this Policy does not supplant or replace those regulations.

I. DEFINITIONS

A. "Official" includes members of the Board of Directors, officers, employees and consultants of the District, as defined under the Political Reform Act and its regulations. "Official" also includes any person required to file an annual Statement of Economic Interests (Form 700) under the District's conflict of interest code.

B. "Immediate family" means the spouse or registered domestic partner and dependent children, of an Official.

II. APPLICATION

A. This Policy applies to tickets or passes provided to an Official by the District when:

1. The ticket or pass is to a facility, event, show or performance for an entertainment, amusement, recreational, or other similar purpose, such as a ticket or pass to a tennis tournament, marathon or theater production. This Policy does not apply to a ticket or pass if the only benefit received at the event is food and beverages, such as a dinner or luncheon; and

2. If the ticket is donated to the District by an outside source,

   a. the ticket or pass is not earmarked by that source for use by a particular Official, and

   b. the District determines, in its sole discretion, which official may use the ticket or pass; or

3. If the ticket is not donated by an outside source, it is obtained by the District (i) pursuant to the terms of a contract for use of public property,

(ii) because the District controls the event, or (iii) by purchase of the District at fair market value; and

4. The District distributes the ticket or pass in accordance with this Policy, including the disclosure requirements.

B. Officials who receive a ticket may elect to treat the ticket as income consistent with applicable state and federal income tax laws. In such event, the District shall report the distribution of the ticket as income to the official on FPPC Form 802 and subject to the disclosure requirements set forth in Section IV of this Policy.

C. This Policy does not apply to tickets or passes provided directly to an Official from source other than the District, or tickets for which the Official elects to pay to the District the value of the tickets.

1. In the case of a ticket that provides one-time admission or access, when the Official elects to pay for the ticket, the "value" is the price that was or would have been offered to the general public for the ticket. This will usually be the face value of the ticket.

2. In the case of a ticket that provides repeated admission or access, such as a season ticket, the "value" to the Official is the fair market value of the actual use of the ticket, taking into account the use by any guests who may be admitted with the ticket, or if the ticket is transferred to another person, the fair market value of possible use by that person.

3. The "fair value" of a ticket or pass that does not have a face value indicated, is the price at which the ticket or pass would otherwise be offered for sale to the general public by the operator of the venue or host of the event who offers the ticket for public sale. Where the price indicated on the ticket does not reflect the actual cost for a ticket in a luxury box or suite, the face value is determined by dividing the total cost of the box or suite by the number of tickets available for that box or suite.

D. Benefits received by the Official at the event which are not included in admission, such as food, beverages or any other item presented to the Official at the event, must be reported as gifts by the Official if they exceed the reporting threshold.

III. DISTRIBUTION OF TICKETS

A. The District's Chief Executive Officer (or his or her designee provided such designation is documented in writing) shall act on behalf of the District under this Policy. The CEO shall manage the receipt, distribution and accounting for all tickets and passes subject to this Policy. The CEO shall determine the value of tickets.

B. The distribution of any ticket to, or at the behest of, an Official shall accomplish one or more of the following public purposes of the District:

1. Category 1 Public Purposes

   a. Performance of a ceremonial role or function representing the District at an event.

   b. The job duties of the Official require his or her attendance at the event.

   c. Promotion of District-controlled or sponsored events, activities or programs.

   d. Promotion of the District on a local, state or national scale.

   e. Encouraging or rewarding District employees.

2. Category 2 Public Purposes

   a. Promotion of healthcare related community programs and resources available to residents within the District's service area.

   b. Attracting or rewarding volunteers at the District's facilities.

C. The CEO or Designee shall give priority in the distribution of tickets or passes for the public purposes in Category 1 Public Purposes, as first priority and Category 2 Public Purposes, as second priority.

D. The CEO or Designee may establish procedures governing the timing and form of requests for tickets consistent with this Policy, provided all such requests shall be required to be in writing.

E. The CEO or Designee may, in his or her discretion, announce the availability of tickets or passes and invite written requests for such tickets or passes. The CEO or Designee may make such announcements to any individuals or group of individuals he or she deems appropriate given the public purpose(s) to be accomplished by such distribution.

F. The CEO or Designee shall evaluate any written requests and distribute tickets or passes in his or her discretion provided such evaluation and distribution is consistent with this Policy.

1. The CEO or Designee may distribute tickets or passes at the behest of a member of the District's Board of Directors if such behest is for one or more of the public purposes stated in this Policy. No other District official may behest tickets or passes.

2. The CEO or Designee may distribute tickets or passes for personal use by an Official's immediate family, or no more than one guest, if such distribution is for one or more of the public purposes stated in this Policy. Officials receiving such tickets shall return any unused tickets to the District, preferably in time for reallocation by the CEO.

3. The CEO or Designee may also distribute tickets or passes to individuals, entities or organizations who are not Officials if such distribution is consistent with one or more of the public purposes stated in this Policy.

4. The CEO or Designee shall not distribute any tickets or passes to a physician unless such distribution is approved by the Compliance Officer of the District.

G. In the event there are tickets or passes that have not been distributed in response to written requests, the CEO or Designee may donate such tickets to a nonprofit, tax-exempt or governmental organization provided such donation accomplishes one or more of the public purposes stated in this Policy.

H. An Official who receives a ticket or pass pursuant to this Policy shall not transfer or distribute such ticket or pass to any other person, except to members of the official's immediate family, or no more than one guest, solely for their personal use.

I. A Board member, department head, or CEO shall be prohibited from the disproportionate use of tickets or passes.

~~I~~J. In all circumstances, the CEO may decline to distribute tickets or passes if he or she determines such distribution would not be consistent with one of the public purposes stated herein.

IV. DISCLOSURE REQUIREMENTS

A. The CEO or his or her designee shall report the distribution of a ticket or pass on FPPC Form 802 within 45 days of distribution. The report shall include all of the information required by 2 Cal. Code Regs. § 18944.1(f) and shall identify at least one of the applicable public purposes described in Section III(B) of this Policy. The District shall maintain completed forms as public records and will post and maintain copies in a prominent fashion on the District's website. The District will e-mail the FPPC a link to the District's website where the forms are displayed.

B. The District shall maintain this Policy as a public record and will post and maintain a copy in a prominent fashion on the District's website within 30 days of adoption or amendment. The District will e-mail the FPPC a link to the District's website where this Policy is displayed. A written inspection report of findings and recommendations by the Official receiving a ticket or pass for the oversight or inspection of facilities shall also be maintained.

Reviewed by the Gov/Leg Committee: 07/13/11
Approved by the Board of Directors: 07/28/11
Reviewed by the Gov/Leg Committee: 04/01/14
Reviewed by the Gov/Leg Committee: 04/01/14
Approved by the Board of Directors: 04/24/14
Reviewed by the Gov/Leg Committee: 10/07/14
Approved by the Board of Directors: 11/06/14
Reviewed by the Gov/Leg Committee: 02/02/16
±Approved by the Board of Directors: 02/25/16
Reviewed by Ad Hoc Bylaw & Policy Committee: 07/2019
Approved by Board of Directors:

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY # ~~16~~19-046

POLICY TITLE: End of Life Option Policy

I. BACKGROUND

The End of Life Option Act (Cal. Health & Safety Code § 443 *et seq.*, referred to in this policy as the "Act"), as enacted by the California Legislature and effective June 9, 2016, allows certain terminally ill adult patients with the requisite mental capacity to make medical decisions requesting the prescription of an aid-in-dying drug to end their life if specified conditions are met.

The Act establishes specific procedures and requirements that must be followed by patients and health care providers who choose to assist them. It also provides that, upon proper notice, a health care provider may "opt out" or prohibit its employees, independent contractors, or other persons or entities from participating in activities authorized under the Act while on premises owned, managed, or directly controlled by the prohibiting health care provider or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider.

PURPOSE

This policy describes Tri-City Healthcare District's ("TCHD") position regarding the Act in TCHD's facilities, programs, and services, and to provide guidance in caring for patients who express interest in ending their life under the Act. TCHD has chosen to opt out and refrain from offering and participating in activities authorized under the Act.

At TCHD, the needs of the patient come first. TCHD provides end-of-life care that addresses the physical, emotional, social, and spiritual needs of the patient and his or her family. The end-of-life care TCHD provides is grounded in the values of respecting the sacredness of life, providing compassionate care to dying and vulnerable persons, and respecting the integrity of health care providers. TCHD believes that compassionate, end-of-life care should neither prolong nor hasten the natural dying process. TCHD will not abandon dying patients or their families and is committed to providing appropriate support for dying persons and their families throughout the final stages of life by supporting patient self-determination through the use of advance directives, offering hospice, palliative, and other supportive care, and providing effective pain and symptom management and other social, spiritual, and pastoral care support and services.

SCOPE

TCHD currently provides end-of-life and supportive care services to ease patient and family suffering. This policy is limited to the conduct permitted by the Act and does not apply to the many end-of-life care services TCHD provides. This policy applies to all TCHD employees, independent contractors, healthcare workers, ministries, providers,

employees, and volunteers, and other professional health care providers while carrying out work-related duties for TCHD while on premises owned, managed, or directly controlled by TCHD.

DEFINITIONS

Adult: an individual 18 years of age or older.

Aid-In-Dying Drug: a drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to a terminal disease.

Attending Physician: the physician who has primary responsibility for the health care of an individual and treatment of the individual's terminal disease.

Qualified Individual: an adult who has the capacity to make medical decisions, is a resident of California, and has satisfied the requirements of the Act in order to obtain a prescription for a drug to end his or her life.

TCHD Facilities: any and all premises owned, managed, or directly controlled by TCHD, including, but not limited to Tri-City Medical Center.

TCHD Healthcare Providers: any employee, independent contractor, healthcare worker, ministry, provider, volunteer, and other professional health care provider providing services, care, and/or treatment at TCHD Facilities.

POLICY

The Act allows an Adult terminally ill patient, with capacity to make health care decisions and seeking to end his/her life, to request an Aid-In-Dying-Drug from his/her Attending Physician.

TCHD prohibits its TCHD Healthcare Providers while at TCHD Facilities from all of the following:

- participating in activities authorized under the Act, including participating in or facilitating physician-assisted death; and
- providing, delivering, administering, or assisting with the administration of any medication intended for physician-assisted death, or be present when a patient ingests medications with the intent of completing physician-assisted death.

TCHD does not permit the ingestion or self-administration of an Aid-In-Dying Drug at its TCHD Facilities.

Patients, families, and TCHD Healthcare Providers are encouraged to explore fully and discuss care and treatment options for terminally ill patients. TCHD respects the rights of

patients and their care team to discuss and explore all treatment options; however TCHD Healthcare Providers do not participate in any way in assisted death. Any member of a patient care team may respond to questions from a patient and family regarding end of life services provided by TCHD.

No patient will be denied medical care or treatment because of the patient's participation under the Act.

The requirements outlined in this policy do not preclude or replace other existing policies at TCHD.

A patient who transfers care from TCHD to a provider participating in the Act in order to obtain an Aid-in-Dying-Drug must promptly be provided with a copy of his or her medical records to facilitate the transfer.

Consistent with this policy, TCHD will continue to provide care to patients who qualify for and request services, regardless of their stated interest in seeking physician-assisted death.

PROCEDURE

Upon admission to Tri-City, all patients will be provided with a copy of Tri-City's "End of Life Option Act" statement, which is attached to this policy as Exhibit 1.

When a patient expresses intent to pursue physician-assisted death as set forth under the Act, the patient will be informed that TCHD's Healthcare Providers do not provide, deliver, administer, or assist patients with obtaining an Aid-In-Dying-Drug. A copy of the statement attached to this Policy as Exhibit 1 will be provided following the patient's inquiry and/or request for the services encompassed by the Act.

TCHD Healthcare Providers will continue to provide all other requested end-of-life and supportive care, and other services to patients and families, regardless of their stated interest in seeking physician-assisted death.

TCHD prohibits patients from ingesting an Aid-In-Dying Drug at its TCHD Facilities. Any such request from a patient will be denied.

REFERENCES

California Department of Public Health:
https://www.cdph.ca.gov/Pages/EndofLifeOptionAct.aspx

California Hospital Association: http://www.calhospital.org/end-life-option-act

Medical Board of California: http://www.ombc.ca.gov/forms_pubs/

Patient Access to Health Records Act, Cal. Health & Safety Code § 123100 *et seq.*: http://www.leginfo.ca.gov/cgi-bin/displaycode?section=hsc&group=123001-124000&file=123100-123149.5

California Health & Safety Code §§ 442-442.7: https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=1.&title=&part=1.8.&chapter=&article=

Approved by the Board of Directors: 08/25/16
Reviewed by Ad Hoc Bylaw & Policies Committee: 07/2019
Approved by Board of Directors:

Exhibit 1

California End of Life Option Act

Tri-City prides itself on providing end-of-life care that addresses the physical, emotional, social, and spiritual needs of the patient and his or her family. The end-of-life care Tri-City provides is grounded in the values of respecting the sacredness of life, providing compassionate care to dying and vulnerable persons, and respecting the integrity of health care providers. Tri-City respects the relationship that exists between a patient and health care provider in making important health care decisions regarding the patient's end-of-life care. As a result, Tri-City has chosen to opt-out of the California End of Life Option Act (Cal. Health & Safety Code § 443 *et seq.*).

How will this affect Tri-City's patients?

Tri-City's decision to opt-out means that Tri-City and its providers, while working at Tri-City, will not deliver, administer, or assist patients with obtaining an aid-in-dying-drug. Patients will also be prohibited from taking an aid-in-dying drug while on Tri-City's premises.

How will this affect individuals who seek the services provided in the End of Life Act?

At Tri-City, all patients will be provided medical care and treatment regardless of the patient's decision to seek aid-in-dying-drug. Tri-City will continue to provide all other requested end-of-life and supportive care, and other services to patients and families, regardless of their stated interest in seeking physician-assisted death. A patient who transfers care from Tri-City to a provider participating in the End of Life Act in order to obtain an aid-in-dying-drug will be provided with a copy of his or her medical records to facilitate the transfer.

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

May 16, 2019 – 1:00 o'clock p.m.
Assembly Rooms 2&3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 1:00 p.m. on May 16, 2019.

The following Directors constituting a quorum of the Board of Directors were present:

Director Rocky J. Chavez
Director George W. Coulter
Director Leigh Anne Grass
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock
Director Tracy M. Younger

Also present were:

Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Barbara Vogelsang, Chief Nurse Executive
Ray Rivas, Chief Financial Officer
Aaron Byzak, Chief Government Affairs Officer
Carlos Cruz, Chief Compliance Officer
Jeremy Raimo, Senior Director, Business Development
Susan Bond, General Counsel
Dr. Victor Souza, Chief of Staff
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairperson, Director Grass, called the meeting to order at 1:00 p.m. in Assembly Room 3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Nygaard led the Pledge of Allegiance.

2. Public Comments – Announcement

   Chairperson Grass read the Public Comments section listed on the Board Agenda. There were no public comments.

3. Approval of agenda.

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

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

   Chairperson Grass made an oral announcement of the items listed on the May 16, 2019 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter involving Potential Litigation, Reports Involving Trade Secrets

with various disclosure dates and Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees.

6. Motion to go into Closed Session

It was moved by Director Reno and seconded by Director Schallock to go into Closed Session at 1:05 p.m. The motion passed unanimously.

10. Open Session

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

Chairperson Grass reported no action was taken in closed session.

12. 2019 AHA Leadership Summit – July 25-27, 2019

Discussion was held regarding the AHA Leadership Summit that is scheduled for July 25-27, 2019 in San Diego which conflicts with the July Regular Board meeting. It was suggested that the Board go "dark" in July to allow all Board members the opportunity to attend the conference. Chairperson Grass noted early registration ends May 20, 2019 and Board members will not be reimbursed for lodging costs due to the close proximity.

Action: The July 25, 2019 Regular Board of Directors Meeting is cancelled.

12. There being no further business, Chairperson Grass adjourned the meeting at 2:49 p.m.

_____
Leigh Anne Grass
Chairperson

ATTEST:

_____
Julie Nygaard
Secretary

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

May 30, 2019 – 2:00 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 2:00 p.m. on May 30, 2019.

The following Directors constituting a quorum of the Board of Directors were present:

Director Rocky J. Chavez
Director George W. Coulter
Director Leigh Anne Grass
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock
Director Tracy M. Younger

Also present were:

Steven Dietlin, Chief Executive Officer
Susan Bond, General Counsel
Ray Rivas, Chief Financial Officer
Dr. Victor Souza, Chief of Staff
Colin Coffey, Board Counsel (via teleconference)
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairperson, Leigh Anne Grass, called the meeting to order at 2:00 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

   Chairperson Grass requested that the Closed Session portion of the agenda be reordered.

   It was moved by Director Reno to approve the amended agenda. Director Nygaard seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

   Chairperson Grass read the Public Comments section listed on the May 30, 2019 Regular Board of Directors Meeting Agenda.

   There were no public comments.

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

Chairperson Grass made an oral announcement of the items listed on the May 30, 2019 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included three matters of Existing Litigation, one matter of Potential Litigation, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committee, one Report Involving Trade Secrets, Public Employee Evaluation: Board Counsel, Public Employee Evaluation: CEO and approval of Closed Session Minutes.

5. Motion to go into Closed Session

It was moved by Director Reno and seconded by Director Schallock to go into Closed Session. The motion passed unanimously (7-0).

6. The Board adjourned to Closed Session at 2:05 p.m.

8. At 3:30 p.m. in Assembly Rooms 1, 2 and 3, Chairperson Grass announced that the Board was back in Open Session.

The following Board members were present:

Director Rocky J. Chavez
Director George W. Coulter
Director Leigh Anne Grass
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock
Director Tracy M. Younger

Also present were:

Colin Coffey, Board Counsel (via teleconference)
Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Barbara Vogelsang, Chief Nurse Executive
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. Chairperson Grass reported no action was taken in Closed Session however the Board will be returning to closed session following today's open session to complete unfinished business.

10. Director Younger led the Pledge of Allegiance.

11. Chairperson Grass read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 24.

12. Special Recognitions

Nurses and Support Staff of the Year for 2019

a) Inpatient – Sara A. Mata, RN, ADN (PACU)

b) Outpatient – Julie O. Nacional, RN (Home Health)

c) Patient Care Support Staff – Jake Cuevas (Surgical Services/OR)

Ms. Barbara Vogelsang, CNE presented the Nurses and Support Staff of the Year for 2019 which included Inpatient – Sara A. Mata, RN, ADN, (PACU); Outpatient – Julie O. Nacional, RN (Home Health) and Patient Care Support Staff, Jake Cuevas (Surgical Services/OR). These individuals were also recognized during our Nurse's Week Celebration.

On behalf of the Board of Directors, Chairperson Grass congratulated the Nurses and Support Staff of the Year for 2019 recipients and expressed the Board's appreciation for their outstanding care.

13. Report from TCHD Auxiliary – Mary Gleisberg, President

Ms. Mary Gleisberg, Auxiliary President gave a brief report on Auxiliary volunteer hours to date which included a total of 544 active volunteers, 100 of which are college "student" volunteers. 15 of the volunteers have served more than 20 years or a minimum of 10,000 hours and one volunteer has served 34 years totaling 15,000 hours.

Ms. Gleisberg reported $73,000 was awarded in Scholarships this past week. She expressed her appreciation to Connie Jones for coordinating and overseeing the event.

Ms. Gleisberg reviewed upcoming activities which included the Annual Installation of Officers & Awards Ceremony scheduled for June 22nd in which new officers will be installed and volunteers who have reached 500 hours or more of volunteer service to Tri-City Medical Center will be recognized with a pin.

Director Schallock expressed his appreciation to Ms. Gleisberg for her leadership the past two years.

Chairperson Grass stated she has received a letter from one of the Scholarship recipients which she will share during her "comment period".

No action taken.

14. Report from Chief Financial Officer

Mr. Ray Rivas reported on the YTD Financials as follows (Dollars in Thousands):

- Net Operating Revenue – $297,033
- Operating Expense – $301,705
- EBITDA - $14,165
- EROE – $1,015

Other Key Indicators for the YTD driving those results included the following:

- Average Daily Census – 154
- Adjusted Patient Days – 83,292
- Surgery Cases – 5,368
- ED visits – 47,110

Mr. Rivas also reported on the current month financials as follows (Dollars in Thousands):

- Operating Revenue - $30,619
- Operating Expense - $30,221
- EBITDA - $2,219
- EROE – $885

Mr. Rivas reported on current month Key Indicators as follows:

- Average Daily Census – 142
- Adjusted Patient Days – 7,761
- Surgery Cases – 516
- ED Visits – 4,665

Mr. Rivas reported on the following indicators for FY19 Average:

- Net Patient Accounts Receivable - $44.5
- Days in Net Accounts Receivable - 53.1

No action was taken.

Mr. Rivas noted critically ill patients drove up the Length of Stay number.

15. New Business –

a) Consideration to approve an independent Physician Recruitment Agreement with Dr. Arash Calafi, Foot & Ankle Specialist in an amount not to exceed $835,000.

It was moved by Director Reno that the Tri-City Healthcare District Board of Directors find it in the best interest of the public health of the communities serviced by the District to approve an independent Physician Recruitment Agreement with Dr. Arash Calafi, Foot & Ankle Specialist for an amount not to exceed $835,000 and a 24-month income guarantee with a three-year forgiveness period in order to facilitate Dr. Calafi to practice medicine in the communities served by the District. Director Schallock seconded the motion.

Mr. Jeremy Raimo, Senior Director of Business Developed provided a brief summary of Dr. Calafi's background and experience. He also commented that Dr. Calafi will bring a technical sophistication (Foot & Ankle Specialist) that has not been in this community for quite some time. Dr. Calafi will be practicing with the Orthopedic Specialists of North County.

Director Reno requested clarification on what is included in the $835,000. Mr. Raimo explained Dr. Calafi's annual compensation comes in well below the

fair market value from the Medical Group Management Association benchmarking firm that the District uses and includes a 24-month income guarantee with a three-year forgiveness period. The amount also includes a small relocation expense.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

b) Consideration to certify SEIU-UHW as the exclusive bargaining representative for Occupational Therapists, Physical Therapists and Social Workers in the Home Health arena.

Ms. Anna Aguilar, Senior Director of Human Resources reported on April 30, 2019 a card count was conducted by a neutral third party for Occupational Therapists, Physical Therapists, and Social Workers in Home Health and confirmed that SEIU-UHW did meet the majority designation for 10 physical therapists, one occupational therapist and one social worker.

It was moved by Director Chavez that the TCHD Board of Directors certify the results of the card count, by neutral third party, to determine the majority of employees within the technical classification voted to be represented by SEIU-UHW to include the following classification of employees in Home Health: i. Occupational Therapists; ii Physical Therapists and iii. Social Workers and to accrete these into the existing SEIU-UHW contract. Director Schallock seconded the motion.

Chairperson Grass questioned if new employees coming in to that area will have the option of joining as well. Ms. Aguilar responded this classification of employees will be covered by the contract for any new employees in that area.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

c) Consideration to certify CNA as the exclusive bargaining representative for registered Nurses in the Outpatient Infusion Center

Ms. Aguilar reported on May 13, 2019 there was a card count by a neutral third party for Registered Nurses in the Outpatient Infusion Center and confirmed that CNA did meet the majority designation for three Registered Nurses.

Ms. Aguilar clarified those are the only nurses in that area.

It was moved by Director Reno that the TCHD Board of Directors certify the results of the card count, by neutral third party, to determine the majority of employees within the technical classification voted to be represented by CNA to include the following classification of employees in Outpatient Infusion Center (RNs) and to accrete these into the existing CNA contract. Director Chavez seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

16. Old Business - None

17 a) Chief of Staff

a. Consideration of May 2019 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on May, 2019.

It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors approve the 2019 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on April 23, 2019. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

b. Consideration of Family Medicine Privilege Card Revision

It was moved by Director Nygaard to approve the Family Medicine Privilege Card Revision as presented. Director Chavez seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

18. Consideration of Consent Calendar

It was moved by Director Nygaard to approve the Consent Agenda. Director Schallock seconded the motion.

It was moved by Director Reno to pull the following Board Policies: 19-009 – Requests for Information or Assistance by Board Members; 19-010 – Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson; 19-011- Placement of Items on Committee Agendas; 19-020 – Business Expense Reimbursement; Ethics Training; and 19-035 – Filling Board Vacancies. Director Coulter seconded the motion.

The vote on the main motion minus the items pulled was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

The vote on the main motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

19. Discussion of items pulled from Consent Calendar

Director Reno who pulled Policy 19-009, Requests for Information or Assistance by Board Members stated the language is harsh and she believes staff are there to help retrieve information when needed. Several Board members commented that the language is in place as a safety measure so there is no abuse of the policy from current or future Board members. Director Reno also commented that the policy is a Board policy and should not give reference to the Chairperson's authority as described in number 6.

Chairperson Grass stated the Ad Hoc Committee made no changes to the existing policy other than the policy number to reflect the current year. Director Chavez stated he supports Director Reno's suggestions to work with staff on modifying the language in the policy.

General Counsel Susan Bond suggested the policy be pulled for further review to evaluate the scope of Directors and what is permitted from a legal standpoint.

It was moved by Director Nygaard to pull the policy for further review by General Counsel and the Ad Hoc Committee. Director Coulter seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno and Younger**
NOES:	**Directors:**	**Schallock**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Director Reno who pulled Policy 19-010 – Board Meeting Agenda Development, Efficiency of Time Limits for Board Meetings, Role and Powers of Chairperson agenda development questioned if there is a committee that submits agenda items. Director Schallock explained the process by which items can be added to the Board agenda through the various Board committees or Board member request. Director Reno also questioned number B. which speaks to a member of the public submitting a written request for an agenda item. Director Reno also commented that the agenda conference date and time has not been consistent. Chairperson Grass responded that the agenda conference is always held the week prior to the Board meeting at a date and time that is convenient for those who need to attend.

Director Chavez suggested the language of the policy remain the same but include a decision chart so that the public is aware of the process. Ms. Donnellan explained that these are policies of the Board and typically these policies are not viewed by members of the public unless specifically inquired about.

It was moved by Director Chavez to add a Decision Chart to the policy. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Reno**
NOES:	**Directors:**	**Grass, Nygaard, Schallock**
ABSTAIN:	**Directors:**	**Younger**
ABSENT:	**Directors:**	**None**

The motion failed.

Director Reno who pulled Policy 19-011 – Placement of Items on Committee Agendas questioned if the language "by action of the committee" refers to all committee members or the Committee Chair. Director Chavez explained there are eight different methods of placement of items on committee agendas as described in the policy. Director Schallock clarified the policy refers to Board Committee Agendas rather than Board Agendas.

It was moved by Director Schallock to approve Policy 19-011 – Placement of Items on Committee Agendas as presented. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Director Reno who pulled Policy 19-020 – Business Expense Reimbursement; Ethics Training stated she had concerns regarding the Board Chair's authority to approve or deny conference requests. Chairperson Grass clarified that language was inserted to give Board member's an opportunity to attend events that might occur prior to the next Board meeting.

It was moved by Director Reno to amend language to include "or brought back to the whole Board for approval at the next Board meeting."

The motion died for lack of a second.

With respect to the same policy, Director Reno had concerns with the statement that "lodging shall not be reimbursed or provided at TCHD expense if the meeting site is within 30 miles of the Director's legal residence…". Director Reno was concerned with the cost of gas to travel to and from meeting sites on consecutive days and suggested the mileage requirement be reduced to 20 miles. Director Chavez stated the State of California requires a 50 mile radius and 30 is quite lenient. He commented that he would not be comfortable as a public official staying in a hotel that was within 20 or even 30 miles of his residence. Chairperson Grass stated in her opinion we are not within state standards for the mileage radius and she would be in favor of increasing to a 50 mile radius. Chairperson Grass also explained Board members are reimbursed mileage rates in accordance with IRS regulations as well.

It was moved by Director Schallock to approve Policy 19-020 Business Expense Reimbursement; Ethics Training as written. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**Reno**
ABSENT:	**Directors:**	**None**

Director Reno who pulled Policy 19-035 – Filling Board Vacancies questioned how the Questionnaire came about. Director Schallock commented that the Questionnaire was developed in approximately 2006 when a Board member resigned and the Board needed to fill the vacancy. Director Chavez stated the Questionnaire is simply an example and he is very supportive of the policy as presented.

It was moved by Director Schallock to approve Policy 19-035 Filling Board Vacancies as written. Director Chavez seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**Reno**
ABSENT:	**Directors:**	**None**

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 congratulated the well-deserving Nurse of the Year recipients and the Patient Care Support Staff who are the backbone of the hospital. He commented on the various events which were held throughout Nurse's Week to honor our nurses.

Mr. Dietlin expressed his appreciation to Mary Gleisberg for leading the Auxilians over the last couple of years. He also welcomed incoming President Mr. Jeff Marks..

Mr. Dietlin reported today is Mr. Carlos Cruz, Chief Compliance Officer's last meeting as he will be relocating to the east coast. Mr. Dietlin expressed his appreciation for Mr. Cruz's exemplary service.

Mr. Cruz expressed his appreciation for the opportunity afforded to him by Tri-City Medical Center. He stated he has enjoyed his time here at Tri-City and believes the organization is headed in the right direction. Mr. Cruz also expressed his appreciation to the Compliance Team, Kristy Larkin and Maria Carapia.

In closing Mr. Dietlin read an excerpt from a grateful patient.

23. Board Communications

Director Schallock congratulated the Nurses and Support Staff of the Year Sarah Mata, RN, Inpatient, Julie Nacional, RN, Outpatient and Jack Cuevas who were recognized today for their outstanding service.

Director Schallock reported at last week's *"Prescription Take-Back Day"*, 400 pounds were collected at Tri-City Medical Center, the second largest in the county. The next *"Prescription Take Back Day"* is scheduled for October 26, 2019.

Director Schallock wished Carlos Cruz, CCO good luck in his future endeavors.

Director Nygaard also wished Carlos Cruz, CCO good luck.

Director Reno congratulated the Nurses and Support Staff of the Year Sarah Mata, RN, Inpatient, Julie Nacional, RN, Outpatient and Jack Cuevas who were recognized today for their outstanding service.

Director Reno recognized Ms. Mary Gleisberg and Ms. Connie Jones for the superb work they have done this past year on the Scholarship Program.

Director Reno expressed her appreciation to Chief Compliance Officer Carlos Cruz.

Director Reno stated she is concerned about serialization and believes Board Member agenda briefings could be construed as serializing. Board Counsel, Colin Coffey referred Director Reno to the AB 1234 Training held on January 14, 2019 in which serial meetings and the Brown Act were discussed and the definition of meeting serialization was described in detail.

Director Chavez expressed his appreciation to Chief Compliance Officer, Carlos Cruz.

Director Chavez congratulated the Nurses and Support Staff of the Year for 2019 winners, Sarah Mata, RN, Inpatient, Julie Nacional, RN, Outpatient and Jack Cuevas, Patient Care Support staff.

Director Coulter stated April was a month of celebrations and he hopes we learn to celebrate each other every single day.

Director Younger congratulated the Nurses and Support Staff of the Year for 2019 winners, Sarah Mata, RN, Inpatient, Julie Nacional, RN, Outpatient and Jack Cuevas, Patient Care Support staff.

Director Younger reported that in the interest of transparency she has requested individual meetings with C-Suite members to discuss their roles and strategic goals.

Director Younger extended her best wishes to Carlos Cruz, CCO.

24. Report from Chairperson

Chairperson Grass once again congratulated the Nurses and Support Staff of the Year for 2019 winners, Sarah Mata, RN, Inpatient, Julie Nacional, RN, Outpatient and Jack Cuevas, Patient Care Support staff.

Chairperson Grass announced the time of the June Regular Board meeting has been changed to 12:00 p.m. to allow Board members the opportunity to attend the *North County Coastal All Elected Officials Reception*. The hospital's website will be amended to reflect the change in time.

Chairperson Grass reported the July Board meeting has been cancelled to allow Board members the opportunity to attend the AHA Leadership Summit in San Diego. In the event sensitive issues arise, the Board will schedule a Special Meeting to address those issues.

Chairperson Grass reported mandatory sexual harassment training will be set up in the near future to comply with AB 1825 and Board Policy 19-020.

Chairperson Grass read a grateful letter from one of the Board's Auxiliary Scholarship recipients.

It was moved by Director Schallock and seconded by Director Nygaard to return to closed session to complete unfinished business. The motion passed unanimously (7-0).

The Board adjourned to Closed Session at 5:17 p.m.

25. At 5:58 p.m. the Board returned to open session with attendance as previously listed.

26. Chairperson Grass reported no action was taken in closed session.

27. There being no further business Chairperson Grass adjourned the meeting at 6:00 p.m.

Leigh Anne Grass
Chairperson

ATTEST:

Julie Nygaard, Secretary

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

June 13, 2019 – 4:00 o'clock p.m.
Assembly Room 1 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 4:00 p.m. on June 13, 2019.

The following Directors constituting a quorum of the Board of Directors were present:

Director Rocky Chavez
Director George Coulter
Director Leigh Anne Grass
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock
Director Tracy Younger

Also present were:

Steve Dietlin, Chief Executive Officer
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairperson, Director Grass, called the meeting to order at 4:00 p.m. in Assembly Room 1 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Nygaard led the Pledge of Allegiance.

2. Approval of agenda.

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

3. Public Comments – Announcement

   Chairman Grass read the Public Comments section listed on the Board Agenda. There were no public comments.

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

   Chairperson Grass made an oral announcement of item listed on the June 13, 2019 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Appointment of Public Employee: Board Counsel.

5. Motion to go into Closed Session

   It was moved by Director Reno and seconded by Director Schallock to go into Closed Session. The motion passed unanimously (7-0).

   Chairperson Grass adjourned the meeting to Closed Session at 4:05 p.m.

6. The Board returned to Open Session at 5:15 p.m. with all Board members present.

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

   Chairperson Grass reported the Board in Closed Session discussed the Appointment of Public Employee: Board Counsel and voted unanimously to hire Mr. Jeffrey G. Scott of the Law Offices of Jeffrey G. Scott as the Board's counsel.

8. It was moved by Director Schallock and seconded by Director Nygaard to adjourn the meeting. The motion passed unanimously (7-0).

9. There being no further business, Chairperson Grass adjourned the meeting at 5:15 p.m.

_____
Leigh Anne Grass
Chairperson

ATTEST:

_____
Julie Nygaard
Secretary

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

June 13, 2019 – 6:00 o'clock p.m.
Assembly Room 1 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 6:00 p.m. on June 13, 2019.

The following Directors constituting a quorum of the Board of Directors were present:

Director Rocky Chavez
Director George Coulter
Director Leigh Anne Grass
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock
Director Tracy Younger

Also present were:

Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Ray Rivas, Chief Financial Officer
Barbara Vogelsang, Chief Nurse Executive
Aaron Byzak, Chief of Governmental & External Affairs Officer
Carlos Cruz, Chief Compliance Officer
Susan Bond, General Counsel
Victor Souza, M.D., Chief of Staff
Mark Yamanaka, M.D., Chief of Staff Elect
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairperson, Director Grass, called the meeting to order at 6:00 p.m. in Assembly Room 1 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. *(The Pledge of Allegiance was recited at today's 4:00 p.m. Special Meeting.)*

2. Approval of agenda.

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

3. Public Comments – Announcement

   Chairperson Grass read the Public Comments section listed on the Board Agenda. There were no public comments.

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

   Chairperson Grass made an oral announcement of items listed on the June 13, 2019 Special Board of Directors Meeting Agenda to be discussed during Closed Session

which included Reports Involving Trade Secrets with disclosure dates to be determined and one matter of Potential Litigation.

5. Motion to go into Closed Session

It was moved by Director Schallock and seconded by Director Nygaard to go into Closed Session. The motion passed unanimously (7-0).

Chairperson Grass adjourned the meeting to Closed Session at 6:05 p.m.

6. The Board returned to Open Session at 7:15 p.m. with all Board members present.

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

Chairperson Grass reported the Board in Closed Session discussed Reports Involving Trade Secrets and no action had been taken in closed session.

8. Open Session

a) Review, discussion and action on the Operating and Capital Budgets for Fiscal Year 2020.

Mr. Ray, Rivas, Chief Financial Officer presented the Operating and Capital Budgets for Fiscal Year 2020 for the Board's review and consideration of approval. He provided a high level summary of the Operating Budget, as well as explanations of several material assumptions incorporated into the budget during presentation. The Fiscal 2020 Budget forecasts Excess Revenue over Expenses (EROE) of $5.2 million, an improvement of $3.2 million over the projected Fiscal 2019 results and is expected to be realized through a combination of revenue increases from payor contract negotiations, service line strategic initiatives and continued expense management and workforce control. The Fiscal 2020 operating results are budgeted to be a $1.8 million improvement over the expected Fiscal 2019 operating results.

Mr. Rivas reviewed the Key Indicators which included a presentation of key inpatient and ancillary patient volume forecasts and other key metrics used to develop the Fiscal Year 2020 Budget.

Mr. Rivas reviewed the Financial Statements which included Tri-City Healthcare District Budgeted Statement of Revenue and Expenses, Balance Sheet, and Statement of Cash Flows.

The final part of the presentation focused on the Capital Budget Plan followed by schedules of budgeted expenditures and prioritized requested capital items. Capital acquisition and renovation investment is projected to be approximately $18.8 million which will be funded partially from cash, partially from new financing and partially from Tri-City Hospital Foundation donations.

It was moved by Director Chavez that the Tri-City Healthcare District Board of Directors approve the Operating and Capital Budgets for Fiscal Year 2020 as presented. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

9. Adjournment

It was moved by Director Schallock and seconded by Director Chavez to adjourn the meeting at 7:48 p.m. The motion passed unanimously (7-0).

_____
Leigh Anne Grass
Chairperson

ATTEST:

_____
Julie Nygaard
Secretary

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

June 24, 2019 – 7:30 o'clock p.m.
Assembly Room 3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 7:30 p.m. on June 24, 2019.

The following Directors constituting a quorum of the Board of Directors were present:

Director Rocky J. Chavez
Director George W. Coulter
Director Leigh Anne Grass
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Absent was Director Tracy M. Younger

Also present were:

Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Ray Rivas, Chief Financial Officer
Aaron Byzak, Chief Government Affairs Officer
Susan Bond, General Counsel
Jeffrey Scott, Board Counsel
Dr. Gene Ma, Chief Medical Officer
Dr. Victor Souza, Chief of Staff
Dr. Mark Yamanaka, Chief of Staff Elect
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairperson, Director Grass, called the meeting to order at 7:30 p.m. in Assembly Room 3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Reno led the Pledge of Allegiance.

2. Public Comments – Announcement

   Chairperson Grass read the Public Comments section listed on the Board Agenda. There were no public comments.

3. Approval of agenda.

   It was moved by Director Schallock to approve the agenda as presented. Director Reno seconded the motion. The motion passed (6-0-0-1) with Director Younger absent.

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

Chairperson Grass made an oral announcement of the item listed on the June 24, 2019 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one Report Involving Trade Secrets with a disclosure date of July, 2019.

6. Motion to go into Closed Session

It was moved by Director Nygaard and seconded by Director Reno to go into Closed Session at 7:35 p.m. The motion passed (6-0-0-1) with Director Younger absent.

10. Open Session

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

Chairperson Grass reported that the Board in Closed Session discussed new programs and services and took no action.

12. There being no further business, Chairperson Grass adjourned the meeting at 8:30 p.m.

_____
Leigh Anne Grass
Chairperson

ATTEST:

_____
Julie Nygaard
Secretary

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

June 27, 2019 – 12:00 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 12:00 p.m. on June 27, 2019.

The following Directors constituting a quorum of the Board of Directors were present:

Director Rocky J. Chavez
Director George W. Coulter
Director Leigh Anne Grass
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock
Director Tracy M. Younger

Also present were:

Steven Dietlin, Chief Executive Officer
Barbara Vogelsang, Chief Nurse Executive
Dr. Gene Ma, Chief Medical Officer
Dr. Victor Souza, Chief of Staff
Susan Bond, General Counsel
Jeffrey Scott, Board Counsel
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairperson, Leigh Anne Grass, called the meeting to order at 12:00 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

   Chairperson Grass requested agenda item 21 (2) B. 18) be struck due to duplication of item 21 (2) B. 18) 9).

   It was moved by Director Schallock to approve the agenda as amended. Director Nygaard seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

   Chairperson Grass read the Public Comments section listed on the June 27, 2019 Regular Board of Directors Meeting Agenda.

   There were no public comments.

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

Chairperson Grass made an oral announcement of the items listed on the June 27, 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 one Report Involving Trade Secrets. Approval of Closed Session Minutes was deferred to the next Regular meeting.

5. Motion to go into Closed Session

It was moved by Director Chavez and seconded by Director Reno to go into Closed Session. The motion passed unanimously (7-0).

6. The Board adjourned to Closed Session at 12:05 p.m.

8. At 1:00 p.m. in Assembly Rooms 1, 2 and 3, Chairperson Grass announced that the Board was back in Open Session.

The following Board members were present:

Director Rocky J. Chavez
Director George W. Coulter
Director Leigh Anne Grass
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock
Director Tracy M. Younger

Also present were:

Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Barbara Vogelsang, Chief Nurse Executive
Ray Rivas, Chief Financial Officer
Aaron Byzak, Chief External Affairs Officer
Dr. Gene Ma, Chief Medical Officer
Dr. Victor Souza, Chief of Staff
Jeffrey Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Chairperson Grass reported the Board in Closed Session discussed one matter of Potential Litigation, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committee and one Report Involving Trade Secrets and took no action.

Chairperson Grass noted one modification to the agenda – item 21 (2) B. 18) was struck due to duplication of item 21 (2) B. 18) 9).

10. Director Chavez led the Pledge of Allegiance.

11. Chairperson Grass read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 24.

12. Special Recognition – Victor Souza, M.D.

Dr. Victor Souza, Chief of Staff stated it has been an honor and privilege to serve the Medical Staff as Chief of Staff the past two years. He acknowledged the support, leadership and collaboration of the Board. Dr. Souza also acknowledged the Administration and in particular CEO Steve Dietlin for his spirit and leadership.

Dr. Souza also acknowledged the Auxiliary and the Foundation for their support.

Dr. Souza commented on his predecessor Dr. Gene Ma, Past Chief of Staff who established a great rapport with Administration and the Board and although Dr. Mark Yamanaka, Chief of Staff Elect could not be here today he is stepping into his new role with great enthusiasm.

Chairperson Grass stated she personally appreciates the "attitude and gratitude" theme that Dr. Souza has brought during his tenure as Chief of Staff. She stated Dr. Souza is a true leader, dedicated, loyal and trustworthy and diplomatic in all his approaches. Chairperson Grass also commented on the Nurse's Appreciation Tea which was established by Dr. Souza and his wife and has been a huge hit.

13. Introductions –

a) Mark Yamanaka, M.D. Chief of Staff Elect – deferred due to absence.

b) Gene Ma, M.D. Chief Medical Officer

Chairperson Grass reported Dr. Gene Ma was previously our Chief of Staff and has recently moved into the role of Chief Medical Officer. On behalf of the Board, Chairperson Grass welcomed Dr. Ma to the C-Suite.

Dr. Ma stated he is extremely grateful for the opportunity to be part of this Administrative team and looks forward to working collaboratively with the Medical Staff and Administration to make this organization shine.

Dr. Ma commented on Dr. Souza's tenure as Chief of Staff and the energy and enthusiasm he brought to the organization.

Director Reno congratulated Dr. Ma on his new role as Chief Medical Officer and expressed her appreciation to Dr. Souza for his service as Chief of Staff.

c) Jeffrey Scott, Esq., Board Counsel

Chairperson Grass Introduced and welcomed newly appointed Board Attorney Mr. Jeffrey Scott.

Mr. Scott stated he considers it a real honor to be able to represent the Board and serve the district and he looks forward to working with the Board and management.

No action taken.

14. Report from TCHD Foundation – Jennifer Paroly, President

Ms. Jennifer Paroly, Foundation President gave a brief report on upcoming Foundation activities including the following:

- The Golf Tournament has been scheduled for September 16, 2019 at The Farms Golf Club in Rancho Santa Fe.
- The Diamond Ball will be held on November 16, 2019 at the Park Hyatt Aviara. Additional sponsorship opportunities have been added due to the immense interest particularly in the $10,000 range. Approximately 18 tables have been sold prior to the "save the date" mailer.
- Dr. Karim El-Sherief participated in a recent social media promotion to talk about our award-winning Heart and Stroke Care Team.
- Dr. Gene Ma and stroke survivor Larry Hull recently shared stroke prevention tips and warning signs at Oceana, an active senior community in Oceanside.
- Social Media Promotions also include Cancer Care Navigator, Renee Ebejer-Swineheart who guides patients from the time of their screening to their abnormality and diagnosis and helps them navigate the process.
- The Foundation is working to partner with the hospital on a state of the art imaging equipment that will be a "game changer" for the hospital.
- The Corporate Council will be launched in July and is a great opportunity to network with community leaders and business owners.
- The Guardian Angel program will be launched in August.

At the request of Director Reno, Ms. Paroly provided additional information on the Guardian Angel program in which a physician, nurse or staff member may be recognized with a Guardian Angel Pin when a patient or family member makes a monetary donation in any amount to the Foundation in recognition for the care or service they received. Additional information regarding the launch will be forthcoming.

No action taken.

15. Appreciation of Mary Gleisberg, Auxiliary President

Chairperson Grass reported today is Mary Gleisberg's last meeting as President of the Auxiliary. She commented on the fact that Mary previously dedicated her life to the community through our school system and has blessed us with her presence as an Auxilian for many years, recently receiving her pin for 2,000 hours of service! On behalf of the Board, Chairperson Grass expressed her appreciation to Ms. Gleisberg for her leadership and the countless hours she gives to the hospital.

Ms. Glesiberg stated it was a pleasure to represent the Auxiliary as President for the past two years and she very much appreciated the support of the Board and Administration.

Ms. Gleisberg invited Mr. Steve Dietlin, CEO to come forward to accept a check from the Auxiliary. Ms. Gleisberg stated each year the Auxiliary makes a donation through the Gift Shop proceeds and this year she is pleased to present a check on behalf of the Auxiliary for $70,000. The Auxiliary works with the Chief Nurse Executive to determine the needs of the hospital and this year the monies will be used towards purchasing equipment for the Emergency Room and Operating Room.

Lastly, Ms. Gleisberg played a brief clip from Channel 10 News which aired recently and showcased Tri-City's Pet Therapy Department bringing comfort to patients after surviving their own trauma.

16. TCHD Auxiliary – Mary Gleisberg, Auxiliary President

1) Introduction of Jeff Marks, President Elect

Ms. Gleisberg introduced Mr. Jeff Marks, who will assume the role of Auxiliary President on July 1st. Ms. Gleisberg commented on Mr. Mark's wealth of knowledge and experience in both the private and public sector as an accomplished photographer and former Director of Marketing in the hotel business for many years. She stated Mr. Marks has been with the Auxiliary the past seven years and has served as second Vice President and First Vice president and did an outstanding job. Board members welcomed Mr. Marks.

17. Report from Chief Financial Officer

Mr. Ray Rivas reported on the YTD Financials as follows (Dollars in Thousands):

- Net Operating Revenue – $328,463
- Operating Expense – $332,902
- EBITDA - $16,386
- EROE – $1,919

Other Key Indicators for the YTD driving those results included the following:

- Average Daily Census – 153
- Adjusted Patient Days – 91,296
- Surgery Cases – 5,925
- ED visits – 51,810

Mr. Rivas also reported on the current month financials as follows (Dollars in Thousands):

- Operating Revenue - $31,430
- Operating Expense - $31,197
- EBITDA - $2,221
- EROE – $904

Mr. Rivas reported on current month Key Indicators as follows:

- Average Daily Census – 143
- Adjusted Patient Days – 8,004
- Surgery Cases – 557
- ED Visits – 4,700

Mr. Rivas reported on the following indicators for FY19 Average:

- Net Patient Accounts Receivable - $44.2
- Days in Net Accounts Receivable - 52.7

No action taken.

18. New Business

Consideration to approve Resolution No. 796, A Resolution of the Tri-City Healthcare District Establishing the Appropriations Limit for Tri-City Healthcare District for the Fiscal Year Commencing July 1, 2019 and Ending June 30, 2020.

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors approve Resolution No. 796, A Resolution of the Tri-City Healthcare District Establishing the Appropriations Limit for Tri-City Healthcare District for the Fiscal Year Commencing July 1, 2019 and Ending June 30, 2020. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

19. Old Business

a) Approval of Board Policy 19-009 – Requests for Information or Assistance by Board Members

It was moved by Director Reno that the Tri-City Healthcare District Board of Directors approve Board Policy 19-009 – Requests for Information or Assistance by Board Members. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

20. Chief of Staff

a. Consideration of June 2019 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on June 24, 2019.

It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors approve the 2019 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on June 24, 2019. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

21. Consideration of Consent Calendar

It was moved by Director Schallock to approve the Consent Agenda. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

22. Discussion of items pulled from Consent Calendar

There were no items pulled from the Consent Calendar.

23. Reports (Discussion by exception only)

24. Comments by Members of the Public

There were no comments by members of the public.

25. Comments by Chief Executive Officer

Mr. Steve Dietlin expressed his appreciation to Dr. Victor Souza, Chief of Staff for his leadership.

Mr. Dietlin welcomed Dr. Mark Yamanaka, Chief of Staff Elect who is well known for his expertise and is well respected by the Medical Staff.

Mr. Dietlin congratulated Dr. Gene Ma in his new role as Chief Medical Officer. Mr. Dietlin noted the Medical Staff also participated in the selection process for the Chief Medical Officer and are very supportive of Dr. Ma.

Mr. Dietlin expressed his appreciation to Ms. Mary Gleisberg for her leadership and welcomed Mr. Jeff Marks for his willingness to step into the role of Auxiliary President and move the Auxilians forward.

Mr. Dietlin also welcomed Board appointed attorney Jeff Scott.

Lastly, Mr. Dietlin commented on the Stroke Team that was recognized recently at the Oceanside Hero's event. He stated that Tri-City's outcomes are second to none!

26. Board Communications

Director Schallock reiterated comments made earlier today regarding Ms. Mary Gleisberg, Dr. Victor Souza and Dr. Gene Ma and expressed his gratitude.

Director Schallock stated it was gratifying to see our Stroke Team recognized at the Oceanside Hero's event and noted Ms. Merebeth Richins, Director of ICU and Pulmonary was also recognized at that event for our Life Sharing program.

Director Nygaard expressed her appreciation to Dr. Souza for his enthusiasm and Ms. Gleisberg for her leadership. She also congratulated Dr. Gene Ma, Chief Medical Officer and welcomed Board appointed attorney Mr. Jeff Scott.

Director Reno stated it has been a pleasure working with Dr. Souza, Chief of Staff and welcomed Dr. Yamanaka. She also welcomed Dr. Gene Ma to his position and stated he is a role model for this hospital. Lastly, Director Reno welcomed Mr. Jeff Scott and stated she looks forward to working with him.

Director Chavez had no comments.

Director Coulter expressed his appreciation to Dr. Souza and stated it has been a pleasure working with him. He also congratulated Dr. Ma in his role as Chief Medical Officer and welcomed Board Attorney Jeff Scott.

Director Younger welcomed Board Attorney Jeff Scott and expressed her delight in the fact that Mr. Scott will be attending meetings in person rather than via video conference.

Director Younger congratulated Dr. Ma on his new role as Chief Medical Officer.

Director Younger stated it was a pleasure getting to know Dr. Souza and expressed her appreciation for his leadership.

27. Report from Chairperson

Chairperson Grass reiterated her previous comments related to the wonderful leadership of Dr. Souza and Ms. Mary Gleisberg.

Chairperson Grass congratulated the Stroke Team and Ms. Merebeth Richins on the Life Sharing recognition.

Chairperson Grass welcomed Board Attorney Jeff Scott as well as Auxiliary President Elect Mr. Jeff Marks.

Chairperson Grass reported there will be no Board meeting in July and the next regularly scheduled Board Meeting will be held on August 29, 2019.

Chairperson Grass reported July 28th is World Hepatitis Day. She explained how vaccinations are available to provide protection against Hepatitis A and to provide long term protection. She also provided tips to avoid the transmission of Hepatitis A.

Chairperson Grass read a touching note from a patient's daughter who wanted us to know that Tri-City is an amazing hospital.

28. There being no further business it was moved by Director Nygaard and seconded by Director Schallock to adjourn the meeting at 1:45 p.m. The motion passed unanimously.

_____
Leigh Anne Grass, Chairperson

ATTEST:

_____
Julie Nygaard, Secretary

State of California-Department of Public Health
San Diego District Office

License Number: 080000099
Expiration Date: 10/31/2019
Invoice Date: 07/09/2019
Invoice Number: 0000173488
Date of Notice: 07/09/2019

Notice of Expiration and Application for Facility License Renewal

Facility:
TRI-CITY MEDICAL CENTER (GACH)
4002 VISTA WAY,
OCEANSIDE, CA 92056-4506

Licensee:
TRI-CITY HOSPITAL DISTRICT
4002 VISTA WAY
OCEANSIDE, CA 92056

RENEWAL FEE INFORMATION

Period of: 11/01/2019 to 10/31/2020
Total Fees Due: **$255,146.00**
Due On: 09/30/2019

Total fees due based on:

11,898.00	18 APH beds at $661.00 per bed
243,248.00	368 GACH beds at $661.00 per bed

NOTE: All fees must be postmarked no later than 10/31/2019 to avoid late payment penalty fees. Make check or money order payable to "The Department of Public Health". DO NOT SEND CASH

If you have any questions about fees, please email RCollection@cdph.ca.gov or call our office at (800) 236-9747

Detach this portion and return with payment

Facility: TRI-CITY MEDICAL CENTER (GACH)
Period of: 11/01/2019 to 10/31/2020
Final Due Date: 10/31/2019

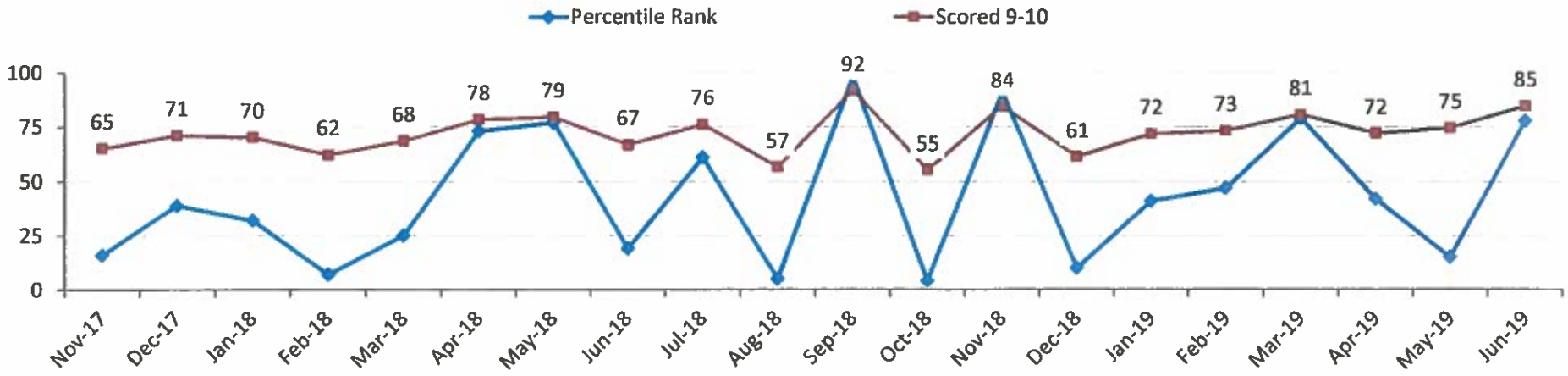
License Number: 080000099
Invoice Number: 0000173488
Total Due: **$255,146.00**

California Department of Public Health
Center for Health Care Quality
Licensing and Certification Program
Fiscal Services and Revenue Collection Unit
MS 3202
P.O. Box 997434
Sacramento, CA 95899-7434

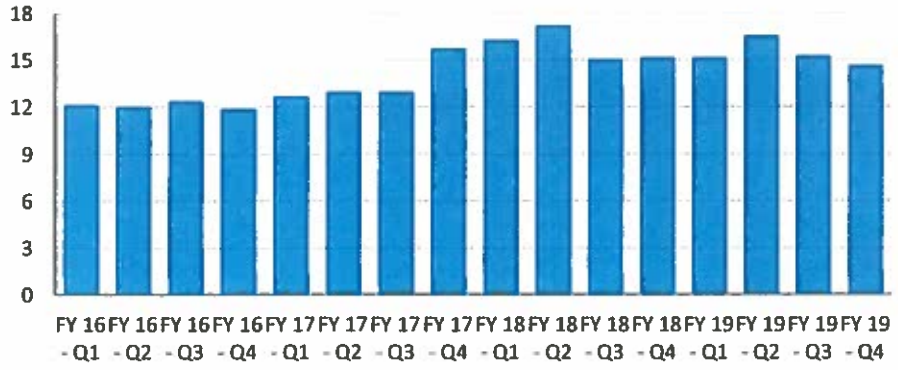
California Department of Public Health
Center for Health Care Quality
Licensing and Certification Program
Fiscal Services and Revenue Collection Unit
MS 3202
1616 Capitol Ave Ste 74.420
Sacramento, CA 95814-7402

Stakeholder Experiences

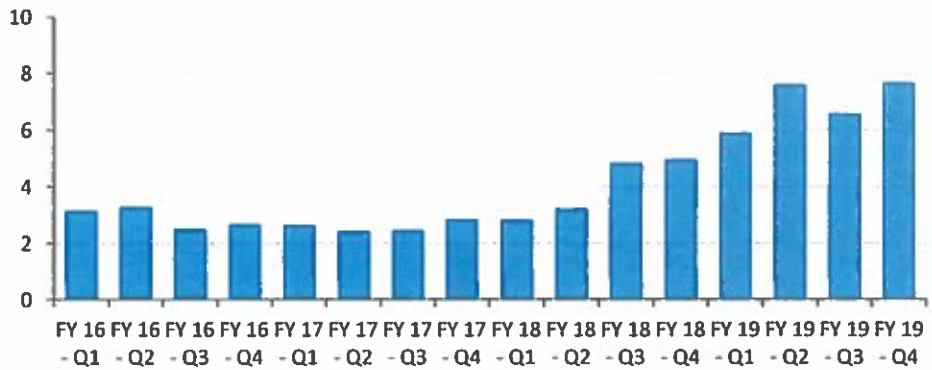
Overall Rating of Hospital (0-10)



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
FY20	16												16
FY19	18	29	19	27	18	24	22	16	23	30	25	24	18

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	9												9
FY19	10	12	3	7	7	9	10	4	16	15	11	12	10

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	9												9
FY19	19	16	12	16	12	16	17	13	18	16	10	15	19

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	19												19
FY19	20	23	18	22	17	21	19	16	18	12	20	24	20

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	33												33
FY19	31	31	27	35	38	31	23	40	36	24	29	36	31

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
FY20	-	-	-	-	-	-	-	-	-	-	-	-	-
FY19	10.8	11.3	9.7	-	-	-	-	-	-	-	-	-	10.8

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	6.2												6.2
FY19	7.4	9.1	6.5	4.7	5.7	5.3	6.8	8.4	7.2	5.8	4.4	6.5	7.4

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	9.4												9.4
FY19	11.4	9.8	10.0	11.0	11.6	8.7	10.1	8.9	11.3	10.0	9.5	10.4	11.4

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	143.4												143.4
FY19	160.3	155.9	146.4	149.6	143.7	153.2	164.8	166.3	157.7	142.4	143.3	146.5	160.3

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	168												168
FY19	186	202	170	187	185	166	170	150	177	131	146	156	186

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	7												7
FY19	8	10	6	8	3	15	6	9	11	10	20	13	8

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
FY20	7												7
FY19	3	4	3	13	13	6	11	17	6	10	7	9	3

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	9												9
FY19	8	8	6	8	4	14	8	10	16	6	7	5	8

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	1.85												1.85
FY19	1.79	1.83	1.90	1.78	1.78	1.70	1.72	1.73	1.75	1.82	1.80	1.79	1.78

Tri-City Medical Center ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending July 31, 2019

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	Ending	Services & Location	Cost Center
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.59	(a)	46,367.60	07/01/17	06/30/27	**OSNC - Carlsbad** 6121 Paseo Del Norte, Suite 200 Carlsbad, CA 92011	7095
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)	5,268.79	01/27/17	05/31/20	**PCP Clinic - Venus** 2067 W. Vista Way, Ste 160 Vista, CA 92083	7093
Camelot Investments, LLC 5800 Armada Dr., #200 Carlsbad, CA 92008 V#15608	Approx 3,563	$1.91	(a)	11,056.30	04/01/16	01/31/20	**PCP Clinic - Radiance** 3998 Vista Way, Ste. C Oceanside, CA 92056	7092
Cardiff Investments LLC 2729 Ocean St Carlsbad, CA 92008 **V#83204**	10,218	$2.58	(a)	27,500.69	07/01/17	06/30/22	**OSNC - Oceanside** 3905 Waring Road Oceanside, CA 92056	7095
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	$2.70	(a)	21,112.00	02/01/15	01/31/20	**PCP Clinic Vista** 1926 Via Centre Drive, Ste A Vista, CA 92081	7090
CreekView Orhopaedic Bldg, LLC 1958 Via Centre Drive Vista, Ca 92081 **V#83025**	Approx 4,995	$2.58	(a)	16,109.57	07/01/17	06/30/22	**OSNC - Vista** 1958 Via Centre Drive Vista, Ca 92081	7095
Elfin Investments, LLC Clancy Medical Group 20136 Elfin Creek Trail Escondido, CA 92029 V#82575	3,140	$2.62	(a)	10,101.37	12/01/15	12/31/20	**PCP Clinic - Clancy** 2375 Melrose Dr. Vista Vista, CA 92081	7091
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)	10,807.45	09/01/17	08/31/19	**OP Physical Therapy** **OP OT & OP Speech Therapy** 2124 E. El Camino Real, Ste.100 Oceanside, Ca 92054	7772 - 76% 7782 - 12% 7792 - 12%
Melrose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 V#43849	7,347	$1.35	(a)	10,399.54	07/01/16	06/30/21	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083	7320
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	4,760	$4.12	(a)	26,713.00	10/01/12	10/01/22	**Chemotherapy/Infusion Oncology Center** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056	7086
Total				$ 185,436.31				

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending July 2019

Cost Center	Description	Invoice #	Amount	Vendor #	Attendees
7400	PERINATAL CONFERENCE	71019EDU	575.00	83541	CYNTHIA KRANZ
8340	NUTRITION FOCUSED WORKSHOP	71519edu	378.81	79501	CHRISTINE CARLTON
8614	ASC CONFERENCE	70219	1,514.30	77376	JEREMY RAIMO
8710	ASER CONFERENCE	051719 EDU	714.55	82501	MANTA MED-JOHNSON
8710	CDCR CONFERENCE	62819EDU	329.47	78648	GENE MA, MD
8740	RN TO BSN TUITION REIMBUSEMENT	71119EDU	2,500.00	83314	AGNES MCCREA
8740	RN TO BSN TUITION REIMBUSEMENT	70319EDU	2,500.00	83542	CHARLINE WILSON
8740	ADN TUITION REIMBUSEMENT	61419EDU	1,717.01	83537	KAREN MACIK
8740	NURSING EDUCATION	61419EDU	1,425.00	83532	TINA BARTON
8740	NATIONAL TEACHING INSTITUTE	72419EDU	200.00	79454	SIRRIRATN TILAKAMONKUL
8740	ACLS RECERTIFICATION	71819 EDU	200.00	78113	GLORIA SHARMAPAL
8740	BOARD CERTIFICATION ONCOLOGY	70319EDU	200.00	82580	ASHLEY DROLSHAGEN
8740	INFECTIOUS DESEASES	70319EDU	200.00	82350	MANUAL ESCOBAR
8740	ACLS RECERTIFICATION	71819EDU	200.00	80547	ALYCE BUDDE
8740	ACLS RECERTIFICATION	62819EDU	200.00	83539	ANDREA KEAST
8740	CSRS CONVENTION	62819EDU	190.00	83540	MICHELLE SAVATDY
8740	ACLS RECERTIFICATION	70319EDU	189.00	83315	NEIL FERNANDA
8740	ACLS RECERTIFICATION	61819EDU	160.00	82857	STACY COX
8740	ACLS RECERTIFICATION	71819EDU	150.00	80110	KAREN ISOLA
8740	PALS RECERTIFICATION	71819EDU	145.00	77983	JULIE MATTISON
8754	RL CONFERENCE	70319EDU	3,111.12	83312	MICHAEL LEVINE

**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.

Seminar Evaluation ForM

2019 AHA LEADERSHIP SUMMIT JULY 25-27, 2019

SAN DIEGO MANCHESTER GRAND HYATT

Reason for Attending: This was a unique opportunity to hear what is going on nationally in Health care. Pre-eminent health care leaders offered a wide variety of innovations for the future of health care covering shifting traditions in business models to address future stregies and approaches for achieving financial sustainability while delivering greater value through operational excellence and creative partnerships. Health care is definitely changing and we need to change with it to survive.

I attended a Keynote presentation on community engagement: It was quite interesting. There focus was that hospitals should be the Hub for social change. There main focus was to have local hospitals be the center for community change, including housing, food inequity, pay inequity and health care needs. Sounded like they believed we should be taking on the total person in general. They were focused on a bigger job than I think we can do. They acknowledged that there is no perfect health care system. They talked about the shift to more out patient care instead of in our hospitals.

I also attended Creating a Culture of Innovation workshop. It was mainly focused on how you go about changing the culture in a hospital to make significant inmprovments in the delivery of service to our patients. They acknowledged that making change is very hard especiallly in a institution that has been around for a long time. People get used to doing things in certain way and don't want to change. This workshop offered a structured way for staff to work together in improve quality. It was a good procedure but more focused on staff than on board members.

I also attended Transform Care through Age-Friendly Health Systems. The AHA has an Age Friendly Health organization that is working on changing the focus of hospitals towards our aging population and what is the best care for these people. They are increasing in numbers and could be a big part of our future. The standard of care for them has changed significantly I think it would be work while for us to look at this issue and what this orgination is proposing. I have included a brief overview that i would like to share.

What was most important:

Most interesting for me was the. Presentation on reshaping Health Care through Disruption: Linda Bernardo is an entrepreneur in the tech industry. She spoke about where health care is going in the future with A I and how it will significantly change how we receive care. She talked about how traditional medicine will change. Health care will be patient centered and easily accessible through our phones. Miss Bernardo shared her enthusiastic outlook on how companies from manufacturing and financing health care can thrive in the I o T economy by shifting our strategy toward opportunities. She was a dynamic speaker and get everyone thinking about the future.

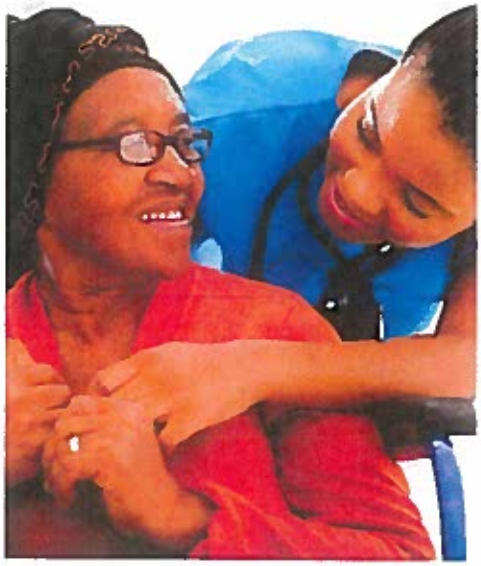
There was a very good lunch time speaker Ira Brock, MD who addressed end of life issues and how we can address the whole person and what they actually want for their care when they are very ill. He talked abou how we can enhance quality and patient experience, reduce costs and improve patient satisfaction. He spoke a lot about palliatives care which we are addressing in our hospital. We need to get more patient centered.

I thought it was a very good conference and am amazed by all the work that is being done in health care in America. Sometimes we get too caught up in our local issues to forget the big

picture. Of course we can all learn from just talking with other health care board members and providers.

Age-Friendly Health Systems

Join the Movement



Age-Friendly Health Systems is an initiative of **The John A. Hartford Foundation** and the **Institute for Healthcare Improvement (IHI)** in partnership with the **American Hospital Association (AHA)** and the **Catholic Health Association of the United States (CHA)**.

The Challenge

Ten thousand adults turn 65 every day, and US Census data show that the population ages 65 and older is expected to nearly double in the next 30 years. Older adults are also expected to experience increased life expectancy. As the US population ages and life expectancy increases, the growing number of older adults, particularly those with multiple chronic conditions, poses challenges to the current health care system. For older adults and caregivers, the current health care system can be difficult to navigate to find the right care at the right place at the right time.

Too often, older adults are needlessly harmed in health care settings and receive care that is inconsistent with what matters to them. We have extensive knowledge of what it takes to improve care for older adults; numerous effective, evidence-based models for geriatric care exist and are in practice. Unfortunately, these models reach only a portion of those who could benefit from them. There is a gap between what is known as the best care for older adults and the care that is provided.

Our Aim

The goal of Age-Friendly Health Systems is to develop a framework for age-friendly care and rapidly spread to 20 percent of U.S. hospitals and medical practices by 2020.

An Age-Friendly Health System is one in which every older adult:

- Gets the best care possible;
- Experiences no health care-related harms; and
- Is satisfied with the health care he or she receives.

In an Age-Friendly Health System, value is optimized for all — patients, families, caregivers, health care providers, and the overall system.

How will we get there? The 4Ms

In 2017, five US health system pioneers partnered with IHI to test, refine, and scale up the Age- Friendly Health Systems Framework: Anne Arundel Medical Center, Ascension, Kaiser Permanente, Providence St. Joseph Health, and Trinity Health. With these pioneer health systems, we learned the four essential elements of an Age-Friendly Health System, now known as the 4Ms.

- **What Matters:** Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.
- **Medication:** If medication is necessary, use age-friendly medications that do not interfere with What Matters, Mobility, or Mentation across settings of care.
- **Mentation:** Prevent, identify, and treat dementia, depression, and delirium across care settings.
- **Mobility:** Ensure that older adults move safely every day in order to maintain function and do What Matters.

Join the Movement

Age-Friendly Health Systems is an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI), in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).

You are invited to learn more and participate in the Age-Friendly Health Systems movement:

1. Visit **aha.org/AgeFriendly** to stay current on progress or **email us** at **ahaactioncommunity@aha.org** to add your name to our communications.
2. Join an **action community** to test and share results with other organizations working towards reliably putting the 4Ms into practice. The next action community begins in Fall 2019. Email **ahaactioncommunity@aha.org** to participate.
3. Participate in **learning calls** or other programs about Age-Friendly Health Systems. Check **aha.org/AgeFriendly** for upcoming options.

Questions?

Contact us at
ahaactioncommunity@aha.org
or **aha.org/AgeFriendly**

Age-Friendly Health Systems

2019 AHA Leadership Summit Evaluation

Location: San Diego Date: July 25-27, 2019

Reason for attending: Receive updated information/concepts on hospital operations and board governance.

Major topics:

** Trends and their impacts on governance—is it time for a new model? (Jaime Orlikoff)

Focus is that governance in the past in how board operates will be insufficient to meet the needs of the future. Must look at other models. Past has been based on 1) community based, 2) voluntary, 3) minimal time constraints, 4) lack of training, 5) long-term board members and 6) conflicts of interests. The current environment is being challenged by a change in economics, demographics, generational and cultural issues. The current model is headed to obsolence with the increased complexity and mergers. Boards need to spend more time on strategic planning. Millennials needs to be attracted to the board but they have different approaches of how use technology, governance, strategic planning and decision making. Use of "outside" board members in the governance model as they have a better understanding of the "new" healthcare model.

** Board and CEO relationships (see attached handout)

With more hospitals involved in healthcare systems, the board has a minimal or no role in CEO selection. Also services and finances are regulated by the system board so the local board role is somewhat diminished. The board does have a significant role in strategic planning and working with the CEO to see that it is developed either at the local level or with the partnership of the system management/board. In addition where there is the local control the interactive role between the CEO and the board is a top priority. Several board members indicated they have difficulty recruiting new members. As a result the board members continue to "age" and millennials are not readily involved.

** Addressing opiate crisis

Discussion on day to day usage and legal controls. The role of the hospital in implementing in-house withdrawal programs and their value to the patient and community. Question is who pays.

Most important topic covered: Trying to keep up with the significant changes in how the government and third-party planners are affecting healthcare in the hospital and how the hospital has to be adaptable and flexible to meet those needs and concerns.

Main speakers: Jim Lovell and Fred Haise, Apollo 13 astronauts, and where technology of nearly 50 years ago has evolved—just like in healthcare. Linda Bernardi current technology expert with Avid AI and Blockchain strategist on how one needs to adapt to the many technology changes as they will happen.

Larry W. Schallock

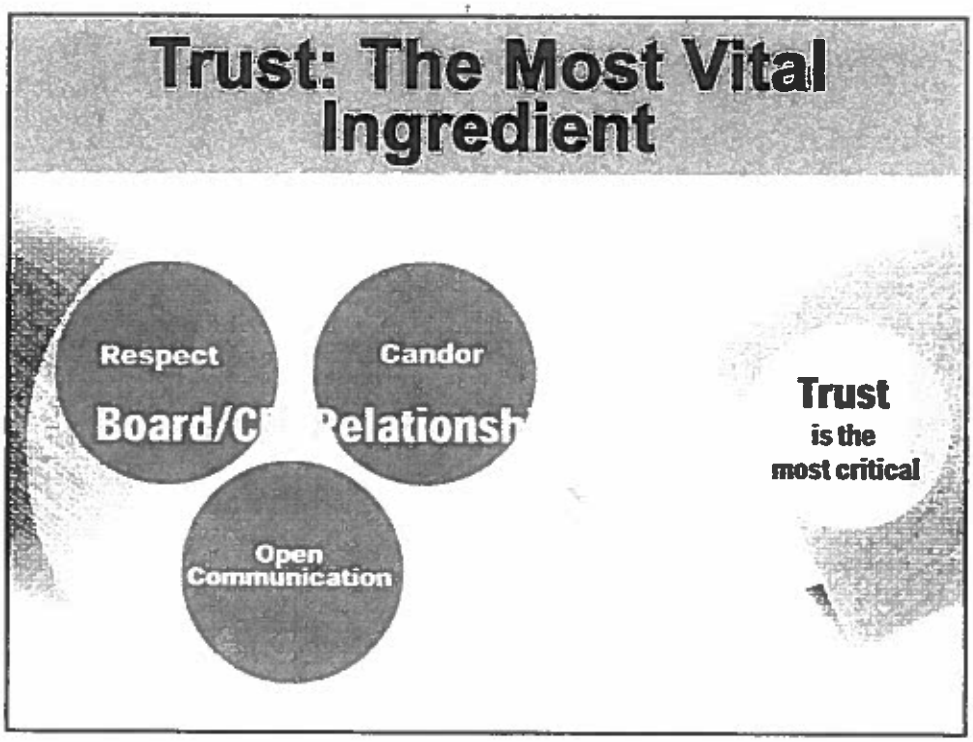
Positive trends indicated by report findings include:

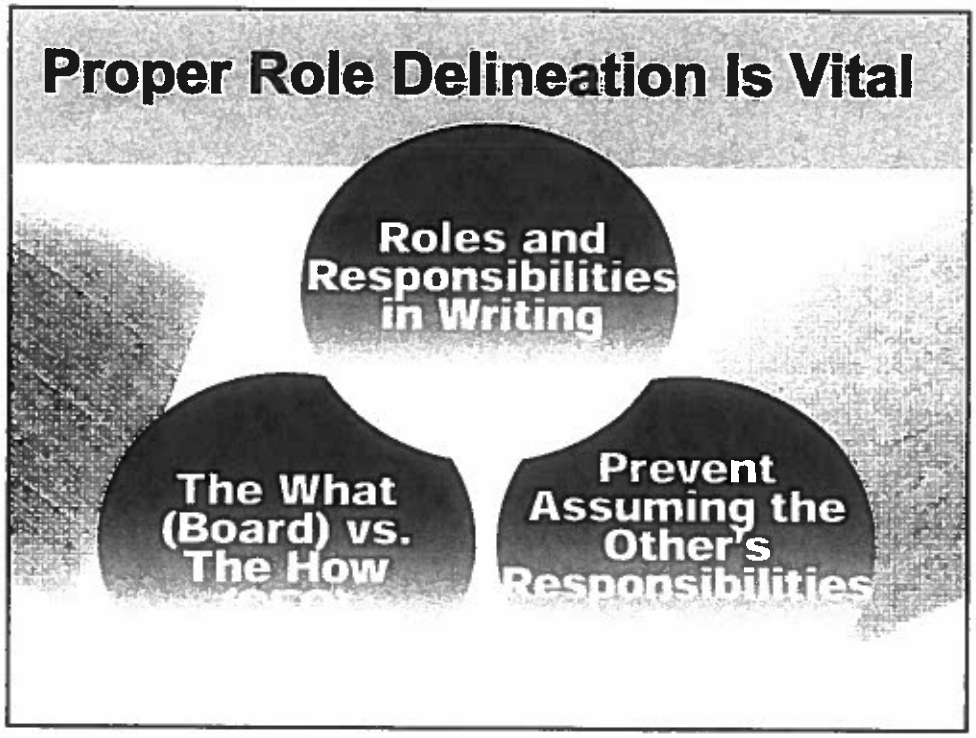
- Consistent growth in use of routine executive sessions over the past three years, considered a governance best practice.
- Some growth in racial and ethnic diversity of board members.
- A solid majority (about two-thirds) of all responding boards engaging in restructuring efforts to improve their governance.
- Increased use of board portals, also considered a governance best practice.
- Inclusion, by almost half of responding system boards, of board members from outside of communities served to add fresh perspective to board deliberations.

However, there are opportunities for improvement:

- Almost a third of all respondents did not use term limits.
- More than 75 percent either did not replace board members during their terms or continued to reappoint them when eligible during the past three years, resulting in low levels of board turnover.
- More than 70 percent of responding boards did not have a continuing education requirement for their members.
- Some 31 percent did not do board, board member or board or committee chair assessments in the past three years.
- Boards surveyed indicated a growing number of older members and fewer younger members.
- Almost half (49 percent) of respondents did not have a formal CEO succession plan.

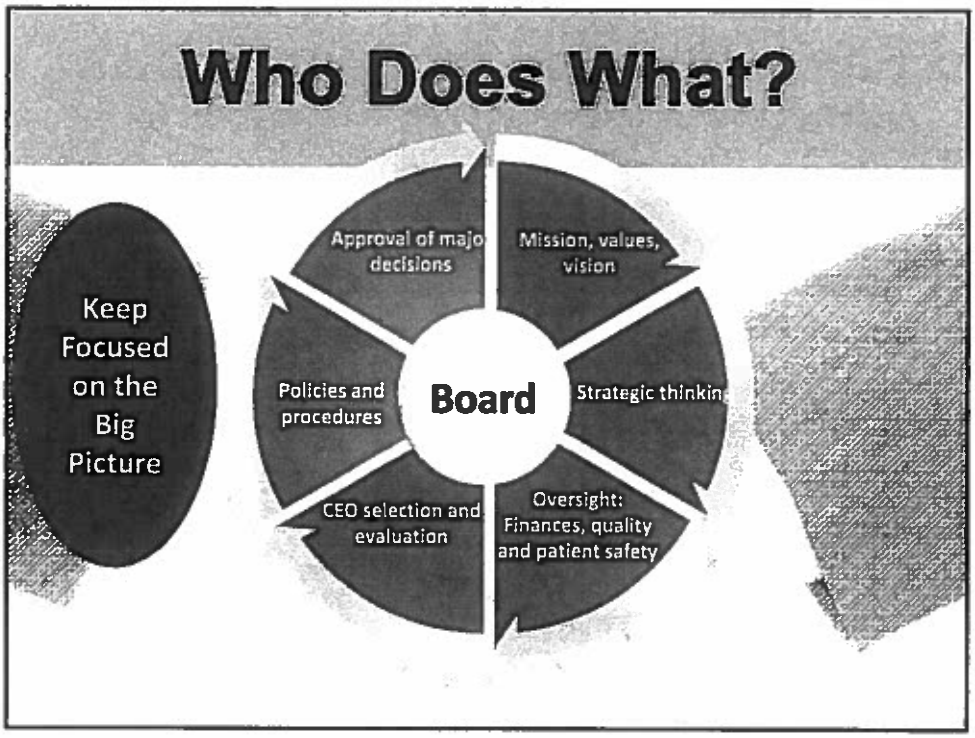
Reflecting on the results of the 2018 survey and comparing their own structure and function with survey report findings can help boards gain insight into their own governance practices and performance. Survey results also provide a useful perspective on the state of health care governance in America. They raise important questions about boards and their governance: How are boards rising to meet the challenges of an evolving health care environment, and what key opportunities exist for them to further enhance their own performance and contributions?

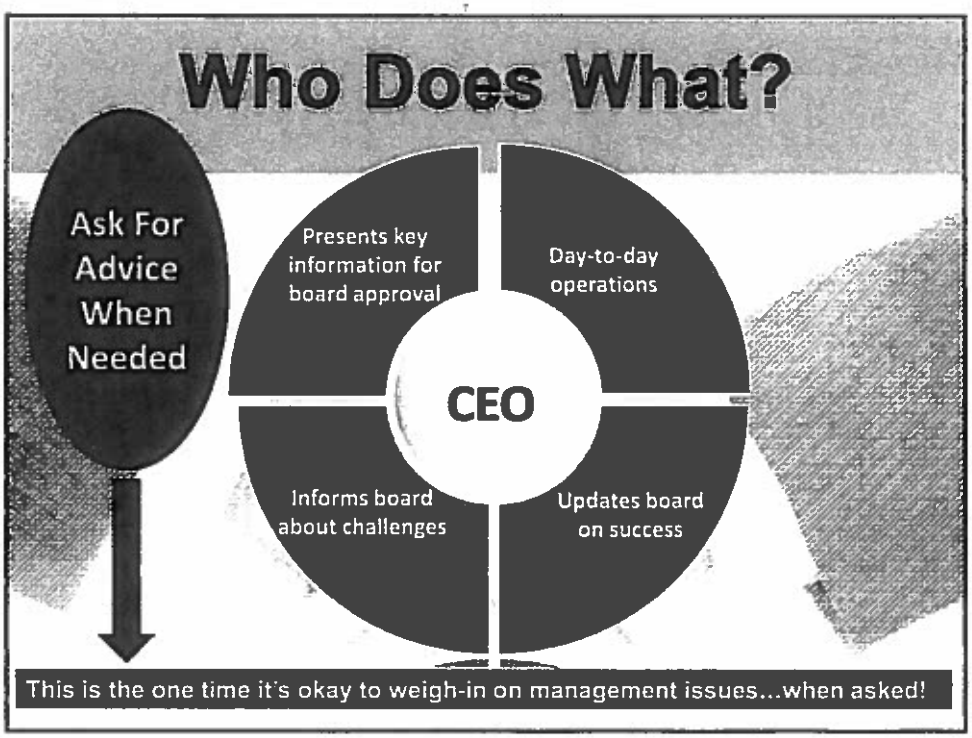

Trust: The Most Vital Ingredient
Respect
Candor
Board/C
elationsh
Open Communication
Trust
is the
most critical


Proper Role Delineation Is Vital
Roles and Responsibilities in Writing
The What (Board) vs. The How
Prevent Assuming the Other's Responsibilities

Board's Most Vital Role

- Select the CEO
- Guide the CEO
- Support the CEO
- Evaluate the CEO
- Succession Plan for a New CEO





Effective Use of the Executive and Governance Committees

Executive Committee
- **Sticky Issues / Kitchen Cabinet**
- **CEO Safe Zone**

Trustee Organization and Education Committee (TOE)
- **Care and Feeding of the Board**
- **Recruitment/Orientation/Assessment/ Education/Code of Conduct**

"Great CEOs want to work for boards that focus on great governance!"