TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
April 30, 2020 – 3:30 o'clock p.m.

In accordance with the current State of Emergency and the Governor's Executive Order N- 25-20, of March 4, 2020, and N-33-20 of March 19, 2020 a virtual platform and/or teleconferencing will be used by the Board members and appropriate staff members during this meeting. Members of the public will be able to participate by telephone, using the following dial in information:

Dial in #: (669-900-6833) To Listen and Address the Board when called upon:
Passcode: 027615#

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	Roll Call / Pledge of Allegiance	3 min.	Standard
4	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
5	March, 2020 Financial Statement Results	10 min.	CFO
6	New Business - None	--	--
7	Old Business - None	--	--
8	Chief of Staff a) Consideration of April 2020 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on April 27, 2020. b) Consideration of Rules & Regulations: 1) Division of Medicine Rules & Regulations – Revised		

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
	2) Division of Subspecialty Surgery Rules & Regulations – Revised c) Consideration of Standardized Procedures: 1) NP – Interventional Radiology - Revised 2) NP – Neurosurgery - Revised 3) Certified Nurse Midwife - Revised 4) RNFA – Standardized Procedure and Scope of Service – Revised d) Consideration of Privilege Forms: 1) Physician Assistant - Revised 2) Orthopedic Surgery - Revised 3) RNFA - Revised		
9	Consideration of Consent Calendar ***Requested items to be pulled require a second.*** (1) Approval of FY2020 Financial Statement Audit Proposal (2) Approval of an agreement with Team Health to provide professional physician services for the Emergency Department for a term of 24 months, beginning June 1, 2020 through May 31, 2022, at no cost to the District. (3) Approval of an agreement with Dr. Victor Souza, Physician Behavior Committee Chairman for a term of fifteen months, beginning March 1, 2020 for a cost of up to $4,500.00 per month, for a total cost for the term not to exceed $67,500.00. 4) Approval of an agreement with Unifirst Corp. for EVS supplies for a term of five (5) years, beginning May 17, 2020 for a cost of $201,592 per year and a total cost for the term of $1,007,960. (4) Approval of an agreement with 3M for software licenses and support for a term of 36 months/3years, beginning May 11, 220 through May 10, 2023, for an annual cost of $226,398.98 and a total cost for the term of $679,196.94 (5) Administrative & Board Committees **A. Administrative Policies** **1) Patient Care Services Policies & Procedures** a) Blanket Warmers Policy b) Deceased Patient Care and Disposition Procedure c) Glucose Monitoring and Exercise Therapy d) Swallow Screening in the Adult Patient Procedure **2) Administrative Policies & Procedures** a) Library Services Mission and Scope of Service 287 **3) Unit Specific – Cardiac Rehab** a) Billing for Cardiac Rehab **4) Unit Specific - Emergency Department** a) Elopement, Patient at Risk-Policy	10 min.	Standard

	Agenda Item	Time Allotted	Requestor

5) Unit Specific – Environmental Services
a) Cleaning Guidelines

6) Unit Specific - Medical Staff
a) Credentialing Criteria, Cardiac Rehab 8710-564
b) Credentialing Criteria, Chronic Non-Healing Wound Care 8710-523
c) Credentialing Criteria, Hyperbaric Medicine Oxygen Therapy, 8710-523A
d) Credentialing Policy, Expedited Credentialing and Privileging Process 8710-550
e) Credentialing Policy, Processing Medical Staff Applications 8710-543
f) Documentation Requirements for Emergency Department Residents 8710-567
g) Peer Review Process: OPPE and FPPE 8710-509
h) Physician/Podiatrist Surgical Assistant 8710-536
i) Requests for Privileges new to TCMC 8710-526
j) Supervision of Residents in Emergency Medicine 8710-571
k) Suspension for Delinquent Medical Records 8710-519
l) Temporary Privileges 8710-515

7) Unit Specific – Neonatal Intensive Care (NICU)
a) Replogle Tube Insertion and Maintenance
b) Weaning from Thermal Support

8) Unit Specific – Outpatient Specialty Clinic
a) Acuity Class System

9) Unit Specific – Pulmonary
a) RCP Staffing Guidelines in the NICU

10) Unit Specific – Surgical Services
a) Anesthesia Equipment Policy
b) Bumping Surgery Procedures Policy
c) Disaster and Emergency Preparedness Policy
d) Food and Drink, Surgery Policy
e) Laser Safety Policy (DELETE)
f) Loaner Trays Policy (DELETE)
g) On Call Policy
h) Operating Room (OR) Committee Policy
i) PACU & SPRA Staffing & Scheduling Practices Policy
j) PACU On Call Coverage Policy
k) Patient Transport to the OR Policy
l) Perioperative Standards of Practice Policy
m) Protective Barriers; Materials for Gowns and Drapes Policy
n) Sanitation; Perioperative Policy
o) Staffing Policy
p) Standard Precautions in Surgery Policy

11) Unit Specific – Wound Care
a) Acuity Classification System
b) Chart Order
c) Collaboration
d) Data Management
e) Discharge Instructions

	Agenda Item	Time Allotted	Requestor
	f) Disseminating Medical Information g) Home Care Referrals h) Nurse-PT Visit i) Outcome Designation for Non-Healing Wounds **12) Unit Specific – Wound Hyperbaric Oxygen Therapy** a) Acuity Classification System b) Admission Procedure c) Bomb Threat d) Earthquake (6) Board Committees **A. Community Healthcare Alliance Committee** Director Chavez, Committee Chair *(No meeting held in April, 2020)* **B. Finance, Operations & Planning Committee** Director Nygaard, Committee Chair Open Community Seats – 0 *(No meeting held in April, 2020)* **C. Audit, Compliance & Ethics Committee** Director Younger, Committee Chair Open Community Seats – 0 *(No meeting held in April, 2020)* (7) Minutes – Approval of: a) March 25, 2020 - Special Meeting b) March 26, 2020 – Special Meeting (8) Meetings and Conferences – None (9) Dues and Memberships - None (10) Reports (a) Dashboard – Included (b) Construction Report – None (c) Lease Report – (March, 2020) (d) Reimbursement Disclosure Report – (March, 2020) (e) Seminar/Conference Reports – None		 CHAC Comm. FO&P Comm. Audit, Comp. & Ethics Comm. Standard
9	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
10	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
11	Comments by Chief Executive Officer	5 min.	Standard
12	Board Communications (three minutes per Board member)	18 min.	Standard
13	Report from Chairperson	3 min.	Standard
15	Adjournment		

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
April 8, 2020

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 5/01/2020 – 4/30/2022)

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 5/01/2020 through 4/30/2022:

- **FARRELL, Robert MD/Teleradiology (StatRad)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
April 8, 2020

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 5/01/2020 – 4/30/2022)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 05/01/2020 through 4/30/2022, 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:

- **CHIAO, Hellen, MD/Gastroenterology/Provisional**
- **CLANCY, John, DO/Internal Medicine/Refer and Follow**
- **DELANEY, Michael, MD/Neurology/Provisional**
- **EIKERMANN, Eric, MD/Anesthesiology/Active**
- **ELCHICO, Erick, MD/Anesthesiology/Active**
- **FIERER, Adam, MD/General Surgery/Active**
- **HURD, Melissa, MD/Family Medicine/Active**
- **JAIN, Atul, MD/Ophthalmology/Active**
- **JESWANI, Sunil, MD/Neurological Surgery/Active**
- **KAYAL, Anas, MD/Nephrology/Active**
- **KELLY, Jon, MD/Orthopedic Surgery/Active Affiliate**
- **LEBOVITS, Marc, MD/Otolaryngology/Active**
- **LEE, Robert, MD/Internal Medicine/Active**
- **PAZ, Pedro, MD/Neonatology/Active**
- **PERTL, Ursula, MD/Pediatrics/Active**
- **RAJAMANICKAM, Anitha, MD/Interventional Cardiology/Active**
- **REEN, Sandeep, MD/Family Medicine/Active**
- **SEIF, David, MD/Anesthesiology/Active**

Attachment B

- SHABANIAN, Leila, MD/Internal Medicine/Active
- SHABRANG, Cyrus, MD/Interventional Radiology/Provisional

SPRINGER, Dewain, DPM/Podiatric Surgery/Active

RESIGNATIONS: (Effective date 4/30/2020 unless otherwise noted)

Automatic:

- BEY, Thomas, MD/Interventional Radiology
- MADANI, Michael, MD/Cardiothoracic Surgery

Voluntary:

- ALLEN, Drew, DPM/Podiatric Surgery
- GANDHI, Dhruvil, MD/Colon & Rectal Surgery
- HARMAN, Herbert, MD/Psychiatry
- HOWDEN, Frederick, MD/Cardiothoracic Surgery
- IYENGAR, Radha, MD/Pediatrics
- THISTLEWAITE, Patricia, MD/Thoracic Surgery

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
April 8, 2020

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given six 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, 2020** would result in these privileges automatically relinquishing.

- **BUI, Hanh, MD** — **Cardiology**
- **FLORES, Edna, MD** — **Oncology**

These practitioners failed to meet the proposed deadline and are approved for an additional 3 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by **July 31, 2020** would result in these privileges automatically relinquishing.

- **GENTILUOMO, Jesse, MD** — **Emergency Medicine**
- **MACEWAN, Jennifer, MD** — **Otolaryngology**
- **ONAITIS, Mark, MD** — **Cardiothoracic Surgery**
- **PERRIZO, Nathan DO** — **Pain Medicine**
- **YAKHNENKO, Ilya, MD** — **Internal Medicine**

ADDITIONAL PRIVILEGE REQUEST (Effective 5/1/2020, unless otherwise specified)

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

- **CIZMAR, Branislav MD** — **OB/GYN**
- **SILLDORFF, Morgan MD** — **Orthopedic Surgery**
- **SPIEGEL, David MD** — **Cardiology**

VOLUNTARY RELINQUISHMENT OF PRIVILEGES

The following providers relinquished the following privileges.

- **JACOBS, Karl MD** — **Psychiatry**
- **SEIDEN, Grant MD** — **Orthopedic Surgery**

STAFF STATUS CHANGE

The following practitioners requested the following change to their staff status; request has been signed off by the Department/Division/Specialty Chief:

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
April 8, 2020

• AL-BALAS, Hassan MD	Teleradiology
• BRADFIELD, Harold MD	Teleradiology
• CIZMAR, Branislav MD	OB/GYN
• HOBART, Edward MD	Teleradiology
• KIRKLAND, Jared MD	Teleradiology
• LORENTS, Evelyn MD	Teleradiology
• MARTIN, Andrew MD	Teleradiology
• PANICKER, Harish MD	Teleradiology
• SCHOENMAN, Erich DO	Teleradiology
• SINGH, Tiger MD	Teleradiology

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
April 8, 2020

PROCTORING RECOMMENDATIONS

• AL-BALAS, Hassan MD	Teleradiology
• AMUNDSON, Janet MD	Teleradiology
• BALL, Lindsay MD	Emergency Medicine
• BRADFIELD, Harold MD	Teleradiology
• DALLA BETTA, Michael DO	Emergency Medicine
• DANG, Christopher DO	Emergency Medicine
• FISCHER, Andrew MD	Emergency Medicine
• GENTILUOMO, Jesse MD	Emergency Medicine
• HENDERSON, Patrick MD	Teleradiology
• HOBART, Edward MD	Teleradiology
• HOTCHKISS, John MD	Teleradiology
• HWANG, Janice MD	Teleradiology
• JACOBS, Karl MD	Psychiatry
• JOHN, Katrina MD	Emergency Medicine
• KANE, Norman MD	Orthopedic Surgery
• KIRKLAND, Jared MD	Teleradiology
• LEE, David MD	Teleradiology
• LORENTS, Evelyn MD	Teleradiology
• MALHOTRA, Kavin MD	Teleradiology

- MARTIN, Andrew MD — Teleradiology
- MISCHIU, Oana MD — Teleradiology
- PANICKER, Harish MD — Teleradiology
- POLLOCK, Max MD — Teleradiology
- RYEL, Justin MD — Emergency Medicine
- SCHOENMAN, Erich DO — Teleradiology
- SEIDEN, Grant MD — Orthopedic Surgery
- SHELLENBERGER, Jeffry — Emergency Medicine
- SINGH, Tiger MD — Teleradiology
- SNYDER, Bradley MD — Teleradiology
- THALKEN, Gregory MD — Teleradiology
- YUH, Theresa MD — Teleradiology

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT
April 8, 2020

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 5/01/2020 – 04/30/2022)

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 5/01/2020 through 04/30/2022:

- **ALLEN, Lindsay PA-C/Allied Health Professional (TeamHealth)**
- **BULGER, Jeffrey PA-C/Allied Health Professional (PA Specialists)**
- **NGUYEN, Diana CNM/Allied Health Professional (No. County Health Svcs.)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT – 1 of 1
April 20, 2020

Attachment B

BIENNIAL REAPPRAISALS: (Effective Dates 05/01/2020 – 04/30/2022)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 05/01/2020 through 04/30/2022, 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:

- **BROWN, Kaley, PA-C/Allied Health Professional**
- **CARLTON, Vivian, PA-C/Allied Health Professional**
- **GUTHRIE, Lesli, AuD/Allied Health Professional**
- **KWAN, Jaclyn, PA-C/Allied Health Professional**
- **TAYLOR, Phyllis, NP/Allied Health Professional**

RESIGNATIONS: (Effective date 04/30/2020 unless otherwise noted)

- **BOHN, Sarah, PhD/Allied Health Professional**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 2 of 3
April 20, 2020

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

These practitioners failed to meet the proposed deadline and are approved for an additional 3 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by **July 31, 2020** would result in these privileges automatically relinquishing.

- **ALLEN, Matthew, PA-C** — **Allied Health Professional**
- **BROWNSBERGER, Richard, PA-C** — **Allied Health Professional**
- **MILLER, Cortney FNP** — **Allied Health Professional**
- **SCHILLINGER, Stephan, PA-C** — **Allied Health Professional**
- **STABLER, Holly, PA** — **Allied Health Professional**

ADDITIONAL PRIVILEGE REQUEST (Effective 5/1/2020)

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

- **EGGEMEIER, Sara CNM** — **Allied Health Professional**
- **MEMEO, Kelly NP** — **Allied Health Professional**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 3 of 3
April 20, 2020

Attachment C

PROCTORING RECOMMENDATIONS

- **DEMASCO, Michael PA** — **Allied Health Professional**
- **VIERRA, Erin NP** — **Allied Health Professional**

I. **MEMBERSHIP**

The Division of ~~Internal~~ Medicine consists of physicians who practice within the specialties of:

- Gastroenterology
- Internal Medicine
- Endocrinology
- Infectious Disease
- Nephrology
- Neurology
- Oncology
- ~~Rheumatology~~
- Physiatry (Physical Medicine and Rehabilitation)
- Pulmonary
- Psychiatry
- Rheumatology

All sub-specialties require Board Certification, recognized by the ABMS ~~Division members practicing Internal Medicine shall be board certified in internal medicine by the American Board of Internal Medicine~~ or American Osteopathic Board of ~~Internal~~ Medicine, in their respective specialties or proof of active progression toward Board Certification within 60 months of initial appointment. Those physicians appointed prior to June 1991 must ~~or have successfully completed an ACGME or AOA accredited residency in Internal Medicine and are able to~~ demonstrate comparable ability, training and experience.

~~Division members practicing Endocrinology, Infectious Disease, Nephrology or Rheumatology shall be board certified in internal medicine and the applicable sub-specialty by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, or successfully completed an ACGME or AOA accredited residency in internal medicine and applicable sub-specialty residency/fellowship and are able to demonstrate comparable ability, training and experience.~~

~~Division members practicing Physical Medicine and Rehabilitation are board certified by the American Board of Physical Medicine and Rehabilitation, or have completed an ACGME/AOA accredited physical medicine and rehabilitation residency training program and are able to demonstrate comparable ability, training and experience.~~

II. **FUNCTIONS OF THE DIVISION**

The general functions of the Division of Internal Medicine shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety and appropriateness of care and treatment provided to patients by members of the Division and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and performance of specified services within the hospital;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Division clinical practice;

D. Review and evaluate Division member adherence to:
   1. Medical Staff policies and procedures;
   2. Sound principles of clinical practice;

E. Submit written minutes to the Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Division review and evaluation activities, actions taken thereon, and the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital;

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, patient safety, and clinical performance or opportunities to improve patient care are identified;

H. Recommend or Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);

I. Approve On-Going Professional Practice Evaluation Indicators; and

J. Formulate recommendations for Division rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. DIVISION MEETINGS

The Division of ~~Internal~~ Medicine shall meet at the discretion of the Chief, but at least ~~annually~~quarterly. The Division will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. ~~Minutes shall be transmitted to the Medical Quality Peer Review Committee, and then to the Medical Executive Committee.~~

Twenty-five percent (25%) of the Active Division members, but not less than two (2) members, shall constitute a quorum at any meeting.

IV. DIVISION OFFICERS

The Division shall have a Chief who shall be a member of the Active Medical Staff in good standing and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the Division.

The Division Chief shall be elected every two years by the Active members of the Division who are eligible to vote. If there is a vacancy for any reason, the Department Chairman shall designate a new Chief, or call a special election. The Chief shall be elected by a simple majority of the members of the Division.

The Division Chief shall serve a ~~one~~ two year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in

the Division. Division ~~officers~~ Chief shall be eligible to succeed themselves for two consecutive terms if elected.

The Division shall have Specialty Chiefs who shall be a member of the Active Medical Staff In good standing and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the representative Divisions.

The Specialty Chiefs shall be elected every two years by the Active members of the Division who are eligible to vote. If there is a vacancy for any reason, the Department Chairman shall designate a interim Specialty Chief, or call a special election. The Chief shall be elected by a simple majority of the members of the Specialty within the Division.

The Specialty Chief shall serve a two year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in the Division. Division officers shall be eligible to succeed themselves for two consecutive terms if elected.

V. DUTIES OF THE DIVISION CHIEF

The Division Chief shall assume the following responsibilities:

A. Be accountable for all professional administrative activities of the Division;
B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;
C. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form;
D. Recommend to the Department of Medicine and the Medical Executive Committee the criteria for clinical privileges in the Division;
E. Recommend clinical privileges for each member of the Division;
F. Assure that the quality, safety and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
G. Other duties as recommended from the Department of Medicine or the Medical Executive Committee.

VI. DUTIES OF THE SPECIALTY CHIEF

The Specialty Chief shall assume the following responsibilities:

A. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form;
B. Recommend to the Department of Medicine and the Medical Executive Committee the criteria for clinical privileges in the Division;
C. Recommend clinical privileges for each member within their specialty
D. Assure that the quality, safety and appropriateness of patient care provided by members of the Division are monitored and evaluated; and

E. Other duties as recommended from the Division Chair, Department of Medicine or the Medical Executive Committee.

~~VI.~~VII. PRIVILEGES

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.

B. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.

C. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.

D. All members of the Division of ~~Internal~~ Medicine are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training, such as in the broad field of internal medicine although not necessarily at the level of sub-specialist. Such physicians may act as consultants to others and may, in turn, be expected to request consultation when:

1. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life threatening illness;
2. Unexpected complications arise which are outside this level of competence;
3. Specialized treatment or procedures are contemplated with which they are not familiar.

VIII. PSYCHIATRY FREQUENCY OF VISITS

A. The attending member must write progress notes at least six days per week on all acute patients in the hospital until the member designates transfer of the patient to a skilled nursing care level (Medical Staff Rules & Regulations – 6/7 days).

IX. PSYCHIATRY CO-TREATMENT BY CLINICAL PSYCHOLOGISTS

A. Clinical psychologists, as independent Allied Health Professionals, may participate in providing co-treatment to patients in the acute hospital. Co-treatment is the process which allows a clinical psychologist to work in collaboration with the hospital interdisciplinary treatment team in providing clinical services to patients in Tri-City Medical Center. In addition, the clinical psychologist may provide co-treatment to patients with other attending members of the medical staff to patients admitted or treated at Tri-City Medical Center;

B. Clinical co-treatment services will be limited to psychotherapy and psychological assessments. Psychologists will be encouraged to participate in interdisciplinary treatment planning meetings;

C. The attending psychiatrist will maintain all responsibilities and rights to admit, discharge and medically treat and attend these patients. The writing of formal orders will be the responsibility of the attending psychiatrist. Involuntarily detained patients, who are being seen by both a psychiatrist and a psychologist in collaborative treatment, may be authorized for early release by the treating psychologist, but only in consultation with the psychiatrist, and the psychiatrist does

not object. If the psychologist and the psychiatrist disagree, the patient shall not be released early, unless the Medical Director overrules the psychiatrist or psychologist opposing the release. If the Medical Director happens to be the attending psychiatrist, then the Chief of the Division of Psychiatry overrules and makes the final decision;

D. The attending psychologist has the option of working with any attending psychiatrist or any other attending physician who is a member of the Medical Staff at Tri-City Medical Center. Co-treatment with a psychiatrist can only occur if the attending psychiatrist approves it;

E. The attending psychologist and attending psychiatrist will work as a team in providing psychotherapeutic treatment to the patient they are co-treating and will work together to arrange the schedule of therapy sessions;

1. The attending psychologist will be required to document each of the therapy visits in the progress notes of the medical records;
2. The attending psychiatrist must write progress notes on each patient at least six days per week;
3. The attending psychologist, as well as the attending psychiatrist, will be encouraged to attend interdisciplinary team meetings on a weekly basis during the patient's hospital stay;

F. Each new psychologist will receive an orientation and introduction to Tri-City Medical Center and the Behavioral Health Unit by the Medical Director. In addition, psychologists will undergo a preceptorship during their first five co-treatment cases. A psychologist, who is an independent Allied Health Professional in good standing, with consultation from the Medical Director, may serve as preceptor.

X. RESTRAINT ASSESSMENT

Physicians, clinical psychologists or nurse practitioners credentialed by the medical staff may serve as restraint evaluators and within one hour after the initiation of the behavior restraint or seclusion, must evaluate the patient's physical or psychological status in person. The supervising psychiatrist must report any death that occurred while a patient was in a behavior restraint or in seclusion to CMS within one day of patient death.

~~3.~~XI.

~~Privileges~~	~~Initial Appointment~~	~~Proctoring~~	~~Reappointment (every 2 years)~~
~~Admit patients~~ ~~Consultation~~ ~~History and physical examination~~	~~1. Board certified in Internal Medicine or applicable sub-specialty by the American Board of Internal Medicine; or~~ ~~2. Successful completion of an ACGME or AOA accredited residency in internal medicine.~~	~~Six (6) in-hospital cases (At least three (3) must be telemetry or ICU admissions).~~	~~N/A~~

~~Surgical Assistant~~	~~See Policy 8710-536~~	~~See Policy 8710-536~~	~~See Policy 8710-536~~
~~Moderate sedation~~	~~See Policy 8710-517~~	~~See Policy 8710-517~~	~~See Policy 8710-517~~
~~INTERNAL MEDICINE PROCEDURES~~			
• ~~Arthrocentesis~~ • ~~Central venous catheter insertion*~~ • ~~Cyst Aspiration~~ • ~~Excision of subcutaneous lesions not requiring skin grafts~~ • ~~Flexible sigmoidoscopy~~ • ~~Incision and Drainage~~ • ~~Lumbar puncture*~~ • ~~Paracentesis*~~ • ~~Percutaneous arterial catheter insertion*~~ • ~~Read EKGs/supervise treadmill EKGs~~ • ~~Removal of toenail~~ • ~~Skin biopsy~~ • ~~Suturing~~ • ~~Thoracentesis*~~ • ~~Treatment of patients in an intensive care environment~~ • ~~Venous cutdown~~	1. ~~Board certified in Internal Medicine by the American Board of Internal Medicine; or~~ 2. ~~Successful completion of an ACGME or AOA accredited residency in internal medicine and documentation of ten (10) cases within 24 months prior to application~~	~~Two (2) cases from this category~~	~~Ten (10) cases from this category. If a privilege is annotated with an asteric (*), one (1) case is required, which counts in the total category volume requirements.~~
~~ENDOCRINOLOGY PROCEDURES~~			
• ~~Admit, evaluate, diagnose, consult, perform history and physical examination, and provide treatment to patients~~	1. ~~Board certified in Endocrinology, Diabetes, and Metabolism by the American Board of Internal Medicine or the American Osteopathic~~	~~Six (6) cases~~	~~Twenty (20) cases~~

~~presenting with illnesses, injuries, or disorders of the endocrine or metabolic systems, including diabetes.~~	~~Board of Internal Medicine; or~~ ~~2. Successful completion of an ACGME or AOA accredited residency in internal medicine or applicable sub-specialty residency/ fellowship and documentation of the management of endocrinology, diabetes, and metabolism problems for at least twenty (20) patients with in the 24 months prior to application.~~		
• ~~Fine needle thyroid aspiration~~	~~Five (5) cases within 24 months prior to application~~	~~One (1) case~~	~~One (1) case~~
~~**NEPHROLOGY PROCEDURES**~~			
• ~~Continuous arteriovenous hemofiltration~~ • ~~Hemodialysis~~ • ~~Peritoneal dialysis~~ • ~~Plasmapheresis~~ • ~~Renal biopsy~~	~~1. Board certified in the subspecialty of Nephrology by the American Board of Internal Medicine; or~~ ~~2. Successful completion of an ACGME or AOA accredited internal medicine residency and either a residency or fellowship in nephrology, and documentation of ten (10) cases within 24 months prior to application.~~	~~Two (2) cases from this category~~	~~Ten (10) cases from this category~~
~~**PAIN MANAGEMENT**~~			
~~Pain management privileges~~	~~Per Medical Staff policy 8710-541~~	~~Per Medical Staff policy 8710-541~~	~~Per Medical Staff policy~~

~~VII.~~XII. REAPPOINTMENT OF CLINICAL PRIVILEGES

At the time of reappointment p~~P~~rocedural privileges ~~will~~may be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. ~~If~~ Those privileges which the minimum number of cases is not performed, ~~the physician will be required to undergo proctoring for all procedures that were not satisfied. T~~will be automatically relinquished and the physician will have an option to ~~voluntarily relinquish~~reapply for his/her privileges for the unsatisfied procedure(s).

~~VIII.~~XIII. PROCTORING OF PRIVILEGES

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Division Chief to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active members of the Division will act as proctors. An associate may monitor 50% of the required proctoring. Additional cases may be proctored as recommended by the Division Chief. It is the responsibility of the Division Chief to inform the monitored member whose proctoring is being continued of any deficiencies noted.

C. ~~THE MONITOR MUST BE PRESENT FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEMBER'S COMPETENCE, OR MAY REVIEW THE CASE DOCUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE PHYSICIAN'S COMPETENCE~~Supervision of the member by the proctor will include concurrent review for invasive cases or retrospective chart review of cognitive process for noninvasive cases and direct observation of procedure techniques. Direct observation means the monitor must be present in the Operating Room for a sufficient period of time to assure himself/herself of the member's competence.

D. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled).

E. The member shall have free choice of suitable consultants and assistants.

F. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.

G. A form shall be completed by the proctor, and should include comments on pre-procedure workup, diagnosis, pre-procedure preparation, technique, judgment, post-procedure care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Medical Staff Office.

H. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.

~~IX.~~XIV. DEPARTMENT QUALITY REVIEW AND MANAGEMENT (PEER REVIEW)

A. The Department of Family Medicine (FM) Quality Review Committee and the Division of Internal Medicine (IM) Quality Review Committee shall be combined into the Internal Medicine/Family Medicine (IM/FM) Quality Review Committee (QRC). The combined IM/FM QRC shall be comprised of no less than two (2) Family Medicine Department members and two (2) Internal Medicine Division members. The Committee chairman may alternate between the Department of Family Medicine and the Division of Internal Medicine as determined by the QRC and each department/division shall have a representative on the Medical Quality Peer Review Committee The Department Chairperson shall appoint the remaining members for a two (2)-year term. Committee members shall be eligible to succeed themselves. The QRC shall meet at least four (4) times per year.

B. **General Function**

1. The IM/FM QRC provides systematic and continual review, evaluation, and monitoring of the quality and safety of care and treatment provided by department members to patients in the hospital.

C. **Specific Functions:**

1. The QRC is established to:
   - i Identify important elements of patient care;
   - ii Establish performance monitoring indicators and standards related to these elements of care;
   - iii Select and approve performance monitoring indicators;
   - iv Integrate relevant information for these indicators and review quarterly as related to these performance monitoring indicators;
   - v Review and evaluate physician practice when specific thresholds are triggered;
   - vi Identify areas of concern and opportunities for improved care and safety, and educate Department members based on these reviews;
   - vii Highlight significant clinical issues and present the specific information regarding qualify of care to the appropriate Department member, in accordance with Medical Staff Bylaws;
   - viii Request, if needed, Focused Professional Practice Evaluation when/if questions arise regarding a physician's practice;
   - ix Monitor and review the effectiveness of intervention and document change.

D. **Other Functions**:

1. Assist in the reappointment process through retrospective review of charts;
2. Review any Internal Medicine-related issues received from other departments;
3. Assist in the collection, organization, review, and presentation of data related to patient care, safety, and department clinical pathways;
4. Review cases involving death(s) in the hospital as applicable by approved departmental indicators.

E. **Reports**

1. Minutes shall be submitted to the Medical Quality Peer Review Committee and the Medical Executive Committee. The QRC shall provide minutes, and as needed, verbal or written communication regarding any general educational information gleaned through

chart review or the Performance Improvement process to Department members and to the Medical Quality Peer Review Committee.

~~X~~XV. EMERGENCY CALL

Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Refer to Medical Staff Policy and Procedure 8710-520.

While serving on the Emergency Department Call Roster, each member shall respond to requests from the Emergency Department by examining and treating patients in the Emergency Department, unless the member and the Emergency Department physician determines that such care may be provided in the member's office. Any member who elects to provide care in his/her office must do so without regard to the patient's ability to pay, and must provide a minimum level of care sufficient to respond to the patient's immediate needs.

When it is discovered that a staff member has previously treated a patient, that member will be given the opportunity to provide further care. The member will then determine whether to provide further care to an Emergency Department patient based upon the circumstances of the case. If a member declines, the on-call physician for unassigned patients will provide any necessary emergency special care AND THE INCIDENT WILL BE REFERRED TO THE Department for discussion/action.

Provisional and ~~Courtesy~~ Active Affiliate staff members may be assigned to the Emergency Department Call Roster by the Chief of the Division. The care provided by an on-call physician will not create an obligation to provide further care beyond the hospital stay.

APPROVALS:

Division of ~~Internal~~ Medicine: ~~6/04/15~~3/20
Department of Medicine: ~~6/12/15~~4/20
Medical Executive Committee:~~6/22/15~~
Board of Directors: ~~7/30/15~~

I. MEMBERSHIP

The Division of Subspecialty Surgery consists of physicians who practice within the specialties of:

- Neurosurgery
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology, Head and Neck
- Oral and Maxillofacial Surgery and Dentistry
- Plastic Surgery
- Podiatric Surgery
- Urology

All sub-specialties require Board Certification, recognized by the ABMS, American Osteopathic Board of Surgery, American Board of Foot and Ankle Surgery, or American Board of Oral and Maxillofacial Surgery, in their respective specialties or proof of active progression toward Board Certification within 60 months of initial appointment. Those physicians appointed prior to June 1991 must demonstrate comparative ability, training and experience.

~~The Division of Subspecialty Surgery consists of physicians who practice within the medical specialties of Otolaryngology Head and Neck Surgery, Oral Maxillofacial Surgery and Plastic and Reconstructive Surgery. Members may be board certified by the American Board of Otolaryngology Head and Neck Surgery and/or by the American Board of Plastic and Reconstructive Surgery, or by the American Board of Oral and Maxillofacial Surgery. The Division of Subspecialty Surgery also consists of, dental specialists and/or dentists who are either Board Certified or Board Eligible (i.e. successful completion of an ADA accredited residency program) or are able to demonstrate comparable ability, training and experience. The Division will accommodate general dentists and dental specialists who demonstrate comparable ability, training and experience as required for licensure in California.~~

II. FUNCTIONS OF THE DIVISION

The general functions of the Division of Subspecialty Surgery shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Division and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;

C. Conduct, participate in and make regarding recommendations regarding continuing medical education programs pertinent to Division clinical practice;

D. Review and evaluate division member adherence to:
   1. Medical Staff policies and procedures;
   2. Sound principles of clinical practice;

E. Submit written minutes to the Medical Quality Peer Review Committee and Medical Executive Committee concerning:

1. Division review and evaluation of activities, actions taken thereon, and the results of such action; and
2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital;

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;

H. Recommend / Request Focused Professional Practice Evaluation as indicated for (pursuant Medical Staff Policy 8710-509);

I. Approve On-Going Professional Practice Evaluation Indicators; and

J. Formulate recommendations for Division rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. DIVISION MEETINGS

The Division of Subspecialty Surgery shall meet at the discretion of the Chief, but at least annually. The Division will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. ~~Minutes shall be transmitted to the Medical Quality Peer Review Committee, and then to the Medical Executive Committee.~~

Twenty-five percent (25%) of the Active Division members of the Department, but not less than two members, shall constitute a quorum at any meeting.

IV. DIVISION OFFICERS

The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be qualified by training and experience, and demonstrate ability in at least one of the clinical areas covered by the Division.

The Division Chief shall be elected every two years by the Active Staff members of the Division who are eligible to vote. If there is a vacancy by the officer for any reason, the Department Chairman shall designate a new Chief, or call a special election. The Chief shall be elected by a simple majority of the members of the Division.

The Division Chief shall serve a ~~one~~two-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from the office, or loses his/her Medical Staff membership or clinical privileges in the Division. Division officers shall be eligible to succeed themselves.

The Division shall have Specialty Chiefs who shall be a member of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the Division.

The Specialty Chiefs shall be elected every two years by the Active members of the Division who are eligible to vote. If there is a vacancy for any reason, the Department Chairman shall designate a new Specialty Chief, or call a special election. The Chief shall be elected by a simple majority of the members of the Specialty within the Division.

The Specialty Chief shall serve a two year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in the Division. Division officers shall be eligible to succeed themselves.

V. DUTIES OF THE DIVISION CHIEF

The Division Chief shall assume the following responsibilities:

A. Be accountable for all professional administrative activities of the Division;
B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;
C. Assure that practitioner's practice only within the scope of their privileges as defined within their delineated privilege form;
D. Recommend to the Department of Surgery and the Medical Executive Committee the criteria for clinical privileges in the Division;
E. Recommend clinical privileges for each member of the Division;
F. Assure that the quality, safety and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
G. Other duties as recommended from the Department of Surgery or the Medical Executive Committee.

I. DUTIES OF THE SPECIALTY CHIEF

The Specialty Chief shall assume the following responsibilities:

A. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form;
B. Recommend to the Department of Surgery and the Medical Executive Committee the criteria for clinical privileges in the Division;
C. Recommend clinical privileges for each member within their specialty
D. Assure that the quality, safety and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
E. Other duties as recommended from the Division Chair, Department of Medicine or the Medical Executive Committee.

I. CLASSIFICATIONS

The Division of Subspecialty Surgery has established the following classifications of surgical privileges:

A. Physicians/Surgeons

Division of Subspecialty Surgery members are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training, such as in the broad field of internal medicine although not necessarily at the level of a sub-specialist. Such physicians may act as consultants to others and may, in turn, be expected to request consultation when:

1. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life threatening illness;
2. Unexpected complications arise which are outside this level of competence;
3. Specialized treatment or procedures are contemplated with which they are not familiar.

B. Supervising Physician
1. A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients;
2. A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physicians specialty or usual customary practice and with the patient's health and condition.

C. Physician Assistants
1. A Physician Assistant may only provide those medical services, which he/she is competent to perform and which are consistent with the physician assistant's education, training and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant;
2. A physician assistant may not admit or discharge patients;
3. The Physician Assistant must adhere to the Allied Health Practitioner (AHP) Rules & Regulations.

D. Nurse Practitioner as Surgical First Assist
1. The Nurse Practitioner is a Registered Nurse who is a nationally certified Perioperative Nurse (CNOR) through the Association of Peri-Operative Registered Nurses (AORN) or certified by the State of California Board of Registered Nursing as a Nurse Practitioner and has successfully completed an AORN-approved Registered Nurse First Assist (RNFA) course.
2. The Nurse Practitioner practices under the supervision of the surgeon during the preoperative, intraoperative, and postoperative phases of the perioperative experience.
3. The Nurse Practitioner functions under standardized procedures and must adhere to the Allied Health Practitioner (AHP) Rules & Regulations.

E. Orthopedic Surgery Technician – See Orthopedic Surgery Technician privilege card.

VI. PRIVILEGES

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Department;

B. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified;

C. Proctoring shall be performed by a member of the Medical Staff at TCMC with the same privileges being proctored.

VII. REAPPOINTMENT OF CLINICAL PRIVILEGES

Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the practitioner will be required to undergo proctoring for all procedures that were not satisfied. The practitioner will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VII. PROCTORING OF PRIVILEGES

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor with current unrestricted privileges as indicated until his or her privilege status is established by a recommendation from the Division Chief to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors;

B. All Active members of the Division will act as proctors. One or all of the member's associates may monitor up to 50% of the required proctoring. Additional cases may be proctored as recommended by the Division Chief. It is the responsibility of the Division Chief to inform the monitored member whose proctoring is being continued whether the deficiencies noted are in: a) preoperative, b) operative, c) surgical technique and/or, d) postoperative care;

C. Supervision of the member by the proctor will include concurrent review for invasive cases or retrospective chart review of cognitive processes for noninvasive cases and direct observation of procedural techniques. The monitor must be present in the Operating Room for a sufficient period of time to assure himself/herself of the member's competence. ;

D. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled);

E. The member shall have free choice of suitable consultants and assistants. The proctor may assist the surgeon;

F. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports;

G. A form shall be completed by the proctor, and should include comments on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified); Blank forms will be available at the front desk in the O.R. or at the Medical Staff Department and provided to the proctor for completion.

H. Forms will be made available to the member scheduling the case for surgery and immediately forwarded to the proctor for completion. It is the responsibility of the new member to notify the Operating Room personnel of the proctor for each case;

I. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.

VIII. EMERGENCY DEPARTMENT CALL

Active Medical Staff Division members may participate in the Emergency Department Call Roster subject to the mandatory Medical Staff Bylaws requirement (Section 3.2-2) as needed or consultation panel as determined by the Medical Staff. Please refer to Medical Staff Policy and Procedure 8710-520.

Consulting and Provisional staff members may participate in the Emergency Department Call Roster at the discretion of the Chief of the Division. The care provided by an on-call physician will not create an obligation to provide further care.

Provisional staff members may participate on the Emergency Department Call Roster at the discretion of the Chief of the Division.

APPROVALS:

Division of Subspecialty Surgery:	~~11/29/2016~~3/20
Department of Surgery:	~~12/12/2016~~4/20
Medical Executive Committee:	01/23/2017
Board of Directors:	01/26/2017

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

NP - Interventional Radiology - (Revised ~~2/19~~2/20)

Provider Name:

Request	Privilege

Criteria:
The nurse practitioners must have the following:
1. Valid, California Registered Nurse license;
2. Successful completion of a Board of Registered Nursing approved Nurse Practitioner program;
3. Certification by the State of California, Board of Registered Nursing as a Nurse Practitioner;
4. Successful completion of the Family, Geriatric, or Adult Nurse Practitioner Credentialing examination or equivalent national specialty certification (preferred);
5. If furnishing drugs and devices, the Nurse Practitioner must possess a furnishing license;
6. Nurse Practitioners wishing to furnish Schedule II controlled substances are required to complete a Board of Registered Nursing approved three (3) hour continuing education course as well as possess a current, valid DEA certificate to prescribe Schedule II-V drugs.

The following privileges may be performed by the Nurse Practitioner in accordance with standardized procedures and protocols.

Proctoring: Ten (10) cases (proctoring for Therapeutic Procedures may be used towards fulfilling this general proctoring requirement.)
Reappointment: Satisfactory evaluation by supervising physician.

___ **General Patient Care Privileges:**

By selecting this privilege, you are requesting the General Patient Care privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Perform history and physical exam

Furnish drugs consistent with the TCMC Formulary and as outlined in the standardized procedures and protocols.

Furnish Schedule II-V controlled substances per the patient specific protocol and per the standardized procedures and protocols. Physician consultation and approval will be obtained prior to furnishing medication.

General evaluation of health status, including but not limited to ordering laboratory procedures, x-rays, respiratory therapy, rehabilitation therapies (physical therapy, occupational therapy, and speech therapy)

Recommend therapeutic diets and exercise

Provide patient education and counseling

Refer to physician or specialty clinic when the diagnosis and/or treatment are beyond the scope of the nurse's knowledge and/or skills, or for those conditions that require consultation

___ **Therapeutic Procedures:** A supervising physician must be physically present in the Radiology Department before therapeutic procedures can be carried out.

By selecting this privilege, you are requesting the Therapeutic Procedures privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Abscess drainage tube manipulation / resuturing

Tri-City Medical Center MEDICAL STAFF

Clinical Privilege Request Form

NP - Interventional Radiology - (Revised ~~2/19~~2/20)

Provider Name:

Request	Privilege

___ Bone marrow biopsy, image guided

Proctoring: Five (5) cases

Central line insertion: Jugular line insertion

Proctoring: Three (3) cases

Central line insertion: PICC line insertion

Proctoring: Three (3) cases

Chest tube removal

Keo feeding tube insertion/Nasogastric tube insertion

Lumbar puncture

Proctoring: Three (3) cases

Paracentesis/Arthrocentesis (i.e. hip injections)/Thoracentesis

Proctoring: Three (3) cases

Peripheral IV line insertion

Removal of drains and tubes

Removal of tunneled catheter

Removal of venous port (Mediport)

Subcutaneous local anesthesia

Suturing and suture removal

___ Moderate Sedation: Refer to Medical Staff policy 8710-517

APPLICANT:

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

_____

Print Applicant Name

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

NP - Interventional Radiology - (Revised ~~2/19~~2/20)

Provider Name:

Request	Privilege

_____

Applicant Signature

_____

Date

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

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

_____

Print Name of Sponsoring Physician

_____

Sponsoring Physician Signature

_____

Date

Approval:

_____

Division/Department Signature (By Signing this form I agree with the granting of these privileges indicated above.)

_____

Date

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Interventional Radiology
Standardized Procedures

Approvals

Radiology Department (Signature): _____

Interdisciplinary Practice Committee (Date): April 21, 2020

Medical Executive Committee (Date): _____

Board of Directors (Date): _____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

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

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

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

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

1. SETTING

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

2. SCOPE OF NP PRACTICE (FUNCTIONS)

The Interventional Radiology NP will:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a) Gastrostomy Tube Placement Order Set CITY v1

b) IR Chemoembolization CITY v1

c) IR Chest Tube Placement CITY v1

d) IR Dialysis Intervention CITY v1

e) IR G-JG Procedure CITY v1

f) IR Image Guided Biopsy/Fiducial Marker CITY v1

g) IR Image Guided Drainage CITY v1

h) IR Image Guided Lung Biopsy CITY v1

i) IR Paracentesis Thoracentesis CITY v1

j) IR Percutaneous GU/GI Drainage CITY v1

k) IR Port/Tunneled Catheter CITY v1

l) IR Stroke/Neurovascular Intervention CITY v1

m) IR TIPS CITY v1

n) IR Tube Check CITY v1

o) IR Vertebral Augmentation CITY v1

p) Paracentesis Orders CITY v1

q) PICC Insertion Request CITY v1

r) Thoracentesis Orders CITY v1

~~a. IR Intra-Specialized Orders~~

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

~~c. IR Intra-Vascular-Procedure Medication Orders~~

~~d. IR Lung Biopsy Multiphase~~

~~e. IR Lung Biopsy Post Procedure~~

~~f. IR Lung Biopsy Pre-Procedure~~

~~g. IR MRI with Sedation Multiphase~~

~~h. IR Percutaneous GU/GI Drainage Multiphase~~

~~i. IR Port/Tunneled Catheter Multiphase~~

~~j. IR Port/Tunneled Catheter Post Procedure~~

~~k. IR Port/Tunneled Catheter Pre Procedure~~

~~l. IR Stroke and Neurovascular Intervention Post Procedure~~

~~m. IR Stroke and Neurovascular Intervention Pre Procedure~~

~~n. IR Stroke/Neurovascular Intervention Multiphase~~

~~o. IR TIPS Multiphase Plan~~

~~p. IR Thrombolysis Intervention Post Procedure~~

~~q. IR Tube Check Multiphase~~

~~r. IR Tube Check Post Procedure~~

~~s. IR Tube Check Pre Procedure~~

~~t. IR Vertebral Augmentation Post Procedure~~

~~u. IR Vertebral Augmentation Pre Procedure~~

III. MANAGEMENT OF CONTROLLED SUBSTANCES

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

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

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

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

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

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

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

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

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

b) Acute exacerbation of a patient's situation;

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

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

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

f) Upon request of the NP.

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

V. QUALIFICATIONS - EDUCATION AND LICENSING

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

VI. QUALITY IMPROVEMENT

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

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

VII. Practice Prerogatives

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

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

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

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Neurosurgery Standardized Procedures

Approvals

Subspecialty Surgery Division (Signature): 

Surgery Department (Signature): _____

Interdisciplinary Practice Committee (Date): April 21, 2020

Medical Executive Committee (Date): _____

Board of Directors (Date): _____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

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

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

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

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

1. SETTING

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

2. SCOPE OF NP PRACTICE (FUNCTIONS)

The Neurosurgery NP will:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a) NEURO Craniotomy Multi Phase
b) NEURO Post Operative Multi Phase
c) NEURO Spine Post Operative Multi Phase Plan
d) NEURO Ventriculostomy (ICP) Management

III. MANAGEMENT OF CONTROLLED SUBSTANCES

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

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

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

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

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

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

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

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

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

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

V. QUALIFICATIONS - EDUCATION AND LICENSING

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

VI. QUALITY IMPROVEMENT

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

VII. Practice Prerogatives

As determined by the NP – Surgical First Assist - Neurosurgery.

Acknowledgement Statements:

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

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

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

NP - Surgical First Assist - Neurosurgery

Provider Name:

Request	Privilege

___ Order or transmit order for x-ray, labs/other diagnostic studies, physical and rehab therapy, and occupational therapy (speech-language pathology)

___ Furnish medications in accordance with standardized procedures and protocols (must have furnishing number and valid DEA certificate)

___ Assist in Mazor robotic surgery - Refer to Credentialing Policy, Mazor Robotic Surgery #8710-566

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

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

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

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

_____
Print Name of Sponsoring Physician

_____
Sponsoring Physician Signature

_____
Date

Approval:

_____

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

NP - Surgical First Assist - Neurosurgery

Provider Name:

Request	Privilege

Division/Department Signature (By Signing this form I agree with the granting of these privileges indicated above.)

_____

Date

Tri-City Medical Center

Allied Health Professional

Certified Nurse Midwife
Standardized Procedures

Approvals

OB/GYN Department (Signature): _____

Interdisciplinary Practice Committee (Date): April 21, 2020

Medical Executive Committee (Date): _____

Board of Directors (Date): _____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF CNM STANDARDIZED PROCEDURES

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

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

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

II. SETTING AND SCOPE OF CNM PRACTICE (FUNCTIONS)

1. SETTING

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

2. SCOPE OF CNM PRACTICE (FUNCTIONS)

The OB/GYN CNM will:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~g.~~e. Discharge Women's

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

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

~~j.~~h. OB 2016 ~~Postpartum~~ L&D Vaginal Delivery

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

III. MANAGEMENT OF CONTROLLED SUBSTANCES

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

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

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

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

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

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

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

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

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

V. QUALIFICATIONS - EDUCATION AND LICENSING

1. Education and training:
   a) Master's degree in Nursing from an accredited college or university; AND
2. Licenses and Certification:
   a) Current, valid RN license issued by the California Board of Registered Nursing
   b) Current, valid NM certificate issued by the California Board of Registered Nursing
   c) Current Furnishing Number issued by the California Board of Registered Nursing
   d) Current certification (or actively pursuing certification; must be certified within one year of initial appointment) by the American Midwifery Certification Board (formerly the ACNM Certification Council, Inc.) College of Nurse Midwives
   e) Current, valid NRP certificate
   f) Current, valid DEA registration
   g) Documentation of participation in relevant continuing education activities.

VI. QUALITY IMPROVEMENT

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

a) Documentation of participation in relevant continuing education activities.

VII. Practice Prerogatives

1. As determined by the Certified Nurse Midwife Card.

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

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

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Certified Nurse Midwife

Provider Name:

Request	Privilege

Criteria:

Certified Nurse Midwives (CNM) practicing in the Department of OB/GYN must:

1. Have a sponsoring physician, confirmed in writing, who is an "Active" Medical Staff member with an unrestricted California medical license, who is actively involved in patient care encounters, and is in good standing at TCMC and who agrees in writing to provide ongoing assessment and continuous overview of the AHP's clinical activities while in the hospital. Additionally, written confirmation by each supervising physician(s) who has an unrestricted California medical license, is actively involved in patient care encounters, and is in good standing at TCMC, and who agrees to provide ongoing assessment and continuous overview of the AHP's clinical activities while in the hospital;
2. Possess a valid and current license as a registered nurse in the State of California;
3. Possess a valid and current certification as a nurse midwife in the State of California;
4. Possess a current furnishing number issued by the State of California;
5. Possess current certification or actively pursuing certification by the American College of Nurse Midwives;
   a. If CNM is not certified by the American College of Nurse Midwives at the time of initial appointment, the CNM must become certified within one (1) year from initial appointment date.
6. Possess a valid and current NRP (Neonatal Resuscitation) certificate;
7. Possess a current, valid U.S. Drug Enforcement Administration (DEA) certificate;
8. Meet and fulfill recent clinical experience defined within their scope of practice that includes training, experience, and demonstration of current clinical competence at an acceptable level of quality and efficiency while in a Joint Commission-accredited hospital in the last two years;
9. ACLS (Advanced Cardiac Life Support) certification is recommended, but not required.

___ Provide admission orders, including a complete history and physical; diagnosis of labor and assessment of the maternal well-being and risk status under the supervising physician(s) (Countersigned by supervising physician within 48 hours).

___ May prescribe medication orders in accordance with standardized procedures and approved formulary. Must have current furnishing number and DEA certificate.

___ Antenatal evaluation of fetal well-being by monitoring and interpretation of stress and non-stress tests.

___ Limited obstetrical ultrasound - AFI and fetal presentation

___ Routine admission orders such as laboratory and diagnostic tests as necessary

___ Management of uncomplicated labor inclusive of pelvic examination, amniotomy, external and internal monitoring, and analgesia using intramuscular and intravenous narcotics and potentiators.
Proctoring: Fifteen (15) cases (five (5) concurrent and ten (10) retrospective)

___ Administer local infiltration of anesthesia

___ Perform episiotomies, including repair of episiotomy and lacerations (1st or 2nd degree)

___ Management of uncomplicated vertex delivery inclusive of episiotomy and lacerations

___ Uterine exploration and manual removal of placenta

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Certified Nurse Midwife

Provider Name:

Request	Privilege

___ Initial routine care of newborn, inclusive of aspiration with syringe and assignment of APGAR scores

___ Care of mother immediately after delivery, which is consistent with physician co-management defined in the standardized procedures

___ Assessment, management and discharge of normal postpartum patients

___ Provide emergency care for complications, including resuscitation of the newborn by bag and mask, or endotracheal intubation (NRP certification required)

___ First assist at c-section only (specific tasks of retraction, suction, ligation, clamping, sponging, and cutting sutures)
Initial: Documentation of appropriate training/education required
Proctoring: Two (2) Cesarean Section assists

___ Evaluate and facilitate breastfeeding during the postpartum period

___ Authority of midwife management under specific circumstances per standardized procedures

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

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

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

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

_____
Print Name of Sponsoring Physician

_____
Sponsoring Physician Signature

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Certified Nurse Midwife

Provider Name:

Request	Privilege

_____
Date

Approval:

_____
Division/Department Signature (By Signing this form I agree with the granting of these privileges indicated above.)

_____
Date

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

RNFA - RN First Assist (2/20)

Provider Name:

Request	Privilege

SERVICE AUTHORIZATION FOR RN FIRST ASSISTANT (RNFA)

Initial:

1. Current California RN license.
2. Certified in advanced cardiopulmonary life support (ACLS).
3. Nationally certified peri-operative nurse (CNOR) through the Association of Operating Room Nurses (AORN).
4. Successful completion of a structured and approved AORN RNFA course.
5. Three (3) years operating experience in both the scrub and circulating roles.
6. Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring physician.
7. Sponsorship by a Department of Surgery medical staff member who is in good standing of the TCMC Medical Staff.
8. Approval from the surgical sub-specialty of the sponsoring physician.

Proctoring: Six (6) cases

Cardiac RNFA must also have three (3) years operating experience in both scrub and circulating roles in cardiothoracic surgery.

Proctoring Cardiac RNFA: Ten (10) cases, 8 cases must be cardiac cases

___ **PROCEDURE(S):**

INTRAOPERATIVE RETRACTIONS:

___ Retract Tissue or organs by use of hand

___ Place or hold surgical retractors

___ Pack sponges into body cavity to hold tissues or organs out of the operative field

___ Manage all instruments in the operative field

INTRAOPERATIVE HOMEOSTASIS

___ Aspiration of blood and other fluids from the operative site

___ Sponge wounds or other areas of dissection

___ Clamp bleeding tissue or vessels

___ Using suture to clamp blood vessels or other bleeding tissue

___ Cauterize and approximate tissue

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

RNFA - RN First Assist (2/20)

Provider Name:

Request	Privilege

___ Place hemoclip or ligating sutures on vessels or tissue

INTRAOPERATIVE TISSUE MANIPULATION:

___ Expose and retract tissue

___ Clamp and sever tissue

___ Grasp and fixate tissue with screws or staples

___ Cauterize and approximate tissues

INTRAOPERATIVE WOUND CLOSURE:

___ Staple skin closure

___ Suture skin closure

___ Apply surgical dressing

___ Assist with applying casts, braces, or plaster splints

___ Care and removal of drains

___ Other: Initiation & Discontinuation of Cardio Pulmonary Bypass - Cardiac RNFA

___ Other: Vein Harvest - Cardiac RNFA

___ Other: Hold camera during laparoscopy/hysteroscopy, assist cesarean section

___ Assist in Mazor robotic surgery - Refer to Credentialing Policy, Mazor Robotic Surgery #8710-566

___ Assist in Xi Robotic

Initial Criteria: Must meet initial and reappointment for Core Robotic assisted privileges and provide certificate of training for Xi Robotic from Intuitive prior to case

Proctoring: Must meet proctoring criteria for Assisting in Da Vinci Robotic Surgery

___ Assist in Makoplasty (Mako) total knee arthroplasty

Initial:

--Currently privileged to assist in surgery AND documentation of completion of Mako or comparable hands-on training program.

Proctoring: One (1) case concurrently proctored by a Mako credentialed/experienced/faculty physician.
If the assistant is privileged to perform Mako-guided knee arthroplasty and has been released from proctoring in the surgeon role, no additional proctoring is required in the assistant role.

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

RNFA - RN First Assist (2/20)

Provider Name:

Request	Privilege

Reappointment: 5 (five) cases per two-year reappointment cycle

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

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

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

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

_____
Print Name of Sponsoring Physician

_____
Sponsoring Physician Signature

_____
Date

Approval:

_____
Division/Department Signature (By Signing this form I agree with the granting of these privileges indicated above.)

_____
Date

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

PA - Physician Assistant - (Revised ~~8/14~~2/20)

Provider Name:

Request	Privilege

DELINEATION OF PRIVILEGES FOR PHYSICIAN ASSISTANT

Initial: The Physician Assistant must have successfully completed a training program approved by the national accrediting organization and recognized by the Physician Assistant Committee and pass a written examination given under the direction of the Committee. The Physician Assistant must provide documentation that they have participated as a Physician Assistant for no less than 20 general surgical cases.

Proctoring: Six (6) total cases from this privilege card need to be proctored by your sponsoring physician.

___ Take a patient history; perform a physical examination and make an assessment and diagnosis therefrom; initiate, review and revise treatment and therapy plans, record and present pertinent data in a manner meaningful to the physician.

___ Order or transmit an order for x-ray, other studies, therapeutic diets, physical/rehab therapy, occupational/speech therapy, respiratory therapy, and nursing services.

___ Order, transmit an order for, perform, or assist in the performance of laboratory procedures, screening procedures and therapeutic procedures.

___ Recognize and evaluate situations that call for immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient.

___ Instruct and counsel patients regarding matters pertaining to their physical and mental health. Counseling may include topics such as medications, diets, social habits, family planning, normal growth and development, aging, and understanding of and long-term management of their diseases.

___ Initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care, including patients at home.

___ Initiate and facilitate the referral of patients to the appropriate health facilities, agencies and resources of the community.

___ Order and administer medications. A physician assistant may not administer, provide or transmit a prescription for controlled substances in schedules II through V without patient-specific authority by a supervising physician. A physician assistant may not order chemotherapy agents.

___ A physician assistant may also act as first or second assistant in surgery, under supervision of an approved supervising physician, including acting as a second assist during cardiac procedures using cardiopulmonary bypass.

___ Perform open harvesting of saphenous vein for use as bypass conduit for cardiac and vascular surgery under the direct supervision of surgeon.

___ Assist in Mazor robotic surgery - Refer to Credentialing Policy, Mazor Robotic Surgery #8710-566

___ Assist in Xi Robotic

Initial Criteria: Must meet initial and reappointment for Core Robotic assisted privileges and provide certificate of training for Xi Robotic from Intuitive prior to case

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

PA - Physician Assistant - (Revised ~~8/14~~2/20)

Provider Name:

Request	Privilege

Proctoring: Must meet proctoring criteria for Assisting in Da Vinci Robotic Surgery

___ Assist in Makoplasty (Mako) total knee arthroplasty

Initial:

--Currently privileged to assist in surgery AND documentation of completion of Mako or comparable hands-on training program.

Proctoring: One (1) case concurrently proctored by a Mako credentialed/experienced/faculty physician.
If the assistant is privileged to perform Mako-guided knee arthroplasty and has been released from proctoring in the surgeon role, no additional proctoring is required in the assistant role.

Reappointment: 5 (five) cases per two-year reappointment cycle

ADDITIONAL PRIVILEGES

Requests for additional privileges must be accompanied by documentation of training and/or experience. Proctoring is required for all additional privileges and will be determined by the Department/Division Chair/Chief. This privilege requires approval of the Cardiothoracic Surgery Division.

___ Harvesting of saphenous vein for use as bypass conduit for cardiac and vascular surgery using endoscopic techniques.

APPLICANT:

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

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

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

SPONSORING PHYSICIAN:

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

_____
Print Name of Sponsoring Physician

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

PA - Physician Assistant - (Revised ~~8/14~~2/20)

Provider Name:

Request	Privilege

_____

Sponsoring Physician Signature

_____

Date

Approval:

_____

Division/Department Signature (By Signing this form I agree with the granting of these privileges indicated above.)

_____

Date

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Orthopaedic Surgery - (Revised 2/~~19~~20)

Provider Name:

Request	Privilege

CRITERIA FOR OBTAINING PRIVILEGES: Must be Board Certified within the first 36 months of Board Eligibility, actively pursuing certification by the American Board of Orthopedic Surgery, or able to demonstrate comparable ability, training and experience. Documentation of training must be provided for additional privileges requested and proctoring of the additional privileges will apply as stated under each privilege.

SITES:
All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056.
Privileges annotated with (F) may be performed at 3925 Waring Road, Suite C, Oceanside CA 92056.
All practitioners who currently hold the privilege to "consult" and/or "perform a history and physical examination" may also perform these privileges via telemedicine.

___ Admit Patients

___ Consultation, including via telemedicine (F)

___ Perform History & Physical Exam, including via telemedicine (F)

BASIC ORTHOPEDIC PRIVILEGES
Initial Criteria: See Basic Qualifications

___ Repair Lacerations (F)

___ Foreign Body Removal (F)

___ Manipulation Joints

___ Tendon Surgery

___ Biopsy (Bone / Soft Tissue)

___ Soft Tissue Management (Debridement) (F)

___ Peripheral Nerve Surgery

___ Skin Grafts

___ Chymopapain

ADVANCED ORTHOPEDIC PRIVILEGES
For Initial, Reappointment and Proctoring criteria see above privilege requested.

Initial: Prerequisite would include evidence of training in residency and/or fellowship of arthroscopic experience, documented by Director of Program and/or documented past case experience, including operative reports and/or documentation of continuing education course in arthroscopic surgery including motor skill which is approved for CME Credit

Provider Name:

Request	Privilege

and 20 cases submitted from the last 12 months.
Proctoring: Two (2) cases
Reappointment: Four (4) cases per two year reappointment cycle

___ Arthroscopy Surgery for Knee, Shoulder, Elbow, Hand, Ankle, Wrist & Hip Joints

Initial: Criteria as stated above
Proctoring: (2) cases must be proctored
Reappointment: (4) cases are required per every two year reappointment cycle

___ Ligament Reconstruction

Initial: Criteria as stated above
Proctoring: (2) cases must be proctored
Reappointment: (4) cases are required per every two year reappointment cycle

___ Bone Grafting

___ Arthrodesis of Extremities

Initial: Criteria as stated above
Proctoring: (2) cases must be proctored
Reappointment: (4) cases are required per every two year reappointment cycle

___ Osteotomy

EXTREMITY-FRACTURES:
Initial: Criteria as stated above
Reappointment: A total of (4) procedures from this category are required for recredentialing of the entire category of procedures.

___ Internal Fracture Fixation (includes joint hemiarthroplasty for fracture repair)

___ External Fracture Fixation (includes joint hemiarthroplasty for fracture repair)

___ Fracture Treatment of hand

___ Pelvic Fracture Care (Open / Closed)

EXTREMITY-DISLOCATION:
Initial: Criteria as stated above

___ Internal Fixation, Dislocation

___ External Fixation, Dislocation

AMPUTATIONS:
Initial: Initial criteria as stated above and (5) cases within the last 24 months or a list from Residency program.

Provider Name:

Request	Privilege

___ Elective amputation

___ Traumatic amputation

TOTAL JOINT ARTHROPLASTY
Initial: Initial criteria as stated above and (10) cases within the last 24 months or a list from Residency program.
Proctoring: (2) cases from each type of arthroplasty need to be proctored
Reappointment: A total of (4) procedures from this category are required for recredentialing of the entire category of procedures.

___ Ankle, Arthroplasty

___ Hip, Arthroplasty

___ Knee, Arthroplasty

___ Shoulder, Arthroplasty

___ Wrist, Arthroplasty

BLUE BELT NAVIO PFS (BBN) GUIDED KNEE ARTHROPLASTY
Criteria:
BBN Primary Surgeon
Initial: The surgeon must be currently privileged to perform underlying procedure without BBN guidance, AND have one of the following:
a. Documentation of training in residency/fellowship and log of ten (10) cases; OR
b. Certificate of completion of BBN or comparable hands-on training program and documentation of ten (10) cases beyond proctoring from another institution; OR
c. Certificate of completion of BBN or comparable hands-on training program.
Proctoring:
a.& b. One (1) case concurrently proctored by a BBN credentialed/experienced/faculty physician
c. Three (3) cases concurrently proctored by a BBN credentialed/experienced/faculty physician
Reappointment: Four (4) cases per two-year reappointment cycle

BBN Assistant
Initial: One of the following:
a. Currently privileged to perform BBN-guided knee arthroplasty; OR
b. Currently privileged to assist in surgery AND documentation of completion of BBN or comparable hands-on training program.
Proctoring: One (1) case concurrently proctored by a BBN credentialed/experienced/faculty physician.
If the assistant is privileged to perform BBN-guided knee arthroplasty and has been released from proctoring in the surgeon role, no additional proctoring is required in the assistant role.
Reappointment: Four (4) cases per two-year reappointment cycle

___ Blue Belt Navio PFS (BBN) guided knee arthroplasty

___ Assist in Blue Belt NavioPFS (BBN) guided knee arthroplasty

Provider Name:

Request	Privilege

Makoplasty (Mako) Guided Knee Arthroplasty
Criteria:

Mako Primary Surgeon:
Initial: The surgeon must be currently privileged to perform underlying procedure without Mako guidance, AND have one of the following:

a. Documentation of training in residency/fellowship and a log of (10) cases; OR
b. Certificate of completion of Mako or comparable hands-on training program.

Proctoring:

a. One (1) case concurrently proctored by a Mako credentialed physician
b. Three (3) cases concurrently proctored by a Mako credentialed physician

Reappointment: Five (5) cases per two-year reappointment cycle

___ Makoplasty (Mako) total knee arthroplasty

Mako Assistant:
Initial:

--Currently privileged to assist in surgery AND documentation of completion of Mako or comparable hands-on training program.

Proctoring: One (1) case concurrently proctored by a Mako credentialed/experienced/faculty physician.
If the assistant is privileged to perform Mako-guided knee arthroplasty and has been released from proctoring in the surgeon role, no additional proctoring is required in the assistant role.
Reappointment: 5 (five) cases per two-year reappointment cycle

___ Assist in Makoplasty (Mako) total knee arthroplasty

MINOR TOTAL JOINT ARTHROPLASTY
Initial: Criteria as stated above
Proctoring: (2) cases from each type of arthroplasty need to be proctored
Reappointment: A total of (4) procedures from this category are required for recredentialing of the entire category of procedures.

___ Fingers, Arthroplasty

___ Toes, Arthroplasty

HAND SURGERY:
Initial: Initial criteria as stated above and (10) cases within the last 12 months or a list from Residency program.
Proctoring: (2) cases from this category need to be proctored
Reappointment: A total of (4) procedures from this category are required for recredentialing of the entire category of procedures.

___ Microvascular Replantation (Hand)

___ Microvascular / Tissue Transfer (Hand)

___ Nerve Repair of hand

___ Tendon Repair (flexor & extensor tendon repair hand)

Provider Name:

Request	Privilege

___ Vascular lesion repair of extremities (Hand)

___ Vein graft to vascular lesion in extremities (Hand)

SPINE:
Initial: Initial criteria as stated above and (10) cases within the last 12 months or a list from Residency program.
Proctoring: (2) cases from this category need to be proctored
Reappointment: A total of (4) procedures from this category are required for recredentialing of the entire category of procedures.

___ Cervical Discectomy

___ Implantables (i.e. spinal cord stimulator)

___ Laminectomy

___ Pedicle Screw

___ Percutaneous and subcutaneous implantation of neurostimulator electrodes and pulse generator

___ Plating

___ Spinal Fixation

SPINAL ARTHRODESIS:
Initial: Initial criteria as stated above
Proctoring: (2) cases from this category need to be proctored
Reappointment: A total of (4) procedures from this category are required for recredentialing of the entire category of procedures.

___ Cervical, Spinal Arthrodesis

___ Lumbar, Spinal Arthrodesis

___ Thoracic, Spinal Arthrodesis

FRACTURE TREATMENT OF THE SPINE:
Initial: Initial criteria as stated above

___ Open Fracture Treatment of the Spine

___ Closed Fracture Treatment of the Spine

CERVICAL FRACTURE TREATMENT:
Initial: Initial criteria as stated above

___ Open Cervical Fracture Treatment

Provider Name:

Request	Privilege

___ Closed Cervical Fracture Treatment

MAZOR ROBOTIC SURGERY:

___ Mazor robotic surgery - Refer to Credentialing Policy, Mazor Robotic Surgery #8710-566

___ Assist in Mazor robotic surgery - Refer to Credentialing Policy, Mazor Robotic Surgery #8710-566

OTHER:

Initial Criteria:
1. MD or DO
2. Complete ACGME/AOA accredited residency program and board certified/eligible in Orthopedic Surgery, Neurosurgery, Neuroradiology, or Radiology AND one of the following:
a. Fellowship training in Spine Surgery or Interventional Radiology or;
b. Current Competence in spine surgery or interventional spine procedures (10 cases in past two years without significant complications)
3. Valid Fluoroscopy Supervisor and Operator permit.
4. Completed training in vertebral augmentation. Evidence of training may be provided via either a certificate of completion from the applicant's vertebral augmentation training program or letter of reference from the director/chief of spine surgery or interventional radiology where applicant currently or most recently has practiced.

Proctoring: Five (5) cases performed during the first twelve (12) months after granting of the privilege by a member of the medical staff with unsupervised vertebral augmentation privileges.

Reappointment: Ten (10) vertebral augmentation procedures performed during the reappointment cycle with acceptable success and complication rates.

___ Vertebral Augmentation (Policy #534)

___ Moderate Sedation - Refer to Medical Staff policy 8710-517

___ Fluoroscopy in accordance with hospital policy
(Refer to Medical Staff Policy #528 and 528A)

_____
Print Applicant Name

_____
Applicant Signature

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Orthopaedic Surgery - (Revised 2/~~19~~20)

Provider Name:

Request	Privilege

_____
Date

_____
Division/Department Signature (By Signing this form I agree with the granting of these privileges indicated above.)

_____
Date

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

Standards for Allied Health Professionals

Registered Nurse First Assist (RNFA)

TABLE OF CONTENTS

[1] **1. RNFAs qualified to perform cardiac surgery may perform all aforementioned standardized procedures. Non-cardiac qualified RNFAs may perform all aforementioned standardized procedures with the exception of (B) "Registered Nurse First Assist (RNFA) – Cardiac Surgery"**

MEDICAL STAFF

Standards for Allied Health Professionals

Registered Nurse First Assist (RNFA)

A. Scope of Service

1. The Registered Nurse First Assist (RNFA) renders direct patient care as part of the perioperative role by assisting the surgeon in the surgical treatment of the patient. The responsibility of functioning as first assistant must be based on documented knowledge and skills acquired after specialized preparation and formal instruction.
2. The RNFA is authorized to perform in an expanded role and may assist on procedures which specify that a first assistant and second assistant is required. The safety and welfare of the patient should be given primary consideration in the selection of a first assistant in surgery. In the absence of a qualified physician, the registered nurse who possesses appropriate knowledge and technical skills is the best qualified non-physician to serve as the first assistant.
3. The RNFA may assist the surgeon during a surgical procedure with specified technical functions. These specific technical functions are:
    a. Intraoperative retraction - Assist with the positioning, prepping and draping of the patient or perform these independently, if so directed by the surgeon.
        i. Provide retraction by:
            a. Closely observing the operative field at all times.
            b. Demonstrating stamina for sustained retraction.
            c. Retaining manually controlled retractors in the position set by the surgeon with regard to surrounding tissue.
            d. Managing all instruments in the operative field to prevent obstruction of the surgeon's view.
            e. Anticipating retraction needs with knowledge of the surgeon's preferences and anatomical structures.
    b. Intraoperative hemostasis - Provide hemostasis by:
            a. Applying electrocautery tip to clamps or vessels in a safe and knowledgeable manner as directed by the surgeon.
            b. Sponging and utilizing pressure as necessary.
            c. Utilizing suctioning techniques.
            d. Applying clamps on superficial vessels and the tying off, electrocoagulation of them as directed by the surgeon.
            e. Placing suture ligatures in the muscle, subcutaneous, and skin layers.
            f. Placing hemoclips on bleeders as directed by the surgeon.
    c. Intraoperative tissue manipulation
    d. Intraoperative wound closure:
        i. Perform knot tying by:
            a. Having knowledge of the basic techniques.
            b. Tying knots firmly to avoid slipping.
            c. Avoiding undue friction to prevent fraying of suture.
            d. Carrying knot down to the tissue with the tip of the index finger and laying the strands flat.
            e. Approximating tissue rather than pulling tightly to prevent tissue necrosis.
        ii. Provide closure of layers by:
            a. Correctly approximating the layers under the direction of the surgeon.
            b. Demonstrating knowledge of different types of closure.
            c. Correctly approximating skin edges when utilizing skin staples.

e. Assist the surgeon at the completion of the procedure by:
   a. Affixing and stabilizing all drains.
   b. Cleaning the wound and applying the dressing.
   c. Assist with applying casts or plaster splints.

f. The RNFA will assist the surgeon with setting up and removing the patient from cardiopulmonary bypass.

4. The RNFA practices under the direct supervision of the surgeon during the surgical intervention.
5. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nursing Practice Act of the State of California.

NOTE: The above specifications are general guidelines and do not reflect all duties in all specialty areas. Therefore, they should not preclude the performance of other duties, which, in the judgment of the surgeon, can be successfully accomplished by the RN First Assistant. However, the RN First Assistant must know his/her limitations and may refuse to perform those functions for which he/she has not been prepared or which he/she does not feel capable of performing.

B. **Qualifications**
1. Current California RN license.
2. Certified in advanced cardiopulmonary life support (ACLS).
3. Nationally certified peri-operative nurse (CNOR) through the Association of Operating Room Nurses (AORN).
4. Successful completion of a structured and approved AORN RNFA course.
5. Three (3) years operating experience in both the scrub and circulating roles.
6. Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring physician.
7. Sponsorship by a Department of Surgery medical staff member who is in good standing of the TCMC Medical Staff.
8. Approval from the surgical sub-specialty of the sponsoring physician.

C. **Scope of Practice**
1. Refer to RNFA Standardized Procedures.

D. **Skills**
1. Refer to RNFA Standardized Procedures.

E. **Supervision**
1. The RNFA shall be supervised by his/her Medical Staff Sponsor.

F. **Proctoring**
1. The RNFA shall be proctored for a minimum of his/her first ten (10) cases using the "Skills Inventory Checklist".
2. The written evaluations (Skills Inventory Checklists) must be completed and returned to the Medical Staff Services Office within 30 days of the procedure.

MEDICAL STAFF

STANDARDIZED PROCEDURE: Registered Nurse First Assistant (RNFA) – Cardiac Surgery

I. **POLICY:**
- A. Function: To provide guidelines for the RNFA assisting a surgeon in the first or second assistant role.
- B. Circumstances:
  1. Setting: Open Operating Room at Tri-City Medical Center.
  2. Supervision: Requires the direct supervision of the primary surgeon.
  3. The RNFA must perform only as first assistant and not concurrently as the scrub nurse.
  4. Only in extreme emergencies should an RNFA be expected to assist on procedures that present an unusual hazard to life.
  5. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.

II. **PROCEDURE:**
- A. The RNFA will use surgical instruments and surgical materials to manipulate tissue (vein harvest) as directed by the surgeon.
  1. Expose and retract tissue.
  2. Cannulate and prepare tissue.
  3. Clamp, sever, and ligate tissue.
  4. Cauterize and approximate tissue.
  5. Close incision in layers, with absorbable subcutaneous and subcuticular sutures.
- B. The RNFA will suture tissue to insure hemostasis and wound alignment by using suture material or instruments as directed by the surgeon.
  1. Correctly approximate tissue layers.
  2. Approximating tissue appropriately to avoid excess tension and tissue necrosis.
  3. Tying knots firmly to avoid slipping.
  4. Using suture, staples, clips or other devices to approximate tissue.
- C. Assist the surgeon at the completion of the procedure by:
  1. Affixing and stabilizing all drains.
  2. Cleaning the wound and applying the dressing.
  3. Assist with applying casts or plaster splints.
- D. Placement of patient on cardiopulmonary bypass:
  1. The RNFA shall:
     a. Assist the surgeon at his/her discretion in safely initiating and conducting cardiopulmonary bypass.
     b. Provide retraction and suction during sternotomy and cannulation, and assist with pericardial retraction sutures.
     c. Prepare pump circuit tubing, cardiotomy, and cardioplegia delivery system lines.
     d. Apply and secure arterial and venous purse string tourniquets.
     e. Alert surgeon in heparin dose administration has not been initiated.
     f. Hold cannulae in place while surgeon tightens tourniquets.
     g. Visually inspect arterial line for the presence of air, and alert the surgeon if observed.
  2. Proper placement and removal of is vital to ensure proper cardiopulmonary bypass.
- E. Removal of the patient from cardiopulmonary bypass:
  1. The RNFA shall:
     a. Assist the surgeon at his/her discretion in safely removal of patient from cardiopulmonary bypass.
     b. Cut suture securing arterial line to sterile field after heparin reversal.
     c. Hold cannulae in place while surgeon loosens purse string tourniquets.
     d. Tie arteriotomy suture while the surgeon remove cannulae.
     e. Visually inspect cannulation sites for hemostasis.

III. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**
- A. Current California RN license.

B. Education: Nationally certified peri-operative nurse (CNOR) through the Association of Operating Room Nurses (AORN).

C. Initial Evaluation: Successful completion of a structured and approved AORN RNFA course. Three (3) years operating experience in both scrub and circulating roles of cardiothoracic surgery. Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring physician, 16 hours or 8 cases must be cardiac cases.

D. Ongoing Evaluation: Approval from the surgical sub-specialty of the sponsoring physician.

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

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

B. Review: Every two (2) years.

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

A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform Registered Nurse First Assist – Cardiac Surgery Standardized Procedure.

MEDICAL STAFF

STANDARDIZED PROCEDURE: Registered Nurse First Assistant (RNFA) - Surgical Assistant During Surgeon Incapacitation or Emergency Surgical Site Evacuation by Physician

I. **POLICY:**
- A. Function: To provide guidelines for the RNFA in providing surgical assistance in the event the surgeon becomes incapacitated or needs to leave for an emergency during surgery.
- B. Circumstances:
  1. Setting: Open Operating Room at Tri-City Medical Center.
  2. Supervision: None required.
  3. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.

II. **PROCEDURE:**
- A. In the event the operating surgeon, during surgery, becomes incapacitated or needs to leave the OR due to and emergency, the RNFA shall:
  1. Maintain hemostasis according to the approved standardized procedure.
  2. Keep the surgical site moistened, as necessary, according to the type of surgery.
  3. Maintain the integrity of the sterile field.
  4. Remain scrubbed in appropriate attire (gown, mask, gloves, cap).
  5. Remain at the field while the RN circulator locates a replacement surgeon.

III. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**
- A. Current California RN license.
- B. Education: Nationally certified peri-operative nurse (CNOR) through the Association of Operating Room Nurses (AORN).
- C. Initial Evaluation: Successful completion of a structured and approved AORN RNFA course. Three (3) years operating experience. Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring physician.
- D. Ongoing Evaluation: Approval from the surgical sub-specialty of the sponsoring physician.

IV. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**
- A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
- B. Review: Every two (2) years.

V. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**
- A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform Registered Nurse First Assist - Surgical Assistant During Surgeon Incapacitation or Emergency Surgical Site Evacuation Standardized Procedure.

MEDICAL STAFF

STANDARDIZED PROCEDURE: Registered Nurse First Assistant (RNFA) – Intraoperative Hemostasis

I. **POLICY:**
- A. Function: To provide guidelines for the RNFA in providing hemostasis of the surgical field to minimize blood loss during surgery.
- B. Circumstances:
  1. Setting: Open Operating Room at Tri-City Medical Center.
  2. Supervision: Requires the direct supervision of the primary surgeon.
  3. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.
- C. Effective hemostasis is essential to carry out surgery in a time-efficient manner and to prevent excessive blood loss. Providing a dry operative field promotes adequate visual assessment and access to the surgical site.

II. **PROCEDURE:**
- A. The RNFA shall assist the surgeon by providing intraoperative hemostasis using the following measures:
  1. Aspiration of blood and other fluids from the operative site, as directed by the surgeon.
  2. Sponging the wound or other area of dissection, as directed by the surgeon.
  3. Using hemostasis or other surgical instruments to clamp bleeding tissue, as directed by the surgeon.
  4. Using sutures to tie off clamped blood vessels or other tissue, as directed by the surgeon.
  5. Using electrocautery or other surgical device to cauterize tissue, or surgical instruments clamped to tissue.
  6. Place hemoclip, or other ligating devices on vessels or tissue, as directed by the surgeon.

III. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**
- A. Current California RN license.
- B. Education: Nationally certified peri-operative nurse (CNOR) through the Association of Operating Room Nurses (AORN).
- C. Initial Evaluation: Successful completion of a structured and approved AORN RNFA course. Three (3) years operating experience. Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring physician.
- D. Ongoing Evaluation: Approval from the surgical sub-specialty of the sponsoring physician.

IV. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**
- A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
- B. Review: Every two (2) years.

V. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**
- A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform Registered Nurse First Assist – Intraoperative Hemostasis Standardized Procedure.

MEDICAL STAFF

STANDARDIZED PROCEDURE: Registered Nurse First Assistant (RNFA) – Intraoperative Retracting

I. **POLICY:**
- A. Function: To provide guidelines for the RNFA in providing retraction of the surgical field to allow adequate surgical exposure without subsequent tissue/organ compromise.
- B. Circumstances:
  1. Setting: Open Operating Room at Tri-City Medical Center.
  2. Supervision: Requires the direct supervision of the primary surgeon.
  3. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.
- C. Selection and placement of and appropriate retraction instrument will assist the surgeon by providing exposure and optimum visualization of the surgical site.

II. **PROCEDURE:**
- A. The RNFA shall assist the surgeon by providing intraoperative retraction using the following measures:
  1. Retracting tissues or organs by the use of the hand.
  2. Placing and holding surgical retractors.
  3. Packing sponges or laporotomy pads into body cavities to hold tissues and organs out of the operative field.
  4. Managing all instruments in the operative field to prevent obstruction of the surgeon's view.

III. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**
- A. Current California RN license.
- B. Education: Nationally certified peri-operative nurse (CNOR) through the Association of Operating Room Nurses (AORN).
- C. Initial Evaluation: Successful completion of a structured and approved AORN RNFA course. Three (3) years operating experience. Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring physician.
- D. Ongoing Evaluation: Approval from the surgical sub-specialty of the sponsoring physician.

IV. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**
- A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
- B. Review: Every two (2) years.

V. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**
- A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform Registered Nurse First Assist – Intraoperative Retraction Standardized Procedure.

MEDICAL STAFF

STANDARDIZED PROCEDURE: Registered Nurse First Assistant (RNFA) – Intraoperative Wound Closure

I. **POLICY:**
- A. Function: To provide guidelines for the RNFA in providing proper suturing of tissue during a surgical procedure, so that tissue heals without complications from the suturing process.
- B. Circumstances:
  1. Setting: Open Operating Room at Tri-City Medical Center.
  2. Supervision: Requires the direct supervision of the primary surgeon.
  3. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.
- C. Proper suturing is vital to ensure hemostasis, wound alignment, and tissue healing.

II. **PROCEDURE:**
- A. The RNFA shall suture tissue using instruments and suture material as directed by the surgeon by:
  1. Correctly approximating tissue layers.
  2. Approximating tissue appropriately to avoid excess tension and tissue necrosis.
  3. Tying knots firmly to avoid slipping.
  4. Using staples, clips, or other devices to approximate tissue.

III. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**
- A. Current California RN license.
- B. Education: Nationally certified peri-operative nurse (CNOR) through the Association of Operating Room Nurses (AORN).
- C. Initial Evaluation: Successful completion of a structured and approved AORN RNFA course. Three (3) years operating experience. Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring physician.
- D. Ongoing Evaluation: Approval from the surgical sub-specialty of the sponsoring physician.

IV. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**
- A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
- B. Review: Every two (2) years.

V. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**
- A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform Registered Nurse First Assist – Intraoperative Wound Closure Standardized Procedure.

MOSSADAMS

T (949) 221-4000
F (949) 221-4001

2040 Main Street
Suite 900
Irvine, CA 92614

February 19, 2020

Ray Rivas, Chief Financial Officer
Members of the Audit Committee
Tri-City Healthcare District
4002 Vista Way
Oceanside, CA 92056

Re: Audit and Nonattest Services

Dear Mr. Rivas:

Thank you for the opportunity to provide services to Tri-City Healthcare District. This engagement letter ("Engagement Letter") and the attached Professional Services Agreement, which is incorporated by this reference, confirm our acceptance and understanding of the terms and objectives of our engagement, and limitations of the services that Moss Adams LLP ("Moss Adams," "we," "us," and "our") will provide to Tri-City Healthcare District ("you," "your," and "Company").

Scope of Services – Audit

You have requested that we audit the Company's financial statements, which comprise the statement of net position and statement of fiduciary net position as of June 30, 2020, and the related statements of revenue, expenses, changes in net position, changes in fiduciary net position, and cash flows for the year then ending, and the related notes to the financial statements. We will also report on whether the schedule of expenditures of federal awards, schedule of mortgage reserve fund, and schedules of net position and revenues, expenses, and changes in net position, presented as supplementary information, are fairly stated, in all material respects, in relation to the financial statements as a whole.

In connection with our audit, we will include one or more paragraphs in our auditor's report accompanying the financial statements regarding whether matters came to our attention during our audit engagement related to your compliance with terms, covenants, provisions, or conditions of the Regulatory Agreement dated March 8, 2017, between the Company and the Department of Housing and Urban Development ("HUD") as required by Paragraphs 22(a) and 22(b) of the Regulatory Agreement.

Our report on the Company's compliance with aspects of the contractual agreement described above will state that our audit was not directed primarily toward obtaining knowledge regarding compliance with provisions of the contractual agreement described above. This report is intended solely for the information and use of the Company and HUD and is not intended to be and should not be used by anyone other than these specified parties. If, for any reason, we are unable to issue a report as a result of our procedures we will inform you of the termination of this engagement as soon as practical. You will be obligated to compensate us for fees earned for services rendered and to reimburse us for all expenses, you acknowledge and agree that in the event we stope work or terminate the agreement for any reason, we shall not be liable to you for any damages that occur as a result of our ceasing to render services.

We understand that you will provide us with the basic information required for our procedures relating to compliance with aspects of the contractual agreement described above and that you are responsible for the accuracy and completeness of that information and ultimately for the Company's compliance with the contractual agreement.

Accounting standards generally accepted in the United States of America provide for certain required supplementary information ("RSI"), such as management's discussion and analysis, to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board (GASB) who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. As part of our engagement, we will apply certain limited procedures to Tri-City Healthcare District's RSI in accordance with auditing standards generally accepted in the United States of America. We will not express an opinion or provide assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide assurance. The following RSI will be subjected to certain limited procedures, but will not be audited:

- Management's discussion and analysis

Scope of Services and Limitations – Nonattest

We will provide the Company with the following nonattest services:

- Assist you in drafting the Data Collection Form as of and for the year ending June 30, 2020.
- Assist you with your implementation of GASB 84, *Fiduciary Activities*, required to be implemented for the year ending June 30, 2020.

Our professional standards require that we remain independent with respect to our attest clients, including those situations where we also provide nonattest services such as those identified in the preceding paragraphs. As a result, Company management must accept the responsibilities set forth below related to this engagement:

- Assume all management responsibilities.

- Oversee the service by designating an individual, preferably within senior management, who possesses suitable skill, knowledge, and/or experience to oversee our nonattest services. The individual is not required to possess the expertise to perform or reperform the services.
- Evaluate the adequacy and results of the nonattest services performed.
- Accept responsibility for the results of the nonattest services performed.

It is our understanding that Ray Rivas, CFO, has been designated by the Company to oversee the nonattest services and that in the opinion of the Company is qualified to oversee our nonattest services as outlined above. If any issues or concerns in this area arise during the course of our engagement, we will discuss them with you prior to continuing with the engagement.

Timing

Stacy J. Stelzriede is responsible for supervising the engagement and authorizing the signing of the report. We expect to perform our interim work during the week of May 25, 2020, begin audit fieldwork on approximately August 3, 2020, complete final fieldwork on approximately August 21, 2020, and issue our report no later than September 25, 2020.

Our scheduling depends on your completion of the year-end closing and adjusting process prior to our arrival to begin the fieldwork. We may experience delays in completing our services due to your staff's unavailability or delays in your closing and adjusting process. You understand our fees are subject to adjustment if we experience these delays in completing our services.

Fees

We estimate our fees as follows:

Month Due	Amount
Financial Statement Audit as of and for the year ending June 30, 2020	$ 160,000
Issuance of separate audit report (excluding Single Audit) as of and for the year ending June 30, 2020	2,500
Requirements for HUD Loan • Single Audit Report • Procedures to provide negative assurance to HUD on the Company's compliance with debt covenants required under the Regulatory Agreement • Supplementary schedules of debt covenant ratios and other information as required under the Regulatory Agreement	14,500
Total	**$ 177,000**

We have agreed to the following payment schedule:

Month Due	Amount
March 2020	$ 29,500
May 2020	29,500
June 2020	29,500
July 2020	29,500
August 2020	29,500
September 2020	29,500
Total	**$ 177,000**

In addition, our fees for audit procedures and consultation relating to the Company's implementation of GASB 84, *Fiduciary Activities*, will billed based on the experience of the individuals involved and the amount of work performed at the following standard billing rates:

Level	Rate
Partner	$550–$575
Senior Manager	$450–$525
Manager	$250–$325
Senior	$200–$225
Staff	$140–$155

In addition to fees, we will charge you for expenses. Our invoices include a flat expense charge, calculated as five percent (5%) of fees, to cover expenses such as copying costs, postage, administrative billable time, report processing fees, filing fees, and technology expenses. Travel expenses and client meals/entertainment expenses will be billed separately and are not included in the 5% charge.

Our ability to provide services in accordance with our estimated fees depends on the quality, timeliness, and accuracy of the Company's records, and, for example, the number of general ledger adjustments required as a result of our work. To assist you in this process, we will provide you with a Client Audit Preparation Schedule that identifies the key work you will need to perform in preparation for the audit. We will also need your accounting staff to be readily available during the engagement to respond in a timely manner to our requests. Lack of preparation, poor records, general ledger adjustments, and/or untimely assistance will result in an increase of our fees.

Reporting

We will issue a written report upon completion of our audit of the Company's financial statements. Our report will be addressed to the Board of Directors of the Company. We cannot provide assurance that an unmodified opinion will be expressed. Circumstances may arise in which it is necessary for us to modify our opinion, add an emphasis-of-matter or other-matter paragraph(s), or withdraw from the engagement. Our services will be concluded upon delivery to you of our report on your financial statements for the year ending June 30, 2020.

At the conclusion of the engagement, we will complete the auditor section of the Data Collection Form and electronically sign the Data Collection Form that summarizes our findings. We will provide electronic copies of our reports to you; however, it is management's responsibility to electronically submit the reporting package (including financial statements, schedule of expenditures of federal awards, summary schedule of prior audit findings, auditors' reports, and corrective action plan, as applicable) along with the Data Collection Form to the Federal Audit Clearinghouse. The Data Collection Form and the reporting package must be submitted within the earlier of 30 days after receipt of the auditors' reports or nine months after the end of the audit period. At the conclusion of the engagement, we will make arrangements with management regarding Data Collection Form submission procedures.

We appreciate the opportunity to be of service to you. If you agree with the terms of our engagement as set forth in this Agreement, please sign the enclosed copy of this letter and return it to us with the Professional Services Agreement.

Very truly yours,

Stacy J. Stelzriede

Stacy J. Stelzriede, Partner, for
Moss Adams LLP

Enclosures

Accepted and Agreed:

This Engagement Letter and the attached Professional Services Agreement set forth the entire understanding of Tri-City Healthcare District with respect to this engagement and the services to be provided by Moss Adams LLP:

Signature:_____

Print Name:_____

Title:_____

Date:_____

Client: #617641
v. 10/10/2019

PROFESSIONAL SERVICES AGREEMENT
Single Audit Version (Uniform Guidance)

This Professional Services Agreement (the "PSA") together with the Engagement Letter, which is hereby incorporated by reference, represent the entire agreement (the "Agreement") relating to services that Moss Adams will provide to the Company. Any undefined terms in this PSA shall have the same meaning as set forth in the Engagement Letter.

Objectives of the Audit

The objective of our audit is the expression of an opinion on the financial statements and supplementary information. The objective also includes reporting on the following:

- Internal control related to the financial statements and compliance with the provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a material effect on the financial statements as required by *Government Auditing Standards*.
- Internal control related to major federal programs and an opinion (or disclaimer of opinion) on compliance with federal statutes, regulations, and the terms and conditions of federal awards that could have a direct and material effect on each major program in accordance with the Single Audit Act Amendments of 1996 and the audit requirements contained in OMB Title 2 U.S. Code of Federal Regulations (CFR) Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance).

The reports on internal control and compliance will each include a statement that the purpose of the report is solely to: describe the scope of testing of internal control over financial reporting and compliance and the result of that testing and not to provide an opinion on the effectiveness of the entity's internal control over financial reporting or on compliance; describe the scope of testing internal control over compliance for major federal programs and major federal program compliance and the result of that testing and to provide an opinion on compliance but not to provide an opinion on the effectiveness of internal control over compliance; that the report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control over financial reporting and compliance and the OMB Uniform Guidance in considering internal control over compliance and major federal program compliance; and, accordingly, it is not suitable for any other purpose.

We will conduct our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS); the standards for financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; the Single Audit Act Amendments of 1996; and the audit provisions of the OMB Uniform Guidance. It will include tests of your accounting records, a determination of major program(s) in accordance with the OMB Uniform Guidance, and other procedures we consider necessary to enable us to express opinions and to render the required reports. If our opinion on the financial statements or the Single Audit compliance opinion is other than unmodified, we will discuss the reasons with you in advance. If, for any reason, we are unable to complete the audit or are unable to form or have not formed an opinion we may decline to express an opinion or to issue a report as a result of this engagement.

Procedures and Limitations

Our procedures may include tests of documentary evidence supporting the transactions recorded in the accounts, tests of the physical existence of inventories, and direct confirmation of certain receivables and certain other assets, liabilities and transaction details by correspondence with selected individuals, funding sources, creditors, and financial institutions. We may also request written representations from your attorneys as part of the engagement, and they may bill you for responding to this inquiry. The supplementary information will be subject to certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves. At the conclusion of our audit, we will require certain written representations from management about the financial statements and supplementary information and related matters. Management's failure to provide representations to our satisfaction will preclude us from issuing our report.

An audit includes examining evidence, on a test basis, supporting the amounts and disclosures in the financial statements. Therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested. Also, we will plan and perform the audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free from material misstatement. Such material misstatements may include errors, fraudulent financial reporting, misappropriation of assets, or noncompliance with the provisions of laws, regulations, contracts, and grant agreements that are attributable to the entity or to acts by management or employees acting on behalf of the entity that may have a direct financial statement impact. Pursuant to *Government Auditing Standards*, we will not provide reasonable assurance of detecting abuse. As required by the Single Audit Act Amendments of 1996 and the audit provisions of the OMB Uniform Guidance, our audit will include tests of transactions related to major federal award programs for compliance with applicable federal statutes, regulations, and the terms and conditions of federal awards that could have a direct and material effect on each major program.

Because of the inherent limitations of an audit, together with the inherent limitations of internal control, an unavoidable risk exists that some material misstatements and noncompliance may not be detected, even though the audit is properly planned

and performed in accordance with U.S. GAAS, *Government Auditing Standards*, and the OMB Uniform Guidance. An audit is not designed to detect immaterial misstatements or noncompliance with the provisions of laws, regulations, contracts, and grant agreements that do not have a direct and material effect on the financial statements or noncompliance with the provisions of federal statutes, regulations, and the terms and condition of federal awards that do not have a direct and material effect on major federal programs. However, we will inform you of any material errors, fraudulent financial reporting, misappropriation of assets, and noncompliance with the provisions of laws, federal statutes, regulations, contracts grant agreements and federal awards that come to our attention, unless clearly inconsequential. We will include such matters in the reports required for a Single Audit. Our responsibility as auditors is limited to the period covered by our audit and does not extend to any time period for which we are not engaged as auditors.

We may assist management in the preparation of the Company's financial statements and supplementary information. Regardless of any assistance we may render, all information included in the financial statements and supplementary information remains the representation of management. We may issue a preliminary draft of the financial statements and supplementary information to you for your review. Any preliminary draft financial statements and supplementary information should not be relied upon, reproduced or otherwise distributed without the written permission of Moss Adams.

Procedures and Limitations—Internal Control

In planning and performing our audit, we will consider the internal control sufficient to plan the audit in order to determine the nature, timing, and extent of our auditing procedures for the purpose of expressing our opinions on the Company's financial statements and on its compliance with requirements applicable to major federal programs.

We will obtain an understanding of the design of the relevant controls and whether they have been placed in operation, and we will assess control risk. Tests of controls may be performed to test the effectiveness of certain controls that we consider relevant to preventing and detecting errors and fraud that are material to the financial statements and to preventing and detecting misstatements resulting from noncompliance with the provisions of laws, regulations, contract and grant agreements and other noncompliance matters that have a direct and material effect on the financial statements.

An audit is not designed to provide assurance on internal control or to identify deficiencies in the design or operation of internal control and accordingly, no opinion will be expressed in our report on internal control issued pursuant to *Government Auditing Standards*. However, if, during the audit, we become aware of any matters involving internal control or its operation that we consider to be significant deficiencies under standards established by the American Institute of Certified Public Accountants, we will communicate them in writing to management and those charged with governance. We will also identify if we consider any significant deficiency, or combination of significant deficiencies, to be a material weakness.

As required by the audit provisions of the OMB Uniform Guidance, we will perform tests of controls to evaluate the effectiveness of the design and operation of controls that we consider relevant to preventing or detecting material noncompliance with compliance requirements applicable to each major federal award program. However, our tests will be less in scope than would be necessary to render an opinion on those controls and, accordingly, no opinion will be expressed in our report on internal control issued pursuant to the OMB Uniform Guidance.

Procedures and Limitations—Compliance

Our audit will be conducted in accordance with the standards referred to in the section titled "Objectives of the Audit." As part of obtaining reasonable assurance about whether the financial statements are free from material misstatement, we will perform tests of the Company's compliance with the provisions of laws, regulations, contracts, and grant agreements that may have a direct and material effect on the financial statements. However, the objective of those procedures will not be to provide an opinion on overall compliance and we will not express such an opinion in our report on compliance issued pursuant to *Government Auditing Standards*.

The audit provisions of the OMB Uniform Guidance require that we also plan and perform the audit to obtain reasonable assurance about whether the auditee has complied with applicable federal statutes, regulations, and the terms and conditions of federal awards that could have a direct and material effect on each major federal program. Our procedures will consist of the applicable procedures described in the OMB Compliance Supplement for the types of compliance requirements that could have a direct and material effect on each of your major federal programs. The purpose of those procedures will be to express an opinion on the Company's compliance with requirements applicable to each of its major federal programs in our report on compliance issued pursuant to the OMB Uniform Guidance.

Management's Responsibility for Financial Statements, Internal Control, and Federal Award Compliance

As a condition of our engagement, management acknowledges and understands that management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted

in the United States of America. We may advise management about appropriate accounting principles and their application and may assist in the preparation of your financial statements, including the schedule of expenditures of federal awards, but management remains responsible for the financial statements and the schedule of expenditures of federal awards. Management also acknowledges and understands that management is responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to error or fraud. This responsibility includes the maintenance of adequate records, the selection and application of accounting principles, and the safeguarding of assets.

You are responsible for informing us about all known or suspected fraud affecting the Company involving: (a) management, (b) employees who have significant roles in internal control, and (c) others where the fraud could have a material effect on the financial statements. You are responsible for informing us of your knowledge of any allegations of fraud or suspected fraud affecting the Company received in communications from employees, former employees, grantors, regulators, or others. In addition, management is responsible for identifying and ensuring that the Company complies with applicable laws and regulations and for taking timely and appropriate steps to remedy any fraud or noncompliance with the provisions of laws, regulations, contract, and grant agreements, that we may report.

Management is responsible for adjusting the financial statements to correct material misstatements and for confirming to us in the management representation letter that the effects of any uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented are immaterial, both individually and in the aggregate, to the financial statements as a whole.

Management is responsible for establishing and maintaining internal control and for compliance with federal statutes, regulations, and the terms and conditions of federal awards and for identifying and ensuring that the Company complies with such provisions. Management is also responsible for informing us of any significant contractor relationships in which the contractor is responsible for program compliance. Management is also responsible for addressing the audit findings and recommendations, establishing and maintaining a process to track the status of such findings and recommendations, and taking timely and appropriate steps to remedy any fraud and noncompliance with federal statutes, regulations, and the terms and conditions of federal awards or abuse that we may report. Additionally, as required by the OMB Uniform Guidance, it is your responsibility to follow up and take corrective action on reported audit findings and to prepare a summary schedule of prior audit findings and a corrective action plan.

Management is responsible for making all financial records and related information available to us and for the accuracy and completeness of that information. Management agrees that as a condition of our engagement, management will provide us with:

- access to all information of which management is aware that is relevant to the preparation and fair presentation of the financial statements, such as records, documentation, and other matters;
- additional information that we may request from management for the purpose of the audit; and
- unrestricted access to persons within the Company from whom we determine it necessary to obtain audit evidence.

Management's Responsibility for Supplementary Information

Management is responsible for the preparation of the supplementary information in accordance with the applicable criteria. Management agrees to include the auditor's report on the supplementary information in any document that contains the supplementary information and that indicates that we have reported on such supplementary information. Management is responsible to present the supplementary information with the audited financial statements or, if the supplementary information will not be presented with the audited financial statements, to make the audited financial statements readily available to the intended users of the supplementary information no later than the date of issuance by the entity of the supplementary information and the auditor's report thereon. For purposes of this Agreement, audited financial statements are deemed to be readily available if a third-party user can obtain the audited financial statements without any further action by management. For example, financial statements on your Web site may be considered readily available, but being available upon request is not considered readily available.

Dissemination of Financial Statements and Reports

We will provide copies of our reports to the Company; however, management is responsible for distribution of the reports and the financial statements. Our report on the financial statements must be associated only with the financial statements that were the subject of our engagement. You may make copies of our report, but only if the entire financial statements (including related footnotes and supplementary information, as appropriate) are reproduced and distributed with our report. You agree not to reproduce or associate our report with any other financial statements, or portions thereof, that are not the subject of this engagement.

Offering of Securities

This Agreement does not contemplate Moss Adams providing any services in connection with the offering of securities, whether registered or exempt from registration, and Moss Adams will charge additional fees to provide any such services. You agree not to incorporate or reference our report in a private placement or other offering of your equity or debt securities without our express written permission. You further agree we are under no obligation to reissue our report or provide written permission for the use of our report at a later date in connection with an offering of securities, the issuance of debt instruments, or for any other circumstance. We will determine, at our sole discretion, whether we will reissue our report or provide written permission for the use of our report only after we have conducted any procedures we deem necessary in the circumstances. You agree to provide us with adequate time to review documents where (a) our report is requested to be reissued, (b) our report is included in the offering document or referred to therein, or (c) reference to our firm is expected to be made. If we decide to reissue our report or provide written permission to the use of our report, you agree that Moss Adams will be included on each distribution of draft offering materials and we will receive a complete set of final documents. If we decide not to reissue our report or withhold our written permission to use our report, you may be required to engage another firm to audit periods covered by our audit reports, and that firm will likely bill you for its services. While the successor auditor may request access to our engagement documentation for those periods, we are under no obligation to permit such access.

Changes in Professional or Accounting Standards

To the extent that future federal, state, or professional rule-making activities require modification of our audit approach, procedures, scope of work, etc., we will advise you of such changes and the impact on our fee estimate. If we are unable to agree on the additional fees, if any, that may be required to implement any new accounting and auditing standards that are required to be adopted and applied as part of our engagement, we may terminate this Agreement as provided herein, regardless of the stage of completion.

Representations of Management

During the course of our engagement, we may request information and explanations from management regarding, among other matters, the Company's operations, internal control, future plans, specific transactions, and accounting systems and procedures. At the conclusion of our engagement, we will require, as a precondition to the issuance of our report, that management provide us with a written representation letter confirming some or all of the representations made during the engagement. The procedures that we will perform in our engagement will be heavily influenced by the representations that we receive from management. Accordingly, false representations could cause us to expend unnecessary efforts or could cause a material error or fraud to go undetected by our procedures. In view of the foregoing, you agree that we will not be responsible for any misstatements in the Company's financial statements and supplementary information that we fail to detect as a result of false or misleading representations, whether oral or written, that are made to us by the Company's management. While we may assist management in the preparation of the representation letter, it is management's responsibility to carefully review and understand the representations made therein.

In addition, because our failure to detect material misstatements could cause others relying upon our audit report to incur damages, the Company further agrees to indemnify and hold us harmless from any liability and all costs (including legal fees) that we may incur in connection with claims based upon our failure to detect material misstatements in the Company's financial statements and supplementary information resulting in whole or in part from knowingly false or misleading representations made to us by any member of the Company's management.

Fees and Expenses

The Company acknowledges that the following circumstances will result in an increase of our fees:

- Failure to prepare for the audit as evidenced by accounts and records that have not been subject to normal year-end closing and reconciliation procedures;
- Failure to complete the audit preparation work by the applicable due dates;
- Significant unanticipated transactions, audit issues, or other such circumstances;
- Delays causing scheduling changes or disruption of fieldwork;
- After audit or post fieldwork circumstances requiring revisions to work previously completed or delays in resolution of issues that extend the period of time necessary to complete the audit;
- Issues with the prior audit firm, prior year account balances or report disclosures that impact the current year engagement; and
- An excessive number of audit adjustments.

We will endeavor to advise you in the event these circumstances occur, however we may be unable to determine the impact on the estimated fee until the conclusion of the engagement. We will bill any additional amounts based on the experience of the individuals involved and the amount of work performed.

Billings are due upon presentation and become delinquent if not paid within 30 days of the invoice date. Any past due fee under this Agreement shall bear interest at the highest rate allowed by law on any unpaid balance. In addition to fees, you may be billed for expenses and any applicable sales and gross receipts tax. Direct expenses may be charged based on out-of-pocket expenditures, per diem allotments, and mileage reimbursements, depending on the nature of the expense. Indirect expenses, such as processing time and technology expenses, may be passed through at our estimated cost and may be billed as a flat charge or a percentage of fees. If we elect to suspend our engagement for nonpayment, we may not resume our work until the account is paid in full. If we elect to terminate our services for nonpayment, or as otherwise provided in this Agreement, our engagement will be deemed to have been completed upon written notification of termination, even if we have not completed our work. You will be obligated to compensate us for fees earned for services rendered and to reimburse us for expenses. You acknowledge and agree that in the event we stop work or terminate this Agreement as a result of your failure to pay on a timely basis for services rendered by Moss Adams as provided in this Agreement, or if we terminate this Agreement for any other reason, we shall not be liable to you for any damages that occur as a result of our ceasing to render services.

Limitation on Liability

IN NO EVENT WILL EITHER PARTY BE LIABLE TO THE OTHER FOR ANY SPECIAL, INDIRECT, INCIDENTAL, OR CONSEQUENTIAL DAMAGES IN CONNECTION WITH OR OTHERWISE ARISING OUT OF THIS AGREEMENT, EVEN IF ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. IN NO EVENT SHALL EITHER PARTY BE LIABLE FOR EXEMPLARY OR PUNITIVE DAMAGES ARISING OUT OF OR RELATED TO THIS AGREEMENT.

Subpoena or Other Release of Documents

As a result of our services to you, we may be required or requested to provide information or documents to you or a third-party in connection with governmental regulations or activities, or a legal, arbitration or administrative proceeding (including a grand jury investigation), in which we are not a party. You may, within the time permitted for our firm to respond to any request, initiate such legal action as you deem appropriate to protect information from discovery. If you take no action within the time permitted for us to respond or if your action does not result in a judicial order protecting us from supplying requested information, we will construe your inaction or failure as consent to comply with the request. Our efforts in complying with such requests or demands will be deemed a part of this engagement and we shall be entitled to additional compensation for our time and reimbursement for our out-of-pocket expenditures (including legal fees) in complying with such request or demand.

Pursuant to authority given by law or regulation, we may be requested to make certain engagement documentation available to an applicable entity with oversight responsibilities for the audit or its designee, a federal agency providing direct or indirect funding, or the U.S. Government Accountability Office for purposes of a quality review of the audit, to resolve audit findings, or to carry out oversight responsibilities. We will notify you of any such request. If requested, access to such engagement documentation will be provided under the supervision of Moss Adams personnel. Furthermore, upon request, we may provide photocopies of selected engagement documentation to the aforementioned parties. These parties may intend, or decide, to distribute the photocopies or information contained therein to others, including other governmental agencies.

Document Retention Policy

At the conclusion of this engagement, we will return to you all original records you supplied to us. Your Company records are the primary records for your operations and comprise the backup and support for the results of this engagement. Our records and files, including our engagement documentation whether kept on paper or electronic media, are our property and are not a substitute for your own records. Our firm policy calls for us to destroy our engagement files and all pertinent engagement documentation after a retention period of seven years (or longer, if required by law or regulation), after which time these items will no longer be available. We are under no obligation to notify you regarding the destruction of our records. We reserve the right to modify the retention period without notifying you. Catastrophic events or physical deterioration may result in our firm's records being unavailable before the expiration of the above retention period.

Except as set forth above, you agree that Moss Adams may destroy paper originals and copies of any documents, including, without limitation, correspondence, agreements, and representation letters, and retain only digital images thereof.

Use of Electronic Communication

In the interest of facilitating our services to you, we may communicate by facsimile transmission or send electronic mail over the Internet. Such communications may include information that is confidential. We employ measures in the use of electronic communications designed to provide reasonable assurance that data security is maintained. While we will use our best efforts to keep such communications secure in accordance with our obligations under applicable laws and

professional standards, you recognize and accept we have no control over the unauthorized interception of these communications once they have been sent. Unless you issue specific instructions to do otherwise, we will assume you consent to our use of electronic communications to your representatives and other use of these electronic devices during the term of this Agreement as we deem appropriate.

Use of Third-Party Service Providers

We may use third-party service providers in serving you. In such circumstances, if we need to share confidential information with these service providers, we will require that they maintain the confidentiality of your information.

Enforceability

In the event that any portion of this Agreement is deemed invalid or unenforceable, said finding shall not operate to invalidate the remainder of this Agreement.

Entire Agreement

This Professional Services Agreement and Engagement Letter constitute the entire agreement and understanding between Moss Adams and the Company. The Company agrees that in entering into this Agreement it is not relying and has not relied upon any oral or other representations, promise or statement made by anyone which is not set forth herein.

In the event the parties fail to enter into a new Agreement for each subsequent calendar year in which Moss Adams provides services to the Company, the terms and conditions of this PSA shall continue in force until such time as the parties execute a new written Agreement or terminate their relationship, whichever occurs first.

Use of Moss Adams' Name

The Company may not use any of Moss Adams' name, trademarks, service marks or logo in connection with the services contemplated by this Agreement or otherwise without the prior written permission of Moss Adams, which permission may be withheld for any or no reason and may be subject to certain conditions.

Use of Nonlicensed Personnel

Certain engagement personnel who are not licensed as certified public accountants may provide services during this engagement.

Dispute Resolution Procedure, Venue and Limitation Period

This Agreement shall be governed by the laws of the state of Washington, without giving effect to any conflicts of laws principles. If a dispute arises out of or relates to the engagement described herein, and if the dispute cannot be settled through negotiations, the parties agree first to try in good faith to settle the dispute by mediation using an agreed upon mediator. If the parties are unable to agree on a mediator, the parties shall petition the state court that would have jurisdiction over this matter if litigation were to ensue and request the appointment of a mediator, and such appointment shall be binding on the parties. Each party shall be responsible for its own mediation expenses, and shall share equally in the mediator's fees and expenses.

If the claim or dispute cannot be settled through mediation, each party hereby irrevocably (a) consents to the exclusive jurisdiction and venue of the appropriate state or federal court located in King County, state of Washington, in connection with any dispute hereunder or the enforcement of any right or obligation hereunder, and (b) WAIVES ITS RIGHT TO A JURY TRIAL. EACH PARTY FURTHER AGREES THAT ANY SUIT ARISING OUT OF OR RELATED TO THIS AGREEMENT MUST BE FILED WITHIN ONE (1) YEAR AFTER THE CAUSE OF ACTION ARISES.

Termination

This Agreement may be terminated by either party, with or without cause, upon ten (10) days' written notice. In such event, we will stop providing services hereunder except on work, mutually agreed upon in writing, necessary to carry out such termination. In the event of termination, (a) you shall pay us for services provided and expenses incurred through the effective date of termination, (b) we will provide you with all finished reports that we have prepared pursuant to this Agreement, (c) neither party shall be liable to the other for any damages that occur as a result of our ceasing to render services, and (d) we will require any new accounting firm that you may retain to execute access letters satisfactory to Moss Adams prior to reviewing our files.

Hiring of Employees

We have a significant investment in the training and development of our accountants, and they are valued employees of Moss Adams. If you should hire one of our accountants either during the audit or within one year after the completion of this engagement, you agree to pay a personnel placement fee of 30% of that employee's salary to compensate Moss Adams. Any offer of employment to members of the audit team prior to issuance of our report may impair our independence, and as a result, may result in our inability to complete the engagement and issue a report.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: April 30, 2020
TEAM PHYSICIANS OF SOUTHERN CALIFORNIA MEDICAL GROUP, INC. (TEAM HEALTH)

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

Vendor's Name: Team Physicians of Southern California Medical Group, Inc. (Team Health)

Area of Service: Emergency Services for Physicians

Term of Agreement: June 1, 2020, through May 31, 2022, Third Amendment
Maximum Totals:

Services	Monthly Cost	Annual Cost	Total Term Cost
		Total:	**No Cost**

Description of Services/Supplies:

This is a professional service agreement between Team Health and Tri-City Healthcare District, to provide professional physician services for the Emergency Department.

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:

Motion:

I move that the TCHD Board of Directors authorize the agreement with Team Health to provide professional physician services for the Emergency Department, for a term of 24 months, beginning June 1, 2020 through May 31, 2022, at no cost to the District.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: APRIL 30, 2020
PROFESSIONAL BEHAVIOR COMMITTEE

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

Vendor's Name: Victor Souza, MD

Area of Service: Chair - Professional Behavior Committee

Term of Agreement: March 1, 2020, through May 31, 2021

Maximum Totals:

Services	Monthly Cost	Annual Cost	Total Term Cost
$150/hour, 15 hrs/month; NTE 30 hrs/mo	Maximum @ 30 hrs= $4500.00	Maximum @ 30 hrs= $54,000.00	Maximum= $67,500
		Total:	**$67,500**

Description of Services/Supplies:

The Medical Staff appointed Victor Souza, MD, to serve as the Chair, Professional Behavior Committee (the "Leadership Position").

Physician will provide a monthly time log to Medical Staff monthly, NTE thirty hours (30) per month. Medical Staff Manager will monitor documentation of physician 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: Sherry Miller, Manager Medical Staff, and Dr. Gene Ma, CMO

Motion:

I move that the TCHD Board of Directors authorize the agreement with Victor Souza, MD as Chairman of the Professional Behavior Committee, for a term of fifteen months, beginning March 1, 2020, for a cost of up to $4,500.00 per month and a total cost for the term not to exceed $67,500.00.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: APRIL 30, 2020
UNIFIRST CORP.

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

Vendor's Name: Unifirst Corp.

Area of Service: EVS Supplies

Term of Agreement: New Agreement Effective 5/17/2020 Five years

Maximum Totals:

Services	Monthly Cost	Annual Cost	Total Term Cost
Mops and Towels – New Agreement	$4744	$61,672	$308,360
Renewal Agreement (projection based on previous year's reimbursement plus the increase)	$11,660	$139,920	$699,600
		Total:	**$1,007,960**

Description of Services/Supplies:
Two Contracts –

1. New Agreement for Mops and Towels
2. Renewal Agreement for mats, scrapers, mop handles, other mops

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

Person responsible for oversight of agreement: Scott Livingstone, Thomas Moore and Hope Chaney

Motion:

I move that the TCHD Board of Directors authorize the agreements with Unifirst Corp for a term of five years, beginning May 17, 2020 for a cost of $201,592 per year and a total cost for the term of $1,007,960.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: April 30, 2020
3M Software Licenses & Support Renewal Proposal

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

Vendor's Name: 3M

Area of Service: Medical Records

Term of Agreement: 36 months, Beginning, May 11, 2020 – Ending, May 10, 2023

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
N/A	$226,398.98	$679,196.94

Description of Services/Supplies:

- Renewal of medical records coding and reimbursement calculation software licenses and support.
- This is a 3 year agreement at $226,398.98 per year for a total spend of $679,196.94.
- This agreement is effective May 11, 2020.
- This product will continue to be used with the Cerner Community Works EMR.

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: (Mark Albright/ Scott Livingstone)

Motion:

I move that the TCHD Board of Directors authorize the agreement with 3M for software licenses and support for a term of 36 months/3 years, beginning May 11, 2020 and ending May 10, 2023 for an annual cost of $226,398.98, and a total cost for the term of $679,196.94.

ADMINISTRATION CONSENT AGENDA
April 20th, 2020

CONTACT: Barbara Vogelsang, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Blanket Warmers Policy	3 Year Review, Practice Change	Forward To BOD For Approval
2. Deceased Patient Care and Disposition Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
3. Glucose Monitoring and Exercise Therapy for Diabetic Patients	3 Year Review	Forward To BOD For Approval
4. Swallow Screening in the Adult Patient Procedure	3 Year Review	Forward To BOD For Approval
Administrative Policies & Procedures		
1. Library Services Mission and Scope of Service 287	3 Year Review, Practice Change	Forward To BOD For Approval
Unit Specific		
Cardiac Rehab		
1. Billing for Cardiac Rehab	3 Year Review	Forward To BOD For Approval
Emergency Department		
1. Elopement, Patient at Risk-Policy	3 Year Review, Practice Change	Forward To BOD For Approval
Environmental Services		
1. Cleaning Guidelines	NEW	Forward To BOD For Approval
Medical Staff		
1. Credentialing Criteria, Cardiac Rehab 8710-564	3 Year Review	Forward To BOD For Approval
2. Credentialing Criteria, Chronic Non-Healing Wound Care 8710-523	3 Year Review	Forward To BOD For Approval
3. Credentialing Criteria, Hyperbaric Medicine Oxygen Therapy, 8710-523A	3 Year Review	Forward To BOD For Approval
4. Credentialing Policy, Expedited Credentialing and Privileging Process 8710-550	3 Year Review	Forward To BOD For Approval
5. Credentialing Policy, Processing Medical Staff Applications 8710-543	3 Year Review	Forward To BOD For Approval
6. Documentation Requirements for Emergency Department Residents 8710-532	3 Year Review	Forward To BOD For Approval
7. Liability Insurance Requirements 8710-558	3 Year Review	Forward To BOD For Approval
8. Management of Conflicts between Medical Staff and MEC 8710-567	3 Year Review	Forward To BOD For Approval
9. Peer Review Process: OPPE and FPPE 8710-509	3 Year Review	Forward To BOD For Approval
10. Physician/ Podiatrist Surgical Assistant 8710-536	3 Year Review	Forward To BOD For Approval

ADMINISTRATION CONSENT AGENDA
April 20th, 2020

CONTACT: Barbara Vogelsang, CNE

Policies and Procedures	Reason	Recommendations
11. Requests for Privileges New to TCMC 8710-526	3 Year Review	Forward To BOD For Approval
12. Supervision of Residents in Emergency Medicine 8710-571	3 Year Review	Forward To BOD For Approval
13. Suspension for Delinquent Medical Records 8710-519	3 Year Review	Forward To BOD For Approval
14. Temporary Privileges 8710-515	3 Year Review	Forward To BOD For Approval
Neonatal Intensive Care (NICU)		
1. Replogle Tube Insertion and Maintenance	3 Year Review, Practice Change	Forward To BOD For Approval
2. Weaning from Thermal Support	3 Year Review, Practice Change	Forward To BOD For Approval
Outpatient Specialty Clinic		
1. Acuity Class System	3 Year Review	Forward To BOD For Approval
Pulmonary		
1. RCP Staffing Guidelines in the NICU	3 Year Review	Forward To BOD For Approval
Surgical Services		
1. Anesthesia Equipment Policy	3 Year Review, Practice Change	Forward To BOD For Approval
2. Bumping Surgery Procedures Policy	3 Year Review	Forward To BOD For Approval
3. Disaster and Emergency Preparedness Policy	3 Year Review, Practice Change	Forward To BOD For Approval
4. Food and Drink, Surgery Policy	3 Year Review, Practice Change	Forward To BOD For Approval
5. Laser Safety Policy	DELETE	Forward To BOD For Approval
6. Loaner Trays Policy	DELETE	Forward To BOD For Approval
7. On Call Policy	3 Year Review, Practice Change	Forward To BOD For Approval
8. Operating Room (OR) Committee Policy	3 Year Review, Practice Change	Forward To BOD For Approval
9. PACU & SPRA Staffing & Scheduling Practices Policy	3 Year Review, Practice Change	Forward To BOD For Approval
10. PACU On Call Coverage Policy	3 Year Review, Practice Change	Forward To BOD For Approval
11. Patient Transport to the OR Policy	3 Year Review, Practice Change	Forward To BOD For Approval
12. Perioperative Standards of Practice Policy	3 Year Review, Practice Change	Forward To BOD For Approval
13. Protective Barriers; Materials for Gowns and Drapes Policy	3 Year Review, Practice Change	Forward To BOD For Approval
14. Sanitation; Perioperative Policy	3 Year Review, Practice Change	Forward To BOD For Approval

ADMINISTRATION CONSENT AGENDA
April 20th, 2020

CONTACT: Barbara Vogelsang, CNE

Policies and Procedures	Reason	Recommendations
15. Staffing Policy	3 Year Review, Practice Change	Forward To BOD For Approval
16. Standard Precautions in Surgery Policy	3 Year Review, Practice Change	Forward To BOD For Approval
Wound Care		
1. Acuity Class System	3 Year Review	Forward To BOD For Approval
2. Chart Order	3 Year Review	Forward To BOD For Approval
3. Collaboration	3 Year Review	Forward To BOD For Approval
4. Data Managment	3 Year Review	Forward To BOD For Approval
5. Discharge Instructions	3 Year Review	Forward To BOD For Approval
6. Disseminating Medical Information	3 Year Review	Forward To BOD For Approval
7. Home Care Referrals	3 Year Review	Forward To BOD For Approval
8. Nurse-PT Visit	3 Year Review	Forward To BOD For Approval
9. Outcome Designation for Non-Healing Wounds	3 Year Review	Forward To BOD For Approval
Wound Hyperbaric Oxygen Therapy		
1. Acuity Classification System	3 Year Review	Forward To BOD For Approval
2. Admission Procedure	3 Year Review	Forward To BOD For Approval
3. Bomb Threat	3 Year Review	Forward To BOD For Approval
4. Earthquake	3 Year Review	Forward To BOD For Approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 02/09	**SUBJECT: Blanket Warmers**
REVISION DATE: 08/12	~~**POLICY NUMBER: IV.OO**~~
Department Approval:	~~03/17~~03/20
Clinical Policies & Procedures Committee Approval:	~~03/17~~03/20
Nursing Executive Council Approval:	~~03/17~~04/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	04/20
Professional Affairs Committee Approval:	~~04/17~~ n/a
Board of Directors Approval:	04/17

A. **PURPOSE:**

1. To ensure **patient safety while using warmed blankets through proper use of** blanket warmers.~~ are maintained according to manufacturer's recommendations.~~

B. **POLICY:**

1. Blanket warmers shall be maintained according to manufacturer's instructions for use (IFU).

~~1.~~**2.** Blankets are stored in the blanket storage compartment of the warmer unit.

~~2.~~**3.** The warmer is not to be overfilled. Leave approximately two inches between stack of blankets and the roof and walls of the blanket warmer.

~~3.~~**4.** Blanket warmer thermostats shall be set to a maximum temperature of 130°F.

a. The temperature should be monitored any time a blanket is removed. Staff should assess the temperature gauge prior to removing blankets from the warmer.

b. If blanket warmer **temperature** gauge is found to be above ~~131 degrees~~**130°F:**~~., then Engineering should be notified.~~**:**

i. Enter a work order and call Building Engineering department

~~i.~~**ii. Place blanket warmer out of service**

~~b.~~**iii. Do not use blankets if they blankets are overheated until the temperatures are within acceptable range.**

~~i. Blankets above 130 degrees may pose a potential risk of skin burns.~~

5. Blanket warmers shall be used for clean blankets only.

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

~~4.~~**1. Blanket Warmer List**

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

1. ECRI Institute Continues to Recommend Maximum Temperature Setting of 130 Degrees Fahrenheit for Blanket Warming Cabinets: https://www.ecri.org/components/PSOCore/Pages/PSMU040114_ecri.aspx; **Published April 1, 2014. Retrieved March 5, 2020.**

2. AORN, Inc. (2020). *Guidelines for Perioperative Practice*. Denver.

~~2. AORN Environment of Care: What are the appropriate temperature settings for blanket warming cabinets?: https://www.aorn.org/guidelines/clinical-resources/clinical-faqs/environment-of-care~~

3. The Joint Commission: Medical Equipment-Blanket Temperature Risk Assessment: ~~https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFaqId=1132&ProgramId=46~~ **https://www.jointcommission.org/en/standards/standard-**

faqs/hospital-and-hospital-clinics/environment-of-care-ec/000001220/; Updated February 21, 2018. Retrieved March 5, 2020.

Blanket Warmer List

Tri City Mediacal Center & All Outpatient Clinics

Site Code: 17823

Asset ID #	Equipment Location	Manufacturer	Model #	Serial #
BW-01	ED	AMSCO	QDJ04	0406309035
BW-02	ED	AMSCO	QDJ01	0413593004
BW-03	1 North	PEDIGO	P-2010S	359983-000
BW-04	PolyStar/ MultiStar			
BW-05	2 Pavilion	PEDIGO	P-2010S	359982-000
BW-06	3 Pavilion	Enthermics	DC350	1325181-000
BW-07	4 Pavilion	PEDIGO	P-2010S	555897-000
BW-08	ICU	AMSCO	QDJO3	046897006
BW-09	2 East	Enthermics	DC350	1213722-000
BW-10	NICU	PEDIGO	P-2010S	
BW-11	3 East	FHC	SWC 24	0111807-703
BW-12	4 East	Enthermics	DC350	1196004-000
BW-13	Surgery /PACU	AMSCO	QDJ04	0401894024
BW-14	Pre-Op	AMSCO	QDJ04	0460793015
BW-15	OR1 &2 Sterile Storage			
BW-16	OR1	AMSCO	QDJ04	0403394101
BW-17	OR2	AMSCO	QDJ04	0401994050
BW-18	OR3	AMSCO	QDJ04	0401994049
BW-19	OR4	AMSCO	QDJ04	0403294012
BW-20	OR5	AMSCO	QDJ04	0403394105
BW-21	OR6	AMSCO	QDJ04	0401994048
BW-22	OR7	AMSCO	QDJ04	0401094006
BW-23	OR8	AMSCO	QDJ04	0403394106
BW-24	OR9	AMSCO	QDJ04	0403294014
BW-25	OR10	AMSCO	QDJ04	0403394103
BW-26	OR11	AMSCO	QDJ04	0403394104
BW-27	OR12	AMSCO	QDJ04	0403294015
BW-28	WCOR1	AMSCO	QDJ04	0401894027
BW-29	WCOR3	AMSCO	QDJ01	0401206080
BW-30	Post Partum	AMSCO	QDJ04	0401194033
BW-31	L&D Recovery	AMSCO	QDJ04	0401894021
BW-32	L&D	AMSCO	QDJ04	0401894023

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**DECEASED PATIENT CARE AND DISPOSITION**
Purpose:	To outline the nursing responsibilities for preparing the deceased for the morgue, transporting to the morgue, and placement into a cooler compartment.
Equipment:	Shrouding kit, morgue gurney, Chux for newborns, Maximal Barrier Protection (cap, mask, gown, gloves and large drape)

A. **PROCEDURE:**

1. If there will be Medical Examiner (ME) involvement, prepare body for viewing per ME guidelines.
2. After ensuring that there will be no ME involvement, remove all lines/equipment, tubes, and valuables (give to family or put in safe) from the body. See Patient Care Services (PCS) Policy – Patient Valuables, Liability and Control.
   a. Tie a knot in lines you are unable to remove.
   b. Place non-sterile dressing over wounds and discontinued invasive line sites and tape firmly.
3. Close patient's eyes and place a pillow under their head for family viewing.
4. Ensure identification band is accurate and in place.
5. Accommodate family religious/culture preference requests if legal and safe.
   a. Specifically ask if any family member wishes to view the deceased before placing in post-mortem bag.
   b. Deceased may stay in the room awaiting family member's arrival, but if room cannot be occupied for extended period other arrangements can be made.
   c. Discuss with the Manager /Administrative Supervisor if there are concerns or questions.
6. If corneal donation is a consideration, initiate the following within two hours of pronouncement of death:
   a. Close the eyes
   b. Elevate the head (a pillow roll is acceptable)
   c. Place a light ice pack over the closed eye lids immediately after death – crushed ice cubes (equivalent of two ice cubes) in an exam glove is placed over the bridge of the nose
7. After family viewing, obtain morgue packet.
   a. Do not use chin straps or strings to bind the deceased patient's chin, wrists or ankles.
   b. Affix Patient Identification labels to three tags ensuring information is legible; ensure information matches patient identification band.
8. For adults, place one tag around the great toe after verifying the name on the tag with the patient's hospital identification band. -Place one tag on the outside of white post-mortem bag tied to the zipper. -Place one tag on a labeled hospital personal belongings bag with the room number and name clearly visible.
   a. If patient is contagious, attach a red biohazard tag to the zipper on the outside of the post-mortem bag.
9. If there are dentures, put them in the mouth. -If unable to do so, place in a labeled denture cup and send home with family. -If family refuses, ~~keep with Release of Deceased formi~~ **items should be sent, with patient belongings, to security**.
10. Place unclothed body into the white post-mortem bag with the head at the bottom of the bag so after it is zipped, the zipper will be at the patient's feet.
    a. If family requests patient be clothed in his garments, this is allowed (mortuary to be notified). If there is drainage, contain with a ~~C~~chux.
11. Close the bag and zip up completely. -The matching of the toe tag and tag on zipper will identify the patient. -The deceased is now ready for transport to the morgue.
    a. Special covered gurney in morgue to be used for transport.

Patient Care Services~~Department~~Content Exper	Clinical Policies & Procedures	Nursing Executive Council	Medical Staff Department or Division	Pharmacy & Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
3/03, 5/07, 6/09, 3/12, **10/19**	3/12, 8/15, **11/19**	3/12, 09/15, **02/20**	n/a	n/a	3/12, 09/15, **03/20**	**04/20**	5/12, 10/15, **n/a**	5/12, 10/15

12. Obtain and sign for the morgue key from Private Branch Exchange (PBX) (office located on lower level). -Retrieve the special covered morgue transport gurney. -Transport the patient to the morgue on the covered gurney and place the deceased feet first into the cooler compartment.
    a. Leave special gurney in morgue when not in use. Use lower level of hospital for transport as much as possible.
13. If all cooler compartments are full, notify the Administrative Supervisor by cell phone 760-644-6968.
14. Return key back to PBX and sign the key back in.
15. Make one copy of the completed Release of Deceased to put in medical record. Take the original report to the Administrative Supervisor or the Patient Representative.

B. **FETAL DEATHS:**

1. Refer to Patient Care Services **(PCS)** Procedure**: Perinatal Death (Miscarriage, Stillborn and Neonatal Death**~~Deceased Newborn/Stillborn,~~ Care **and Disposition**~~of~~.

C. **FORMS/RELATED DOCUMENTS:**

1. PCS **Procedure**~~Manual –~~**:** Patient Valuables, Liability and Control
2. PCS **Procedure**~~Manual –~~**: Perinatal Death, Stillborn and Neonatal Death**~~Deceased Newborn Stillborn,~~ Care **and Disposition** ~~of Procedure~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 04/17

SUBJECT: Glucose Monitoring During Exercise Therapy for ~~Diabetic~~ Patients with Diabetes

REVISION DATE(S):

Patient Care Services Content Expert~~Department~~ Approval ~~Date(s)~~:	**~~05/16~~12/19**
Clinical Policies and Procedures Approval ~~Date(s)~~:	**~~02/17~~01/20**
Nurse Executive Committee Approval ~~Date(s)~~:	**~~02/17~~02/20**
Medical Staff Department/Division Approval ~~Date(s)~~:	**n/a**
Pharmacy and Therapeutics Approval ~~Date(s)~~:	**n/a**
Medical Executive Committee Approval ~~Date(s)~~:	**~~03/17~~03/20**
Administration Approval:	**04/20**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~04/17~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**04/17**

A. **PURPOSE:**

1. To provide safe, therapeutic care for outpatients with diabetes during their exercise training session in Tri-City Healthcare District (TCHD) rehabilitation facilities.

B. **POLICY:**

1. All phase **two (2)** patients who are taking insulin or oral diabetes medications **which can cause hypoglycemia** will have their blood glucose level checked before and after exercise during their first **three (3)** exercise sessions by the **staff trained and competent (for example** Registered Nurse RN or Respiratory Care Practitioner (RCP)**)** ~~staff trained~~ in the use of the Nova Stat Strip glucose monitoring system.
2. If blood sugars are stable (between 100-300 mg/dL) after 3 visits pre and post exercise, patients will no longer need to continue having checks (unless symptomatic).
3. If blood sugars are unstable (under 100 or over 300 mg/dL) ~~after 3 visits~~, patient must make an appointment with their Primary Care Provider (PCP) to have their medication and diet reviewed. The patient will need to bring back a note from PCP stating he/she is cleared to return to exercise.
4. The RN/RCP will again check blood sugars pre and post exercise over the next 3 visits. If stable (100-300 mg/dL), patient does not need to continue being checked. If unstable (below 100 or above 300 mg/dL) patient will again need clearance from PCP to return to exercise. A referral to a diabetes educator will be given to patient, as well as other educational materials.

C. **PROCEDURE:**

1. RN/RCP on staff shall test diabetic patients' pre and post exercise blood sugars for their first 3 visits followed immediately with action based on results.
2. If blood glucose is less than 100 mg/dL, the patient shall eat a pre-exercise snack of 15 grams of carbohydrate which they are instructed to bring to every session. Juice, glucose tabs, and glucose gel are kept in the department in case the patient did not bring his/her own snack. (Examples of fast acting carbohydrate are ½ cup orange juice, 1 cup skim milk, 3-4 glucose tabs or glucose gel equal to 15 grams, 8-10 lifesaver candies).
3. For patients with a pre exercise blood sugar less than 100 mg/dL who have eaten a 15 gram carbohydrate snack, wait 15 minutes after snack and recheck blood sugar. If below 100, repeat treatment. Notify physician for repeated low blood sugar levels.

4. If blood glucose is greater than 300 mg/dL, patient may not exercise that day. Notify physician if patient is unable to exercise due to elevated blood glucose level.
5. If the patient is driving him/herself, the post exercise blood sugar should be 100 mg/dL or greater. If the post exercise blood sugar is less than 100 mg/dL he/she should have a snack of 15 grams carbohydrate and re-check in 15 minutes and repeat until blood sugar is 100 or greater before being discharged home.

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**SWALLOW SCREENING IN THE ADULT PATIENT**
Purpose:	To screen for appropriateness of oral intake.
Supportive Data:	The swallow screen is performed on any medically stable patient who is at risk for aspiration secondary to the inability to swallow safely. This includes the nursing assessment of patient alertness, respiratory status, secretion management, voice quality and an effective cough. Oral intake is contraindicated if any of the above are compromised. This would constitute failure of the swallow screen.

A. **PROCEDURE:**

1. Prior to **three (3)** Ounce Water Protocol check patient's ability to swallow by giving the patient a teaspoon of water and assess for laryngeal movement, clear vocal quality, coughing, choking, or throat clearing during swallowing up to one minute. If able to swallow without difficulty proceed to 3 Ounce Water Protocol.
2. 3 Ounce Water Protocol:
   a. Observe patient.
      i. If patient is not alert then make patient **nothing by mouth (**NPO**)** until alert and then screen the patient.
      ii. If patient is alert, face is symmetrical, and tolerating their own secretions, proceed with swallow screen.
         1) Sit patient upright.
         2) Ask patient to drink entire 3 ounces (90 mL) of water from a cup or through a straw in sequential swallows without stopping.
         3) Assess patient for coughing, choking, or throat clearing during swallowing and up to one minute after drinking.
   b. Results
      i. Pass: Able to drink 3-ounces of water sequentially without overt signs or symptoms of aspiration.
      ii. Fail: Inability to drink the entire amount sequentially or demonstration of coughing or choking during trial.
3. If patient passes protocol, diet per physician/Allied Health Professional's order
4. If patient fails protocol:
   a. Keep NPO, notify the physician as needed
   b. Obtain order for Swallow Evaluation by Speech Pathologist as needed
5. Document results in electronic health record under Swallow Screen

B. **REFERENCES:**

1. Suiter DM, Leder SB, Karas DE. The 3 ounce (90 **mL**~~cc~~) water swallow challenge: A screening test for children with suspected oropharyngeal dysphagia. Otolarygology Head & Neck Surgery 2009;140:187-190.
2. Suiter DB, Leder SB. Clinical utility of the 3 ounce water swallow test. Dysphagia 2008; 23:244-250
3. Suitor, D. S., Sloggy, J., & Leder, S.B. (2014). Validation of the Yale Swallow Protocol: A Prospective Double-Blinded Videofluoroscopic Study. *Dysphagia*, 199-203.

Patient Care Services Content Expert ~~Revision~~ Dates	Clinical Policies & Procedures	Nurse Executive Council	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
6/06, 7/09, 1/12, 10/16, **10/19**	09/11, 4/15, 11/16, **11/19**	10/11; 4/15, 01/17, **02/20**	n/a	n/a	11/11; 05/15, 01/17, **03/20**	**04/20**	1/12; 06/15, ~~02/17~~ **n/a**	6/15, 02/17

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY MANUAL
DISTRICT OPERATIONS

ISSUE DATE: 9/05 **SUBJECT:** Library Services Mission and Scope of Service

REVISION DATE: 11/08; 12/10, 07/13 **POLICY NUMBER:** 8610-287

Administrative Content Expert~~Department~~ Approval ~~Date(s)~~:	~~04/16~~02/20
Administrative Policies & Procedures Committee Approval:	~~04/16~~02/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	03/20
Administration Approval:	04/20
Professional Affairs Committee Approval:	~~05/16~~ n/a
Board of Directors Approval:	05/16

A. **PURPOSE:**

1. To define the mission and scope of service provided by Library Services at **the** Tri-City **Healthcare District (TCHD)**~~Medical Center~~.

B. **MISSION:**

1. **TCHD**~~Tri City Medical Center~~ Medical Staff and Health Science Library is committed to:
   a. Providing high quality information resources and services which support clinical decision-making and excellence in patient care;
   b. Serving as an educational resource to all medical and hospital personnel;
   c. Continuing improvement in quality through education and adaptation of technological advances;
   d. Supporting the mission, strategic initiatives, and value statements of Tri-City Medical Center.
   e. Supporting Joint Commission Standard IM.03.01.01 for continuous access to knowledge based resources.

C. **SCOPE OF SERVICE:**

1. The aim of the service is to provide information that can be used to support clinical and management decision-making, quality improvement processes, continuing education of staff, research, and when appropriate, patient and family education. -Information is to be provided in a cost-effective and customer-friendly manner.
2. Use and Access
   a. The **Medical Staff and Health Science ~~l~~Library** is available **24 hours via key pad access** to all ~~Tri-City Medical Center~~ Physicians~~, hospital employees, students officially rotating through~~ (**Allied Healthcare Professionals,** residents, physician assistant**/nurse practitioner** students~~, nursing students, and interns in other disciplines), and volunteers~~. ~~24-hour access is available for physicians and hospital personnel~~ only. ~~Patients, their significant others and community members may use the Library at the discretion of the Information Specialist, and only when the Information Specialist is present.~~ Use is limited to patient care and educational purposes.
3. Services
   a. Reference Services
      i. **Staff can request** ~~A~~assistance ~~is provided~~ in locating factual and bibliographic information. Research and literature searches can be requested. This includes, but is not limited to, information for direct patient care, in-services, and administrative health care issues. -Literature searches needed for urgent patient care issues or

urgent administrative issues receive top priority~~. The library also provides user education programs upon request. The Information Specialist may be reached by telephone, fax, or e-mail.~~

~~b. Circulation of Library Materials~~

~~i. Library books may be checked out for 3 weeks.~~

~~ii. A complete list of journals currently in the library is available, and details the title, the years held, and whether the journal is a current subscription.~~
~~Journals may circulate in the Medical Staff Library for 2 weeks; a photocopier is available in the library so that a needed article may be reproduced.~~

~~1)~~**ii.** Photocopies of library-related materials may be made in the library at no charge.

iii. Copyright restrictions apply to all materials.

~~c. Interlibrary Loans~~

~~i. Materials that are not available in Tri-City Medical Center's library can usually be obtained through interlibrary loan within twenty-four to forty-eight hours. Interlibrary loans for urgent patient care issues or urgent administrative issues receive top priority. Service is provided at discretion of the librarian and interlibrary loan charges may apply.~~

~~d.~~**b.** Computer Services

i. ~~Patrons may utilize l~~**L**ibrary computers **may be used** for reference and hospital-related purposes. ~~-~~Current online subscriptions include **Clinical Key**~~MDConsult~~ and **UpToDate**~~CINAHL~~. Use is limited to patient care and educational purposes. ~~Computer use for urgent patient care issues or urgent administrative issues receives top priority.~~ Tri-City's Information Technology Internet Access Policy regulates all computer use.

~~e. Library Hours of Service:~~

~~i. 24-hour access for physicians and hospital personnel via keypad entry. Access for individuals not associated with Tri City Medical Center available only when information specialist is in attendance.~~

D. **REFERENCES:**

1. Joint Commission Standard IM.03.01.01

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 11/88 **SUBJECT: Billing for Cardiac Rehab**

REVISION DATE: 2/06, 11/07, 12/12

Cardiac Rehabilitation Department Approval:	**02/20**
Division of Cardiology Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Apprvoal:	

A. **PURPOSE:**
1. To establish guidelines for the billing process for the Cardiac Wellness Program.

B. **POLICY:**
1. To ensure that certain requirements are met before enrolling a patient into Phase II and IV of the Cardiac Wellness Program.

C. **PROCEDURE:**
1. TCMC admitting and registration department shall be responsible for:
   a. Verifying insurance coverage
   b. Scanning into the system the insurance authorization when necessary
   c. Ensuring information is correctly entered in Cerner system
2. Upon enrollment into the program, patients shall receive a specific account number for the cardiac rehabilitation program (CRP). All insurance accounts shall receive a (CRP) after their account, whereas all cash accounts shall receive a (CRPM). Two face sheets and two sheets of labels will be printed and given to the CR department for the patient's medical record.
3. All non-contracted Phase II patients shall be billed on a daily basis. Maintenance patients shall be billed on a monthly basis. The maintenance billing shall be done before the end of every month.
4. The charges for each patient are entered in the computer using the patient's most recent CRP or CRPM number.
5. Each patient shall be billed according to his or her program status (Phase) in the Cardiac Wellness Program. This status/including insurance information shall be listed on the patient's exercise flow sheet.
6. The phases are listed as follows:
   a. Phase I – (inpatient)
   b. Phase II – first one to twelve weeks of cardiac rehabilitation
   c. Phase IV – (maintenance) – ongoing program
7. Patient's registering as a cash account shall be coded in Admitting as a CRPM. All others shall be coded as CRP
8. All patients in Phase II shall be charged for "monitored exercise" after each individual visit on a daily basis. All Phase IV (maintenance) patients shall be billed a monthly charge of a "full month", a "spouse" charge, a "½ month", or a "six month subscription".
9. To perform the actual billing, you need to select log on to "compass" open the "*batch charge entry*" application and proceed as follows:
10. Enter patient's last name, first name in appropriate window and press "enter."
11. Select the appropriate patient (there may be more than one, so you may need to compare DOB), select the *"recurring CRP"* or *"recurring CRPM"* encounter.
12. Go to the drop-down menu and select ***"cardiac rehab charge."***

13. Select appropriate charges (you may select more than one charge at a time) and click on "submit button to move to charge window.
14. If correct charge is chosen and you are satisfied with selection, press, "submit charges." Otherwise, at this point, you may make any necessary changes to your selection.
15. Once selection is correct, press "enter"
16. Information shall be filed.

D. **EXCEPTION DETAIL REPORT:**

1. The Exception Detail Report shall be printed daily and reviewed for errors by the department Clinical Manager, and when she/he is not there, it shall be monitored by the person in charge of doing the daily billing.
2. All errors shall be investigated and corrected immediately.

Tri-City Medical Center
Oceanside, California

EMERGENCY DEPARTMENT

ISSUE DATE:

SUBJECT: **Elopement, Wandering, Patient at Risk from ED**

REVISION DATE(S):08/0/; 02/11

~~**POLICY NUMBER: 7010-005**~~

Emergency Department Approval:	**02/20**
Department of Emergency Medicine Approval:	**n/a**
Pharmacy and Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**04/20**
Professional Board Committee Approval:	**n/a**
Board of Directors Approval:	

A. **DEFINITIONS:**

1. To define a process for the management**, prevention and documentation** of patients who are at risk for leaving the Emergency Department (ED) without authorization.

B. **POLICY:**

1. Identify patients at risk for wandering and/or for leaving the ED without authorization.

~~1.~~2. Appropriate steps shall be taken to attempt to prevent at risk patients from leaving the ED without authorization.

~~B.~~C. **PROCEDU~~U~~DRE:**

1. **Staff ~~responsibilities~~interventions:**
   - a. Identify patient is at risk.
   - b. Have patient undress and don a hospital gown.
   - c. Apply Wandering Band.
   - d. Alert ~~AUM and/or~~ Charge RN, Physician**/Allied Health Professional (AHP)**, Security and Team members of patient at risk.
   - e. Communicate patient is at risk from care-giver to care-giver.
   - f. Assign a Sitter and communicate responsibilities of assignment.
   - g. Escort all patients at risk for elopement to the restroom and monitor the door.
2. **Identifiers for patients at ~~of~~ risk for elopement:**
   - a. History of wandering or elopement.
   - b. Restless, agitation and pacing.
   - c. Verbalizing intent to leave.
   - d. Confusion **or change in mental status.**~~,~~
   - **e.** Request clothing and/or personal belongings.
   - **~~e.~~f. Active 5150 hold.**
3. **Patient determined to be missing:**
   - **~~3.~~a. Any staff observing an at risk patient attempting to leave the premises without authorization shall attempt to prevent such departure. Should the attempt fail, the staff member shall immediately notify the Charge RN.**
   - **b. When identified, ~~T~~t**he ~~AUM and/or~~ Charge RN will notify the attending physician, Security, Police Department, ED Clinical ~~Operations~~ Manager, ~~and~~ Administrative Coordinator**, and family as appropriate.**
   - **c. Attempts shall be made to locate the patient. Hospital security and/or law enforcement shall be notified as appropriate.**

~~C.~~**D. DOCUMENTATION:**

1. Complete a clinical note in the patient's chart, which includes **a summary of the events that led to the incident, actions for prevention instituted, the time the patient was determined missing, attempts to locate patient, who was notified of the patient's elopement,** ~~the time the patient was determined missing, actions for prevention instituted~~ and actions taken for retrieval.
2. ~~Communicate to family members.~~
3. ~~Complete a QRR form.~~

~~D. APPROVAL PROCESS:~~

1. ~~Emergency Department Medical Director~~
2. ~~Board of Directors~~

Tri-City Medical Center
Oceanside, California

Environmental Services

ISSUE DATE: **NEW** **SUBJECT: Cleaning Guidelines**

REVISION DATE:

Environmental Services Approval:	**04/20**
Infection Control Committee Approval:	**04/20**
Administration Approval:	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To ensure Environmental Services staff members can identify the basic elements listed below that are required and used when cleaning patient rooms. The basic elements are as follows:
   a. Solutions and / or chemicals needed to clean and / or disinfect
   b. Tools and equipment
   c. Consumables e.g., toilet tissue, tissue, paper towel, etc.
2. To identify the safety measures to implement when cleaning patient rooms.

A. **DEFINITIONS:**

1. Cleaning: the physical removal of foreign material including dust, soil, and organic material such as blood, secretions, excretions, and microorganisms. Cleaning physically removes rather than kills microorganisms and is accomplished with water, detergents and mechanical actions. Cleaning is performed prior to disinfection or sterilization.
2. Disinfection: the inactivation of disease producing microorganisms. Used on inanimate objects a and surfaces. Disinfection usually involves chemicals, heat, or ultraviolent light.
3. Equipment: cleaning equipment is placed into two groups; non-powered (requires the individual and provide the energy to make it function and powered (requires electricity or batteries). Non-powered equipment includes cleaning and transport carts, mop buckets and wringers, micro-fiber systems. Powered equipment includes wet and dry vacuum cleaners, carpet extractors, floor buffers, high-speed burnishers, sweepers, and automatic floor scrubbers.
4. High-Level Disinfection – destroys all forms of microbial life, except high numbers of bacterial spores.
5. Intermediate-Level Disinfection – kills vegetative bacteria, tubercle bacilli, fungi, and some viruses
6. Low-Level Disinfection – kills most vegetative bacteria, fungi, and viruses. Does not kill spores and some viruses
7. Sterilization: the destruction of all forms of microbial life including bacteria, viruses, spores, and fungi.
8. Tools: brushes, mops, mop handles, buckets, micro-fiber systems

B. **POLICY:**

1. Check electrical cords for damage before using powered equipment.
2. Ensure the powered equipment is working proper before using
3. Follow the hospital policy for performing hand hygiene
4. Check posted signage prior to entering a patient room. Wear the appropriate personal protective equipment (PPE) based on the posted signage before entering a patient room or cleaning department

5. Ensure to place the appropriate wet floor or caution signs when cleaning floors or vacuuming
6. Practice proper lifting techniques and request assistance when objects are too heavy
7. Use chemicals as directed by the manufacturer's guidelines
8. Do not mixt or combine chemicals
9. Review the Material Safety Data Sheets (MDS) and / or labels when selecting chemicals for cleaning
10. All occupied patient rooms shall be cleaned daily and as needed (PRN).
11. All patient rooms will be terminally cleaned when a patient is discharged or transferred to another level of care according to Tri-City Medical Center (TCMC) procedures.
12. EVS staff members will use the electronic bed board system to inform inpatient areas when a patient room is cleaned.
13. EVS staff members notify the nursing staff and used the electronic bed board system to place rooms on hold when one or all of the following listed below are remain in a discharged or transfer room. The room will be cleaned once the items are removed.
    a. Intravenous (IV) tubing and/or solutions are attached to an IV pole or IV tubing remains inserted in an infusion pump
    b. Bedside commodes (BSC), urine or stool output collection containers, i.e., urinals or hats contents are not discarded
14. The following safety measures shall be implemented:
    a. Standard precautions or the isolation precautions.
    b. When using a cleaning cloth and bucket system, never re-immerse cloths into the bucket, instead change cloths
    c. If using pop-up disposable wipes:
        1) Use properly by changing frequently to ensure proper application
        2) Ensure the item remains wet for the appropriate dwell time
        3) Ensure to close the pop-up wipe top after use to prevent the wipes from drying out

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

1. **Environmental Services Procedure:** Cleaning Cart Set-up
2. **Environmental Services Procedure:** Patient Rooms Daily and Terminal Cleaning
3. Isolation Patient Rooms Daily and Terminal Cleaning

D. **REFERENCE(S) ~~LIST~~:**

1. Association for the Healthcare Environment of the American Hospital Association. (2012). Practice guide for healthcare environmental cleaning (2nd ed).

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 09/11

SUBJECT: Credentialing Criteria, Cardiac Rehab (Outpatient)

REVISION DATE(S): 09/11, 07/17

POLICY NUMBER: 8710 – 564

Medical Staff Department Approval:	~~03/17~~02/20
Credential Committee Approval:	~~04/17~~03/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~06/17~~03/20
Administration Approval:	04/20
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

A. **PURPOSE:**

1. To provide criteria for use in credentialing physicians who request privileges in cardiac rehabilitation at the centers located at 4002 Vista Way, Oceanside and at 6250 El Camino Real, Carlsbad.

B. **INITIAL CREDENTIALING:**

1. Board certified by the American Board of Cardiology, American Board of Internal Medicine, American Board of Family Practice or the American Board of Emergency Medicine; or completion of an ACGME-approved residency in Cardiology, Internal Medicine, Family Medicine or Emergency Medicine;
2. For non-cardiologists, experience in cardiovascular care;
3. Current ACLS certificate or experience and knowledge in emergency procedures.

C. **PRIVILEGE AND PROCTORING REQUIREMENTS:**

PRIVILEGE	PROCTORING	REAPPOINTMENT
Consultation, cardiac rehab locations	2	10

D. **ONGOING PROFESSIONAL PRACTICE EVALUATION:**

1. Cases will be reviewed on an ongoing basis and reported to the practitioner's primary department/division with the goal of patient safety and successful performance of the procedure(s).

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 02/07	**SUBJECT:** Credentialing Criteria, Chronic Non Healing Wound Care
REVISION DATE(S): 03/07; 03/10; 07/11; 07/12	**POLICY NUMBER:** 8710 – 523

Medical Staff Department Approval ~~Dates(s)~~:	~~03/17~~2/20
Credentials Committee Approval ~~Date(s):~~	~~03/17~~2/20
Pharmacy and Therapeutics Approval ~~Date(s):~~	n/a
Medical Executive Committee Approval ~~Date(s):~~	~~03/17~~03/20
Administration Approval:	04/20
Professional Affairs Committee Approval ~~Date(s):~~	~~04/17~~ n/a
Board of Directors Approval ~~Date(s):~~	04/17

A. **PURPOSE:**

1. The following sites have been designated as locations with adequate resources to allow the performance of the designated privileges:
   ~~a. 161 Thunder Drive, Suite 112, Vista, California~~
   ~~b.~~**a.** 6260 El Camino Real, Carlsbad California
   ~~c.~~**b.** 4002 Vista Way, Oceanside, California

B. **POLICY:**

1. Physicians/Allied Health Professionals/podiatrists who request wound care privileges must work within their scope of practice (*Podiatrists scope of practice means foot and ankle only) and shall demonstrate the ability to care for chronic non-healing wounds, including but not limited to: pressure, diabetic, venous, arterial, collagen vascular, autoimmune, and oncologic, and provide assessment and evaluations for patients with chronic non-healing wounds inclusive of:
   a. Routine review of patient record and recent labs
   b. Physical examination of all patient's bony prominences for evidence of excessive pressure or skin breakdown
   c. Determination of the number of observed chronic non-healing wounds and definition of their acuity
   d. Evaluation and management of any medical problems that would prevent wound healing
   e. Development of a treatment plan that facilitates wound healing
2. Physicians/Allied health Professionals/podiatrists shall be knowledgeable and capable of managing:
   a. Wound colonization and infection
   b. Appropriate antibiotics usage
   c. Prescription of needed support surfaces
   d. Advisement on off-loading techniques
   e. Enzymatic, mechanical and sharp debridement
   f. Wound biopsy techniques
   g. Pain management
   h. Indications for the use of adjunctive chronic wound care therapy such as, but not limited to: Vacuum Assisted Closure Devices, Collagen Matrix Implants, Platelet Derived Growth Factor, Oxidized Regenerated Cellulose, Living Dressings, Selective Impedance Electrical Stimulation and other adjunctive therapy which may, from time to time, become available.
   i. Referrals - demonstrate proficiency in knowing when and to whom to refer a patient

requiring specialized care outside of his/her area of expertise.

C. **CREDENTIALING CRITERIA:**

1. Initial Criteria:
   a. Surgeon: The applicant must have completed an ACGME accredited residency program in one of the following: Orthopedic Surgery, General Surgery, Vascular Surgery, Plastic Surgery or possess Board Certification in Podiatric Medicine.
   b. Non-Surgeon: The applicant must have completed an ACGME accredited residency program in one of the following areas: Family Practice, Internal Medicine, Infectious Disease, Emergency Medicine, Physical Medicine and Rehabilitation, Interventional Cardiology, Interventional Radiology, a fellowship in a field that includes the care of wounds, or completion of applicable course work within specified time frame.
   c. Allied Health Professionals: The applicant must be licensed by the Physician Assistant Board of California and have completed hands-on training that includes the care of wounds or completion of applicable course work within specified time frame.
2. Proctoring Criteria:
   a. Non-Surgeon: The proctoring of five (5) cases of debridement must be done by a physician or surgeon who routinely performs unsupervised debridement at Tri-City Healthcare District (TCHD) or at another Joint Commission-approved facility.
   b. Allied Health Professionals: The proctoring of five (5) cases of debridement must be done by a physician or surgeon who routinely performs unsupervised debridement at TCHD or at another Joint Commission-approved facility.
   c. Surgeon: Does not require proctoring.
3. Reappointment Criteria:
   a. Twenty (20) documented procedures of chronic wound care per two-year reappointment cycle.
   b. Physician/Allied Health Professionals- specific quality data outcomes for reappointment time frame as defined by the Chronic Wound Care Program. If a physician's wound healing outcomes, healing rates and debridement rates fall below the 65th percentile success rating, his/her reappointment shall then be based on a thorough review of his or her performance by physician(s) who hold unsupervised wound care privileges and compliance with any and all recommendations arising from that review.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 02/07	**SUBJECT:** Credentialing Criteria, Hyperbaric Medicine Oxygen Therapy
REVISION DATE(S): 03/07, 03/11, 01/12, 07/12, 12/13	**POLICY NUMBER:** 8710 – 523A

Medical Staff Department Approval ~~Dates(s)~~:	~~03/17~~02/20
Credentials Committee Approval ~~Date(s)~~:	~~03/17~~02/20
Pharmacy and Therapeutics Approval ~~Date(s)~~:	n/a
Medical Executive Committee Approval ~~Date(s)~~:	~~03/17~~03/20
Administration Approval:	04/20
Professional Affairs Committee Approval ~~Date(s)~~:	~~04/17~~ n/a
Board of Directors Approval ~~Date(s)~~:	04/17

A. **PURPOSE:**

1. The following sites have been designated as outpatient chronic non-healing wound care centers ("WCCs") with adequate resources to allow the performance of the designated privileges:
   ~~a. 161 Thunder Drive, Suite 112, Vista, California~~
   ~~b.~~**a.** 6260 El Camino Real, Carlsbad, California
2. The following criteria shall be used in credentialing physicians who request privileges for Hyperbaric Medicine Oxygen Therapy in the WCCs.

B. **CREDENTIALING CRITERIA:**

1. Initial Criteria:
   a. M.D., D.O., or DPM
   b. The applicant must have completed an ACGME accredited residency program in one of the following areas: Family Practice, Internal Medicine, Infectious Disease, Emergency Medicine, Physical Medicine and Rehabilitation, Orthopedic Surgery, Interventional Cardiology, Interventional Radiology, General Surgery, Vascular Surgery, Plastic Surgery, or hold a license to practice Podiatric Medicine.
   c. The applicant must have malpractice insurance that includes coverage for hyperbaric medicine.
   d. In addition to the above, the applicant must have one of the following:
      i. Completion of a Residency or Fellowship Training in hyperbaric medicine.
      ii. Completion of a hyperbaric medicine Training course approved by the American College of Hyperbaric Medicine (ACHM) or the Undersea and Hyperbaric Medical Society (UHMS)
      iii. Certified by the American Board of Preventive Medicine or the American Board of Emergency Medicine, in the subspecialty of Undersea and Hyperbaric Medicine.
   e. If more than two years has elapsed since completion of training, documentation of a minimum of sixteen (16) hours of CME related to hyperbaric medicine must be submitted.
2. Proctoring Criteria:
   a. A TCMC physician with unsupervised privileges in hyperbaric medicine, or a physician who holds hyperbaric medicine privileges at another Joint Commission-approved facility will proctor the first five (5) hyperbaric medicine therapy consults for practitioners with newly approved hyperbaric medicine privileges.
3. Reappointment Requirements:
   a. A minimum of sixteen (16) hours of CME related to hyperbaric medicine must be documented per two-year reappointment cycle. Half of this requirement can be met by

reading hyperbaric literature, with the rest being fulfilled through attending meetings and making presentations on hyperbarics.

b. Hyperbaric Medicine Oxygen Therapy: twelve (12) documented cases per two-year reappointment cycle.

c. Physician specific quality outcome data will be evaluated on an on-going basis as defined in Medical Staff Policy #8710-509.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 06/08	**SUBJECT:** Credentialing Policy, Expedited Credentialing and Privileging Process
REVISION DATE(S): 06/08; 03/14	**POLICY NUMBER:** 8710 – 550

Medical Staff Department Approval ~~Dates(s)~~:	~~03/17~~02/20
Credentials Committee Approval ~~Date(s)~~:	~~03/17~~02/20
Pharmacy and Therapeutics Approval ~~Date(s)~~:	n/a
Medical Executive Committee Approval ~~Date(s)~~:	~~03/17~~03/20
Administration Approval:	04/20
Professional Affairs Committee Approval ~~Date(s)~~:	~~04/17~~ n/a
Board of Directors Approval ~~Date(s)~~:	04/17

A. **PURPOSE**:
1. An expedited Board of Directors approval process may be used for initial appointments, reappointments, and granting privileges when the Board of Directors is unable to meet and established criteria is met.
2. The Chief Executive Officer (CEO) or Chief Board of Directors or Designee shall be responsible for granting membership and privileges when the Chief of Staff or designee, Department Chair/Division Chief, Credentials Committee, and the Medical Executive Committee have recommended the applications for the expedited approval process.

B. **EXPEDITED PROCESS:**
1. Schedule for Initial Applications:
   a. All expedited initial applications will be processed as outlined in Medical Staff Policy, Credentialing Policy, Processing Medical Staff Applications #8710-543.
2. Schedule for Reappointment Applications:
   a. All expedited reappointment applications will be processed as outlined in Medical Staff Policy, Credentialing Policy, Processing Medical Staff Reappointments #8710-548.

C. **POLICY:**
1. The Medical Executive Committee will determine which applications meet the expedited criteria.
   a. An applicant for privileges is ineligible for the expedited process if any of the following has occurred:
      i. The applicant submitted an incomplete application.
      ii. The applicant reports an unacceptable health status.
      iii. The Medical Executive Committee makes a final recommendation that is adverse or has limitations.
      iv. There is a current challenge or previously successful challenge to licensure or registration.
      v. The applicant has received an involuntary termination of medical staff membership at another hospital.
      vi. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.
      vii. The Medical Staff determines there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

2. Each credentialing application will be considered on a case-by-case basis.
3. The expedited application/reappointment reports will be forwarded the following month as an informational agenda item to the Board of Directors.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 02/07

SUBJECT: Credentialing Policy, Processing Medical Staff Applications

REVISION DATE(S): 01/09; 04/09; 09/09; 06/10; 01/12; 01/13; 03/13

POLICY NUMBER: 8710-543

Medical Staff Department Approval ~~Dates(s)~~:	~~03/17~~02/20
Credentials Committee Approval ~~Date(s)~~:	~~03/17~~02/20
Pharmacy and Therapeutics Approval ~~Date(s)~~:	n/a
Medical Executive Committee Approval ~~Date(s)~~:	~~03/17~~03/20
Administration Approval:	04/20
Professional Affairs Committee Approval ~~Date(s)~~:	~~04/17~~ n/a
Board of Directors Approval ~~Date(s)~~:	04/17

A. **PURPOSE:**

1. To provide an objective, evidence-based credentialing process that enables the Medical Staff to make informed recommendations to the governing body ensuring candidates for Medical Staff membership are credentialed according to The Joint Commission, CMS, and Medical Staff Bylaw requirements.
   a. If the Medical Staff determines during the review process that more information is required to complete an applicant's application, the applicant shall be notified immediately to provide additional documentation and the application shall be deemed incomplete until such information is received and the Medical Staff considers the application complete.

B. **POLICY:**

1. Applications shall be processed in accordance with the timeframes set by the Medical Staff Bylaws to the extent possible.
2. Each individual medical staff member or applicant shall have a separate credentials file.
3. Telemedicine applicants shall be fully privileged and credentialed according to Tri-City Healthcare District (TCHD) Medical Staff policies, rules and regulations, and bylaws.
4. The applicant's ability to perform privileges requested shall be evaluated and documented in the applicant's credentials file.
   a. If there is a concern about the applicant's ability to perform privileges requested, an evaluation by an external and internal source may be required to ascertain that the applicant can perform the requested privilege(s).
5. Requests for peer recommendations should address the following competencies:
   a. Medical/Clinical knowledge
   b. Technical and clinical skills
   c. Clinical judgment
   d. Interpersonal skills
   e. Communication skills
   f. Professionalism
   g. Ability to perform the requested privilege (e.g., physical and mental health status)
6. Requests for verification of internship, residency, fellowship, hospital affiliations and employment verification should address the following competencies:
   a. Patient care
   b. Medical/Clinical knowledge
   c. Practice-Based learning and improvement

d. Interpersonal and communication skills
e. Professionalism
f. Systems-based practice

7. The following Joint Commission/CMS approved primary source verification sources shall be utilized:

Item Requiring Primary Source Verification	The Joint Commission/CMS Approved Verification Source
i. Medical education	AMA or AOA Physician Masterfile, ECFMG certificate for foreign medical schools, or directly from source.
ii. Postgraduate Training (Internship, residencies, fellowships)	AMA or AOA Physician Masterfile, or directly from source.
iii. Board Certification	ABMS or services designed by ABMS as an official display agent.
iv. Current Licensure	Directly from state licensing board. LVS system or the Osteopathic Medical Board of California for any 805 reports.
v. Sanctions against licensure	Directly from the state Medical Boards and/or National Practitioner Data Bank (NPDB).
vi. Peer Recommendation/Current Competence	Peer Reference forms that include the six areas of "General Competencies." Directly from the peer reference provided by the applicant.
vii. Medicare/Medicaid Sanctions	NPDB, AMA/OIG, and SAM (System for Award Management)
viii DEA Certificate	National Technical Information Service (NTIS) website query or the Drug Enforcement Agency verification website

8. The following additional queries shall be performed:
   a. Criminal background check via contracted agency
   b. NPDB (Claims history, OIG)
   c. Hospital Affiliations/Medical Staff Membership (past and present)
      i. Telemedicine applicants – If more than 10 affiliations/medical staff memberships, randomly select ten (10) entities to query. If necessary, more entities may be queried.
   d. Work History (within the past five (5) years)
9. The applicant shall explain all time gaps greater than thirty (30) days in writing.
   a. If clinical privileges are being requested and a time gap away from medicine is identified, the Credentialing Specialist shall collect as much information as possible to assist the Medical Staff in making a determination of competence.
   b. If the applicant identifies an entity that can be queried to verify the gap, the Credentialing Specialist shall attempt to contact that source.
   c. If a gap of a year or longer away from the applicant's practice is identified, the applicant must provide documentation of medical practice activity and/or CME within two (2) years of the application date to determine the applicant's competency.
10. The applicant shall explain in writing any convictions or guilty pleas to a criminal offense (felony or misdemeanor other than minor traffic violations).
    a. The applicant shall be referred to the Physician Well-Being Committee for evaluation in cases when the applicant's conduct or substance use is in question. His/her application will not be considered complete until an initial evaluation is completed and reported to the Credentialing Specialist.
11. The applicant's identity shall be verified using the "Positive ID" form in accordance with The Joint Commission Standard MS.06.01.03 (EP 5). Appropriate identification includes a valid state-issued identification card, driver's license, or a valid military ID. (This element shall be completed onsite by an authorized individual prior to final approval. Verification of the identity of telemedicine practitioners who will not be entering the facility may be performed by a Joint

Commission accredited organization, with verification provided by the organization.)

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 02/05	**SUBJECT:** Documentation Requirements for Emergency Department Residents
REVISION DATE(S): 03/07, 04/17	**POLICY NUMBER:** 8710 – 532

Medical Staff Department Approval ~~Dates(s)~~:	03/17, 02/20
Emergency Medicine Approval ~~Date(s)~~:	03/17, 03/20
Pharmacy and Therapeutics Approval ~~Date(s)~~:	n/a
Medical Executive Committee Approval ~~Date(s)~~:	~~03/17~~03/20
Administration Approval:	04/20
Professional Affairs Committee Approval ~~Date(s)~~:	~~04/17~~ n/a
Board of Directors Approval ~~Date(s)~~:	04/17

A. **PURPOSE:**
1. To establish documentation requirements for Emergency Department Residents.

B. **POLICY:**
1. The Emergency Medicine residents evaluating patients in Tri-City Healthcare District's Emergency Department and responding to codes in the Medical Center are to do so under the supervision of the Emergency Medicine staff.
2. The resident will document the patient encounter in the same manner that a staff emergency physician would document the patient encounter when seeing a patient without the resident. A dictation, or electronic note, meeting Emergency Medicine standards is to be completed by the resident for each patient evaluated.
3. All patients evaluated in the Emergency Department by a resident will also be personally evaluated by a staff physician. The staff physician in turn will document his/her shared encounter with the patient and will create a summary dictation, or create an electronic summary note, that meets Emergency Medicine standards.
4. The staff physician is responsible for authenticating all resident dictations and orders.
5. The Medical Records Department will review all Emergency Department records for the documentation requirements outlined above to ensure timely completion of all records.

C. **ATTACHMENT(S):**
1. Dictation Format - Sample
2. Attending Summary Dictation – Sample

DOCUMENTATION FORMAT

A. **DEMOGRAPHICS:**
   1. Resident name, Attending Physician name, patient name Medical Record Number, and admit date.

B. **MODE OF ARRIVAL:**
   1. Triage or Ambulance, police, helicopter, etc.

C. **CHIEF COMPLAINT:**

D. **PRE-HOSPITAL CARE:**
   1. Summarize EMS run information if any

E. **HISTORY OF PRESENT ILLNESS:**
   1. Detailed history of present illness with duration and course of illness including pertinent negatives.

F. **PAST MEDICAL HISTORY:**
   1. Pertinent diseases important to HPI. Also other important diseases like diabetes, TB, hypertension.

G. **FAMILY HISTORY:**
   1. Relevant to present illness. Also, include heart, lung, and kidney disease, etc.

H. **SOCIAL HISTORY:**
   1. Pertinent work status, marital status, smoking history, use or abuse of alcohol or drugs, foreign travel, etc.

I. **MEDICATIONS:**

J. **ALLERGIES:**
   1. Type of reactions, if possible.

K. **REVIEW OF SYSTEMS:**

L. **VITAL SIGNS:**

M. **PHYSICAL EXAM:**
   1. General Appearance
   2. Pertinent aspects of the exam including pertinent negatives

N. **RESULTS:**
   1. Lab and X-ray results and their significance
   2. EKG results, ABG results, ultrasound results, etc.

O. **ED COURSE:**
   1. Summary of evaluation and treatment done in the Emergency Department, Including conversations with consultants or other facilities

P. **MEDICAL DECISION MAKING:**
   1. differential diagnosis
   2. Medical necessity for each exam ordered
   3. Reasons for this patient's particular treatment and disposition

Q. **CLINICAL IMPRESSION:**
   1. List the primary or most acute diagnosis first

R. **PLAN:**
   1. Admission
   2. Treatment as an outpatient
   3. Referral

S. **CONDITION ON DISCHARGE OR TRANSFER**

ATTENDING SUMMARY DICTATION (WHEN RESIDENT DICTATES)

A. Summary is generally included at the end of the Resident's documentation and may include:
   1. Pertinent History
   2. Pertinent Physical Exam
   3. Lab/X-Ray Findings
   4. Assessment
   5. Plan

Tri-City Health Care District
Oceanside, California

Medical Staff Policy Manual

ISSUE DATE: 12/19	**SUBJECT:** Liability Insurance Requirements
REVISION DATE(S): 12/09, 03/11	**POLICY NUMBER:** 8710 – 558

Medical Staff Department Approval ~~Date~~:	**~~03/17~~02/20**
Credentials Committee Approval ~~Date~~:	**~~03/17~~02/20**
Pharmacy and Therapeutics Approval ~~Date~~:	**n/a**
Medical Executive Committee Approval Date:	**~~03/17~~03/20**
Administration Approval:	**04/20**
Professional Affairs Committee Approval ~~Date~~:	**04/17**
Board of Directors Approval ~~Date~~:	**04/17**

A. **PURPOSE:**

1. To require professional liability insurance or approved form of financial security.

B. **POLICY:**

1. Consistent with Article VIII of the Tri-City Healthcare District Bylaws and Sections 2.2-1(c) and 4.5-1(g) of the Tri-City Medical Center Medical Staff Bylaws, every Practitioner on the medical staff or with privileges to attend patients at Tri-City Medical Center must, as a condition of holding staff membership or privileges, either carry professional liability insurance with an insurance company admitted to transact business in California in limits of not less than one million dollars ($1,000,000.00) per occurrence or claim/three million dollars ($3,000,000.00) annual aggregate, or furnish an approved form of equivalent financial security as described below in subsection 3.
   a. The Medical Executive Committee may, without the need to obtain the approval of the staff, modify the foregoing limits from time to time as may be appropriate to meet the needs of the Hospital and the Medical Staff and to reflect developments in the insurance industry, with the approval of the Board of Directors.
2. Each insured Practitioner must cause a current certificate of insurance or other acceptable evidence of liability coverage to be furnished to the Hospital. The certificate or other evidence of liability coverage must specify the expiration date of the policy, the amount of insurance, and reflect coverage for the privileges sought/granted.
   a. If the insurance policy or other coverage is restricted in any manner, the Practitioner must furnish a copy of such restrictions to the Hospital.
   b. The Practitioner shall not perform at the Hospital any procedure excluded from the insurance policy or other coverage. The Practitioner shall immediately notify the Hospital if the Practitioner's insurance or equivalent coverage expires, is reduced below the limits then in effect at the Hospital, or is canceled or terminated.
3. For purposes of this policy, an "approved form of equivalent financial security" means either:
   a. Insurance coverage that is written by or issued in connection with the Practitioner's membership in a cooperative, as defined in Section 1280.7 of the California Insurance Code; or successor legislation with minimum coverage conforming to the then applicable requirements; or
   b. Insurance coverage from an irrevocable trust established by an incorporated professional group to insure its members against damages and defense costs arising out of malpractice claims or litigation, and which has been actuarially determined to meet minimum coverage requirements then applicable.
   c. Self insurance coverage established by an incorporated professional group or other entity to insure the Practitioner against damages and defense costs arising out of

malpractice claims or litigation and which has been actuarially determined to meet minimum coverage requirements then applicable.

4. The "approved" forms of equivalent security shall be subject to review and approval by the Medical Executive Committee and Board of Directors.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 05/12

SUBJECT: Management of Conflict between Medical Staff and the Medical Executive Committee (MEC)

REVISION DATE(S): 05/12

POLICY NUMBER: 8710 – 567

Medical Staff Department Approval ~~Date~~:	~~03/17~~02/20
Credentials Committee Approval ~~Date~~:	~~03/17~~02/20
Pharmacy and Therapeutics Approval ~~Date~~:	n/a
Medical Executive Committee Approval ~~Date~~:	~~03/17~~03/20
Administration Approval:	04/20
Professional Affairs Committee Approval ~~Date~~:	~~04/17~~ n/a
Board of Directors Approval ~~Date~~:	04/17

A. **PURPOSE:**

1. To define the process for resolution of conflicts that may arise between the organized Medical Staff and the Medical Executive Committee.
2. Nothing in this policy is intended to prevent Medical Staff members from communicating with the Board of Directors on a rule, regulation, or policy adopted by the organized Medical Staff or the Medical Executive Committee. The Board of Directors shall determine the method of communication, and shall provide timely notification to the Medical Executive Committee, through the Chief of Staff, of any such communications.

B. **POLICY:**

1. In the event that a member of the Medical Staff has an issue or concern regarding a proposed Medical Staff Bylaws addition/amendment, the provisions of Article XIV of the Medical Staff Bylaws shall apply.
2. In the event that a member of the Medical Staff has an issue or concern regarding a proposed Medical Staff Rules and Regulations addition/amendment, the provisions of Section 13.1 of the Medical Staff Bylaws shall apply.
3. In the event that a member of the Medical Staff has an issue or concern regarding a proposed or adopted Medical Staff Policy or other issues not encompassed within items 1 and 2 above, the following process shall apply:
   a. The Medical Staff member shall provide a written description of the specific issue/concern to the Chief of Staff. The Chief of Staff may request further information, and may attempt to resolve the issue/concern through informal discussion.
   b. If the Chief of Staff' is unable to resolve the issue/concern pursuant to informal discussion described above, the specific issue/concern will be placed on the Medical Executive Committee agenda for discussion at the next scheduled meeting.
   c. The Chief of Staff will discuss the outcome of the MEC meeting discussion with the referring Medical Staff member.
   d. If the referring Medical Staff member feels the issue/concern is not resolved, the member may have the issue/concern addressed at a meeting of the MEC at which up to three (3) representatives may attend, upon submission of a petition signed by at least ten percent (10%) of the Medical Staff members eligible to vote.
   e. If after such MEC meeting the issue/concern still has not been resolved to the members' satisfaction, the matter shall be referred to the Joint Conference Committee.

C. **REFERENCES:**

1. The Joint Commission, Hospital Accreditation Standards 2017

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 01/07	**SUBJECT:** Peer Review Process: OPPE and FPPE
REVISION DATE: 03/08, 05/08, 06/08, 07/15, 04/17	**POLICY NUMBER:** 8710 – 509

Medical Staff Department Approval:	~~06/17~~03/20
Medical Staff Committee Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~06/17~~03/20
Administration Approval:	04/20
Professional Affairs Committee Approval ~~Date~~:	~~07/17~~ n/a
Board of Directors Approval:	07/17

A. **POLICY:**

1. Medical Staff members, departments, divisions and committees participate in peer review activities in accordance with this policy as well as the Medical Staff Bylaws, Medical Staff Rules and Regulations, Department/Division Rules and Regulations, and as required by licensure regulations, accreditation standards and conditions of participation in Federally funded programs. Peer review includes all evaluation activities involving members of the Medical Staff ("Practitioners"), including quality improvement, utilization review, monitoring, proctoring, focused review, Focused Professional Practice Evaluation (FPPE), On-going Professional Practice Evaluation (OPPE) and medical record review. The results of peer review activities are utilized to assess a Practitioner's professional practice as part of the credentialing, privileging, and corrective action processes.

B. **ONGOING PROFESSIONAL PRACTICE EVALUATION ("OPPE"):**

1. Ongoing Evaluation: At eight (8) month intervals, every Practitioner will undergo ongoing evaluations defined by each Department/Division. Relevant data is collected and assembled for review by the applicable Department Chair/Division Chief, who shall determine whether the Practitioner is performing: 1) well/within desired expectations and that no further action is warranted; or 2) that an issue exists that requires a focused evaluation; or 3) recommending revocation of a privilege because it is no longer required, recommending suspension of a privilege; or 4) that there has been zero performance of a privilege thereby triggering focused review (proctoring) whenever the practitioner performs the privilege; or 5) determining that a privilege should be continued without change because the organization's mission is to be able to provide the privilege to its patients. Ongoing evaluations shall be included in the Practitioner's credential file as part of the reappointment process. This process will evaluate a Practitioner's professional performance on an on-going basis, utilizing the following six (6) areas of General Competencies:
    i. Patient Care
    ii. Medical / Clinical Knowledge
    iii. Practice-based learning and Improvement
    iv. Interpersonal and communication skills
    v. Professionalism
    vi. Systems / Based Practice
2. Routine Individual Case Review is initiated based on department/division established criteria, reported deviations from expected care, statistical analysis showing (i) important single events, levels of performance, or patterns or trends varying significantly from expected; (ii) performance

varying significantly from other organizations; (iii) performance varying significantly from recognized standards, variances from utilization practices, (iv) risk management concerns involving quality of care, complaints from patients/family or staff relating to quality of care, (v) notices from regulatory bodies, accreditation agencies or third party payors involving quality of care, or if an appropriate, (vi) medical staff officer determines a need.

a. Initial Review: will be performed by the applicable department, division or committee (or designee thereof in accordance with the Medical Staff Bylaws or Rules and Regulations). Review findings will be documented and rated in accordance with a system established by the Medical Quality/Peer Review Committee (MQPR).

b. Review Timelines: Peer review of a particular matter shall be conducted as soon as reasonably possible based on when the matter is discovered and the complexity of the matter to be reviewed. In general, initial review of those circumstances identified herein should be carried out within thirty (30) days of discovery. Completion of the peer review process of a particular circumstance should occur within ninety (90) days of discovery, unless unusual events interceded, include but not limited to, focused review or referral to another department/division. Delays in review shall be reported to the MQPR and Medical Executive Committee. Expedited reviews are appropriate in the event there may be an imminent threat to the health or safety of an individual.

c. Reporting Findings: The findings of peer review activities are reported through the department/division/quality review committee to the MQPR Committee and on to the Medical Executive Committee within forty-five (45) days of completion.

d. Action: Consistent with the provisions of the Medical Staff Bylaws, the department/division/quality review committee/chair/chief may take action or make recommendations for action, including implementation of monitoring, proctoring and focused evaluation activities. Any recommendations for corrective action which may give rise to hearing rights shall be processed in accordance with the Medical Staff Bylaws.

C. **FOCUSED PROFESSIONAL PRACTICE EVALUATION("FPPE"):**

1. FPPE includes monitoring, proctoring and focused review activities. These activities are intended to evaluate the privilege-specific competence of a practitioner granted new/initial privileges, where activity is insufficient to evaluate competence at time of privilege renewal, or when questions arise regarding a practitioner's ability to provide quality care.
2. Monitoring: Monitoring shall consist of the on-going scrutiny of a Practitioner's practice without limitations or obligations on the monitored Practitioner. Examples include, but are not limited to, retrospective chart review, concurrent chart review, and concurrent observation.
3. Proctoring:
   a. Concurrent proctoring is when a Practitioner is obligated to arrange for another Practitioner to be present during a patient care episode and, except in the case of an emergency, when the Practitioner may not proceed with the specific patient care unless the proctor is present.
   b. Retrospective proctoring is when a Practitioner's provision of care and treatment is evaluated through review of the medical record. In the case of newly or initially granted privileges, all Practitioners shall be subject to such proctoring requirements as set for the in the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department/Division Rules and Regulations. In addition, in cases where a Practitioner has insufficient activity in a particular privilege to evaluate competence at time of renewal, the proctoring process may be utilized.
   c. The provisions of the Bylaws and Rules and Regulations shall be followed with regard to the methods of proctoring, duration of proctoring, criteria for conclusion of proctoring, process for conclusion of proctoring, etc.
4. Focused Review: In case where, based on the evaluation of a Practitioner's current clinical competence, compliance with standards, or ability to perform requested privileges, questions arise regarding a Practitioner's ability to provide quality care, focused review may be initiated. Circumstances which may give rise to focused professional practice evaluation include, but are

not limited to, provision of inappropriate care, including a single egregious incident or a clinical practice trend; mortality/morbidity complication rates at variance with applicable standards; failure to comply with hospital or medical staff policies, procedures, rules, regulations, bylaws, laws, regulations or standards; action by a licensing agency or other governmental entity; a significant pattern of malpractice claims; and a significant number or dollar amount of malpractice settlements, judgments or arbitration awards.

a. INITIATION PROCESS: Request for a FPPE must be in writing, submitted to the MQPR Committee and MEC, with supported reference to the specific activities or conduct alleged. Monitoring for the FPPE may include but is not limited to periodic chart review, concurrent chart review, direct observation, monitoring diagnostic and treatment techniques, interviews with staff.
b. Time frame for the FPPE: The Medical Executive Committee will approve the time frame required for monitoring
c. Monitoring Plan: If the MEC initiates the request for an FPPE, the Practitioner will be notified in writing within five business days. The initial written notice shall include a statement of facts demonstrating the request for FPPE was reasonable and warranted. This communication must also include what is wrong with the performance and what improvements are expected.

D. **GENERAL RULES SURROUNDING PEER REVIEW ACTIVITIES:**

1. Participants in the Peer Review Process:
   a. Peer: Within the context of this policy, a "peer" is one with similar clinical competence and scope of responsibility, and to the extent possible, in the same or related specialty, with the experience to render technically sound judgment of the clinical circumstances under review.
   b. Reviewer(s): The Department/Division/Committee Chair/Chief shall appoint Practitioners to perform case screening. The reviewer shall not be personally involved in the care of the patient, and to the extent possible should not be a member of the same practice group or have other personal or professional conflicts.
   c. Affected Practitioner: A Practitioner whose practice is being reviewed shall participate in the peer review process at the earliest reasonable time to afford the affected Practitioner with an opportunity to provide additional information or obtain education regarding the particular circumstances. This participation may include, but is not limited to, written response or attendance at a meeting, as determined by the Department/Division/Committee. In cases where the peer review process advances to the investigation for corrective action stage, the process shall comply with the provisions of the Medical Staff Bylaws.
   d. Support Staff: Employees of the hospital may be designated to assist the Medical Staff with its peer review activities. Employees acting in such roles shall be under the direction and supervision of the Medical Staff, and shall comply with all Medical Staff confidentiality requirements with regard to peer review materials.
   e. Data Sources/Collection: The cases for peer review are derived from quality review reports, patient satisfaction surveys, department specific criteria and reports generated from coded medical records.
   f. Criteria shall be reviewed by each department/committee/ annually. The criteria can be changed before the annual review with request from Department Chair.
   g. Cases involving more than one discipline are referred to other areas for additional input or action. These are tracked in the original committee until completed.
   h. Incomplete case reviews are referred to the next scheduled meeting.
   i. Cases referred for review shall be reviewed by the Practitioner screener of each committee (or designee), who shall determine whether to refer the case to the full committee for discussion, and make the preliminary assignment of category.
   j. Cases referred for discussion shall be summarized in sufficient detail to ascertain the salient facts of the case, the issue under discussion, and the reasoning underlying the

committee(s) decision.

k. Peer Review results are used in the reappointment process and in ongoing performance improvement activities for all members of medical staff.

l. Cases requiring immediate action or intervention are shared directly from Risk Manager to Department Chairman or Chairman of MQPR Committee and may require direct intervention.

m. For cases of Practitioner comportment, refer to Medical Staff Policy 511.1, Physician Behavior Policy.

E. **CATEGORY OF ASSIGNMENTS:**

1. Not Physician Related
   a. These events are casually related to the patient, to support care provided within the hospital, or care provided outside the hospital. Trending data from this category would not enhance or identify opportunities to improve physician-specific performance but may demonstrate trends useful for departmental or hospital wide management.
2. Within The Standard of Care
   a. These events reflect care that is within the contemporary standards of the specialty or expected standards of the department.
   b. These events reflect care that resulted in a complication and or prolonged clinical course, but the care remained within the contemporary standards of the specialty or the department.
3. Departure From The Standard of Care
   a. In each occurrence below, the physician will be notified:
      i. Minimal Variance
         a. These events reflect care that is minimally outside the contemporary standards of the specialty or expected standards of the department, and which might be to the detriment of the patient. There could be review, response or further study by the committee.
      ii. Moderate Variance
         a. These events reflect care that is clearly outside the contemporary standards of the specialty or expected standards of the department to the detriment of the patient. There must be review, response, trending, or further study by the committee.
      iii. Significant Variance
         a. These events represent gross departures from expected standards, raise immediate questions about judgment or technique and require an immediate response from the committee or department. In each occurrence, the physician will be notified.
      iv. Violation of Hospital Policy Includes poor communication or inadequate documentation.
      v. Violation of Physician Code of Conduct These behavioral events will initiate an immediate response. The physician will be notified.

F. **APPEAL PROCESS:**

1. Practitioner(s) asked for information by a reviewing committee with regard to quality events of a particular case(s) must respond within 30 days of receipt of such request. If no response is received within 30 days, the committee will make its determination without that physician(s) input.
2. If the Practitioner disagrees with the category assigned, he/she may request appeal from the committee where the assignment is made. If the appeal is not resolved to the satisfaction of the Practitioner, the MQPR Committee shall serve as the appeal review body and the MEC as the final appeal body.
3. The Medical Staff member may review his/her file on request as outlined in the Medical Staff Bylaws.

4. MQPR Committee oversees and supervises all medical staff peer review activity. When a subsidiary peer review body is not performing appropriately, the MQPR Committee is responsible for resolving issues.
5. When the MQPR Committee disagrees with an assigned significance category, the case will be referred back to the Department Quality Peer Review Committee for reconsideration. If no agreement is reached, referral will be made to the Medical Executive Committee for final arbitration.
6. Any evaluation of a quality event that is not completed within six (6) months of initial review will be reported to the MQPR Committee and may be subject to assessment by the committee chairperson.

G. **REFERENCES:**

1. Medical Staff Standards, Joint Commission 2017
2. Effective Peer Review A Practical Guide to Contemporary Design, 3rd Edition, Robert Marder, May 2013

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 10/05	**SUBJECT: Physician/Podiatrist Surgical Assistant**
REVISION DATE(S): 03/08, 11/14	**POLICY NUMBER: 8710 – 536**

Department Approval ~~Date~~:	**03/17, 02/20**
Credentials Committee Approval ~~Date~~:	**03/17, 03/20**
Pharmacy and Therapeutics Approval ~~Date~~:	**n/a**
Medical Executive Committee Approval ~~Date~~:	**~~03/17~~03/20**
Administration Approval:	**04/20**
Professional Affairs Committee Approval ~~Date~~:	**~~04/17~~ n/a**
Board of Directors Approval ~~Date~~:	**04/17**

A. **PURPOSE:**
1. To provide credentialing criteria for non surgeon physicians and podiatrists in non-podiatric cases to act as surgical first assistants.

B. **SCOPE OF PRIVILEGES:**
1. Provides aid in exposure, hemostasis, use of surgical instruments on tissues, and other technical functions to help the surgeon carry out a safe operation.

C. **CREDENTIALING CRITERIA:**
1. Letter(s) of reference from individual responsible for formal training and/or a surgeon who is familiar with the physician's experience as a surgical first assistant; **and**
   a. Completion of a surgical residency from a program accredited by the Accreditation Council for Graduate Medical Education (ACGME); **or**
   b. Completion of a surgical rotation during internship training of at least (six weeks) in duration; **or**
   c. A licensed Doctor of Podiatric Medicine, licensed after 1984.

D. **PROCTORING:**
1. A minimum of three (3) cases in which the physician acts as the surgical first assistant shall be proctored by the primary surgeon. There should be at least two (2) different primary surgeons.

E. **REAPPOINTMENT:**
1. A minimum of three (3) cases as a surgical first assistant shall be performed per two-year reappointment cycle. Quality assurance mechanisms will be applied and considered in the reappointment process.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 10/03

SUBJECT: Requests for New Privileges/Technologies New to TCHD

REVISION DATE(S): 03/08, 08/12

POLICY NUMBER: 8710 – 526

Medical Staff Department Approval ~~Date~~:	~~02/17~~02/20
Credentials Committee Approval ~~Date~~:	~~03/17~~02/20
Pharmacy and Therapeutics Approval ~~Date~~:	n/a
Medical Executive Committee Approval ~~Date~~:	~~03/17~~03/20
Administration Approval:	04/20
Professional Affairs Committee Approval ~~Date~~:	~~04/17~~ n/a
Board of Directors Approval ~~Date~~:	04/17

A. **POLICY:**

1. The Tri-City Healthcare District (TCHD) Medical Staff shall review requests for new procedures/technologies.

B. **PURPOSE:**

1. To provide a mechanism to evaluate requests for new procedures/technologies, to determine if criteria must be developed, and whether the resources necessary to support the request are available.

C. **PROCEDURE:**

1. Practitioners requesting new procedures/technologies must submit a request in writing along with supporting documentation and proposed criteria to the Medical Staff Office.
2. Upon receipt of a new procedure/technology request, the Medical Staff Office shall evaluate to determine the following:
    a. Is the procedure/technology new to TCHD: https://www.nlm.nih.gov/services/ctconsent.html
        i. If no, refer to appropriate department/division rules and regulations for criteria.
        ii. If yes, submit request and supporting documentation to the appropriate Department/Division to determine if it is similar to an existing procedure. If there is a similar procedure/technology, are there additional qualifications?
            1) If no, add to the appropriate Rules and Regulations and process for approval. Upon Board approval, add the procedures to the appropriate privilege list.
            2) If yes, assess resource availability.
                a) Submit request to the appropriate department director to determine; if there is sufficient space, equipment, staffing, and financial resources either in place or available within the specified time frame to support each requested privilege.
                b) If resources are available, the Medical Staff Office shall contact the appropriate Division and/or Department to review the request and develop criteria in collaboration.
                    i) If the request involves more than one Division and/or Department, the criteria should be outlined in policy format.
                    ii) If the request involves a single Division and/or Department,

the criteria shall be outlined in the appropriate rules and regulations.

c) Develop criteria based on current standards. Resources to consider include, but are not limited to:
   i) Clinical White Papers
   ii) Clinical resources
   iii) Community standards.

d) Criteria shall address as applicable:
   i) Board certification or equivalent training
   ii) Procedure-specific certification/training
   iii) Documentation of Current Competency – i.e. case logs
   iv) Initial Criteria
   v) Proctoring Criteria
   vi) Reappointment Criteria.

e) If resources are not available, request shall be denied.
   i) Such denial is not considered practice specific and is not subject to procedural rights of the Medical Staff Bylaws.

3. Upon finalization of proposed criteria, the Medical Staff Office shall submit the proposed criteria to the appropriate Division and/or Department, and the clinical director (as applicable) for review.
4. Upon Division and/or Department approval, the request shall be forwarded to:
   a. Credentials Committee along with the appropriate Division/Department's recommendation, if the criteria involve one or more Divisions and/or Departments, then to the Medical Executive Committee (MEC).
   b. Medical Executive Committee (MEC) along with the appropriate Division/Department's recommendation, if the criteria involve a single Division and/or Department..
5. Favorable recommendations from the MEC shall be submitted to the Board of Directors for approval.
6. Upon approval, the criteria shall be incorporated into the appropriate privilege forms and made available to Medical Staff members.

D. **ONGOING EVALUATION**:

1. The Medical Staff works in collaboration with administration to consistently review the resources needed to perform the requested privileges.

E. **REFERENCES:**

1. Joint Commission Medical Staff Standards 2017
2. The Compliance Guide to the Joint Commission Medical Staff Standards

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE:	**06/02**	**SUBJECT:**	**Supervision of Residents in Emergency Medicine**
REVISION DATE:	**06/02, 02/06, 04/08, 10/13, 05/16 07/17; 2/20**	**POLICY NUMBER:**	**8710 – 571**

Medical Staff Department Approval:	**02/20**
~~**Medical Division Approval:**~~	~~**02/17**~~
~~**Department of**~~ **Emergency Medicine Approval:**	**05/17, 03/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	~~**06/17**~~**03/20**
Administration Approval:	**04/20**
Professional Affairs Committee Approval:	~~**07/17**~~ **n/a**
Board of Directors Approval:	**07/17**

A. **POLICY:**

1. All medical care provided by Emergency Medicine (EM) Residents is under the supervision of the Director of the Emergency Residency Rotation or a designated Medical Staff member(s) who are member (s) of Tri-City Healthcare District (TCHD) Medical Staff. Each emergency medicine resident is at least a 3rd or 4th year emergency medicine resident who is doing a clinical rotation at TCHD to round out their community hospital education. Every patient seen by an emergency medicine resident, on either required or elective clinical rotation, will have a designated emergency medicine physician medical staff member (s) who will be responsible for and will supervise all medical care provided by the residents, and will be directly involved in the treatment of every patient. Each emergency resident is orientated to his/her responsibilities, job description (function in the department), documentation requirements, and potential participation in departmental grand rounds before starting his/her month long rotation. The residency rotation director gives individual verbal feedback of the residents' performance during the course of the rotation, in addition to submitting a formal written evaluation to the Emergency Medicine Residency Program Director at the completion of each resident's rotation (see sample Resident evaluation form). Finally, the progress of the program is reviewed at the GME committee annually, and on an ad hoc basis in the Emergency Department meeting.

B. **PROCEDURE:**

1. Orientation:
   a. Each emergency resident is orientated to his/her responsibilities, job description (function in the department), documentation requirements (P&P 8710-513), and potential participation in departmental grand rounds before starting his/her month long rotation.
2. Orders:
   a. Emergency medicine residents may write orders on the chart, or type in orders utilizing the computer ordering system, under supervision and review by an attending emergency department physician - a member of the TCHD medical staff and the department of Emergency Medicine.
   b. Verbal orders are permitted during codes and extreme emergency situations with instantaneous review from the supervising emergency physicians present with the resident and patient.
      i. If a nurse or other hospital employee has any question about any order given by the emergency medicine resident they may immediately question the resident

and the supervising emergency department physician.

c. The supervising emergency department physician will review all orders.

3. Documentation:
   a. Documentation on each patient will be dictated by the emergency medicine resident (complete dictation), or entered into the computerized documentation system. The attending emergency department physician will also document an attending summary either via dictation or using the computerized documentation system. (See P&P 8710-513).
4. Direct versus Indirect Supervision of Residents In the Emergency Department In accordance with the Common Program Requirements established by the Accreditation Council for Graduate Medical Education (ACGME), this section defines the levels of supervision provided to residents rotating through the emergency department at TCHD for different stages of their training and for various labels of knowledge and skills.
   a. Levels of Supervision
      i. Direct Supervision: The supervising physician is physically present with the resident and the patient.
      ii. Indirect Supervision with Direct Supervision immediately available: The supervising physician is physically within the hospital and usually, within the department, and is immediately available to provide direct supervision.
   b. Permissible Level of supervision by graduate year of training
      i. Emergency medicine residents in Post Graduate Year 1 and 2 must be directly supervised at all times.
      ii. Emergency medicine residents in Post Graduate Year 3 and 4 may be indirectly supervised with direct supervision immediately available.
   c. While it is expected that the sequential levels of supervision allow for progressive independence and autonomy, residents rotating through TCHD emergency department may not supervise less experience residents but instead must be supervised only by an attending physician who is board certified (or board eligible) in emergency medicine.
5. Emergency Resident Position Description (job description) during TCHD rotation:
   a. Goals and objectives of the EM residency training program are set forth in the EM residency curriculum document. Overall, the goal of the EM training program is to provide EM residents with an extensive experience in the art and science of emergency medicine in order to achieve excellence in the diagnosis, care and treatment of emergency patients-Additionally, this experience will help to establish the trainee's eligibility to participate in the American Board of Emergency Medicine's board examination. In accordance with this curriculum, the EM resident trainee agrees to do the following while at TCHD, other institutions and the parent organization:
      i. Develop and participate in a personal program of self-study and professional growth with guidance from the EM faculty teaching staff.
      ii. Under the supervision of the EM faculty, participate in safe, effective, and compassionate patient care, consistent with the trainee's level of education and experience and in accordance with the Residency's description of graduated responsibility.
      iii. Participate fully in the educational activities of the residency program and assume responsibility for participation in the teaching of more junior physicians, of medical students and students in allied health professions.
   b. The required educational activities of the EM residency are summarized as follows:
      i. A minimum attendance level at all mandatory EM conferences either offsite or onsite.
      ii. Record and update procedure logs, ultrasound logs, and patient follow up logs. Participate in procedure labs and follow up conference. Participate in institutional programs and activities involving the medical staff and adhere to established practices, procedures, and policies of the institution.
      iii. Develop an understanding of ethical, socioeconomic, and medical/legal issues

that affect graduate medical education and the practice of emergency medicine. Learn cost containment measures in the provision of patient care.

iv. Perform all duties in accordance with the established practices, procedures and policies of the institution, the emergency medicine program, and other institutions to which the resident is assigned.

v. Formulate diagnostic, therapeutic and disposition decisions independently. The EM-3 resident will be able to competently perform all the major critical procedures for the stabilization and treatment of emergency patients. Administrative skills of appropriate transfer of ED patients in accordance with applicable state and federal regulations and interfacing with representatives of HMOs and other third party payers will be stressed.

vi. The EM-3 resident will have developed skills as a clinical teacher and mastered presentation skills in case conference and lecture formats. Original research has been conducted, and the resident has developed skills in literature review and critical appraisal. The basic skills to provide evidence-based healthcare have been acquired. Significant teaching and academic responsibilities are included in the EM-3 experience.

vii. Adhere to the emergency department schedule of assigned shifts, as well as the call schedule and assignments of off service rotations, in a prompt and timely fashion.

c. Document patient care in the medical record in a timely fashion as per medical staff policy.

i. Adhere to the ACGME institutional requirements and the ACGME-RRC program requirements for emergency medicine.

ii. Participate in the evaluation of the EM training program.

iii. Comply with the licensure requirements of the State of California and/or State of California requirements if in Active Duty, and the laws of the State and Federal Governments.

iv. Adhere to the policies of the Emergency Medicine Residency- parent and rotation and adhere document entitled; Guidelines for Managing Impaired Residents.

v. Adhere to the principles of the SAEM and CORD Statement on Professionalism in Emergency Medicine summarized as follows:

1) The specialty of emergency medicine recognizes the importance of defining its professional responsibilities, values, and commitments. Trainees must be taught and emergency physicians must practice the following:

a) To make clinical decisions according to the best interests of the patient.

b) To behave in a manner that enhances patient trust.

c) To deliver high quality emergency medical care, maintaining the highest level of knowledge and skills.

d) To listen attentively, maintain confidentiality, and communicate truthfully, respectfully, openly, and honestly.

e) To be an advocate for the health care needs of emergency patients and the community.

f) To place the interest and well-being of the patient above self-interest.

g) To serve as a role model for health care professionals in training.

h) To work collegially with others, helping to create a productive and effective work environment.

d. Summary:

i. Professionalism is defined as behaviors that enhance the trust of patients and of society. This is accomplished by putting the needs of patients ahead of the physician's self-interest. Professionalism must be demonstrated by all

emergency medicine professionals, integrated into residency training programs, and continually reinforced. At this time of tumultuous change, professionalism serves as a point of reference, at the core of the identity of the emergency medicine specialist.

C. **GRADUATED RESPONSIBILITY FOR EMERGENCY MEDICINE RESIDENTS:**

1. The emergency medicine (EM) residency provides a graduated level of responsibility for EM trainees. Residents enter into the EM residency after successful completion of a PG-I (general internship) and in the case of the Navy residents some in the field practice. These residents are assumed to have developed the basic skills of history-taking and physical examination, as well as general medical and surgical patient work-up and management
2. Before the emergency medicine resident arrives at TCHD, he/she will be expected to have mastered basic skills in initial stabilization, essential diagnostic work-up, emergency core procedures, and emergency department management of individual acutely ill and injured patients in the unique environment of the ED.
3. By completion of the EM-2 (PGY-III) year, EM residents will have acquired expertise in multi-tasking and managing both patient care and administrative responsibilities simultaneously. The EM-2 resident will be comfortable in managing, and prioritizing the patient care of multiple patients. Furthermore, EM-2 residents will be able to take on the additional responsibilities of the stabilization and work-up of emergency department patients, emergency core procedures, and coordinating further inpatient or outpatient evaluation and care with representatives of other specialties. Furthermore, EM-2 residents will actively participate as base hospital physicians directing paramedic pre-hospital providers.
4. Upon completion of the EM-3 (PGY-IV) year of residency, EM trainees will have mastered all the above skills and in addition be capable of supervising all operational issues regarding patient flow and prioritization in the ED, as well as the pre-hospital setting. An EM faculty member is continuously present in the ED, but the EM-3 resident is expected to formulate diagnostic, therapeutic and disposition decisions independently. The EM-3 resident will be able to competently perform all the major critical procedures for the stabilization and treatment of emergency patients. Administrative skills of appropriate transfer of ED patients in accordance with applicable state and federal regulations and interfacing with representatives of HMOs and other third party payers will be stressed. The EM-3 resident will have developed skills as a clinical teacher, and mastered presentation skills in case conference and lecture formats. Original research has been conducted, and the resident has developed skills in literature review and critical appraisal. The basic skills to provide evidence-based healthcare have been acquired. Significant teaching and academic responsibilities are included in the EM-3 experience.
5. Residency progress will be reviewed; problems with communication, suggestions for improvement, and other questions of a general nature will be addressed. Any specific medical problem with the resident's management will be discussed in the monthly Department QA meetings as necessary.

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

1. Resident Evaluation Form – Sample

Resident Evaluation Form – Sample

Tri-City Medical Center
Medical Staff Office
4002 Vista Way
Oceanside, CA 92056
(760) 940-3071 (phone) * (760) 940-3486 (fax) plantsm@tcmc.com (e-mail) *

ANNUAL ASSESSMENT "EFFECTIVENESS OF GENERAL MEDICAL EDUCATION PROGRAM"

The Medical Executive Committee is interested in your comments regarding the GME program held at TCMC. Your feedback is vital to the continued success of the program.

ANNUAL ASSESSMENT "Effectiveness of GME Program"	Yes	No
1. Do you feel that the GME Program meets your needs? **Comments:**		
2. Have the medical students/residents/fellows been well received by the patients and staff? **Comments:**		
3. Are the medical students/resident's/fellows rotations sufficient to enable them to experience all acuity levels of the patients? **Comments:**		
4. Has the supervision of the medical students/residents/fellows been consistent with the standards? **Comments:**		
5. Was this program successful in meeting the needs of the hospital, patients and participants, and should the program be continued? **Comments:**		
6. During peer review, have there been any identified outliers that have not been consistent with the standard of care within the department? **Comments:**		
7. Has the clinical decision making process been appropriate and dependable? **Comments:**		
8. Were all safety precautions/protocols identified/followed? **Comments:**		
9. **Any additional comments/suggestions:**		
10. **Future Goals and Actions for 2017:**		

Thank-you for participating in the evaluation of TCMC's GME Program.

Signature *Date*

Please return completed form to the Medical Staff Office: Attn: Sarah Plant

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE:	**07/01**	**SUBJECT:**	**Suspension for Delinquent Medical Records & Fine Process**
REVISION DATE:	**03/05, 04/06, 03/07, 07/07, 03/08, 09/09, 10/14, 03/15; 04/16**	**POLICY NUMBER:**	**8710 – 519**

Medical Staff Department Approval ~~Date~~:	**~~03/17~~3/20**
Medical Staff Committee Approval ~~Date~~:	**n/a**
Pharmacy and Therapeutics Approval ~~Date~~:	**n/a**
Medical Executive Committee Approval:	**~~03/17~~03/20**
Administration Approval:	**04/20**
Professional Affairs Committee Approval:	**~~04/17~~ n/a**
Board of Directors Approval:	**04/17**

A. **POLICY**:

1. It is the policy of Tri-City Healthcare District (TCHD) and its Medical Staff that all medical records are completed in a timely manner, in accordance with Medical Staff Policy 8710-518, Medical Record Documentation Requirements, applicable laws, and accreditation standards.

B. **PROCEDURE**:

1. Applicable TCHD departments shall enforce pre-procedure requirements for History and Physical exam, as outlined in Medical Staff Policy 8710-518, Medical Record Documentation Requirements.
2. In order to facilitate timely medical record completion and appropriate practitioner notification, the TCHD IT Department shall develop and implement such automated notification mechanisms as requested by the Medical Records/HIM Department.
3. The Medical Records/HIM Department is responsible for reviewing medical records and identifying deficiencies of dictations and signatures, as outlined in Medical Record Documentation Requirements.
4. The practitioner is responsible for identifying any error(s) in assigned dictations/signatures by "refusing" the item within the Cerner Message Center, and indicating the appropriate practitioner if possible.
5. The Medical Records/HIM Department will run a weekly report to identify dictations and signatures that are not complete following patient discharge.
   a. A letter under the Chief of Staff's signature will be initiated to each practitioner weekly when the practitioner has any deficiencies aged 7 days from discharge. A second communication will be sent at 10 days post discharge.
6. Each week the Medical Records/HIM Department will submit to the Chief of Staff (via the Medical Staff Office) a list of verified deficiencies.
7. The Medical Staff Office shall:
   a. Call the physician to give verbal notice of the impending suspension.
   b. Prepare and send a written Notice of Automatic Limited Suspension to the physician.
8. Limited suspension shall apply to the practitioner's right to admit, treat or to provide services to new patients in the hospital, but shall not affect the right to continue to care for a patient the practitioner has already admitted or has scheduled to treat or to perform any invasive procedure. Obligations to fulfill ED On-Call duties as per existing schedule shall remain in effect.

9. Practitioners whose privileges have been suspended for delinquent records may admit patients only in life threatening situations, when no other physician of the appropriate specialty is available.
10. In the case of a patient care emergency, the suspension may be lifted by the Chief of Staff or his/her designee, otherwise the suspension shall continue until the medical records are complete.
11. If the physician is on vacation or has an illness when his or her records become delinquent, with Chief of Staff approval, such physician shall have five (5) days of returning to practice from vacation or illness to complete the records.

C. **MEDICAL STAFF FINES FOR DELINQUENT MEDICAL RECORD DICTATION:**

1. Purpose:
   a. To provide a Policy and Procedure for implementation and ongoing enforcement of fines for Medical Staff members with delinquent medical record dictation.
2. Definition Of Terms For Fine Process:
   a. Delinquent Dictation: A medical record is considered "delinquent" 14 calendar days after discharge, however, for this purpose fines will only be imposed for "dictations only", i.e. H&P, Op Reports, and Discharge Summary.
   b. Limited Suspension: A Limited Suspension permits the practitioner to continue to care for a patient he/she is already treating in the hospital or has scheduled to treat prior to the date of the imposed suspension.
   c. Fines: A fine of $10.00 will be imposed and billed to any practitioner who appears on the suspension list for each delinquent dictation. The $10.00 fine will be compounded weekly if not completed.
3. Policy And Procedure:
   a. Each Monday, prior to suspension, Medical Records sends Medical Staff office a list of physicians with delinquent dictation(s). Medical Staff office notifies the practitioner of the delinquent dictations indicating that the delinquent dictation(s) must be completed by the following Wednesday or a $10 per each delinquent dictation will be assessed.
   b. Medical Staff suspends each Wednesday. Physicians with delinquent dictation(s) will be billed $10 per delinquent report via the Medical Staff Department.
   c. Fines are due and payable when the practitioner receives a bill. (Physicians must notify Medical Records prior to leaving on vacation in order to be considered "exempt" from the fining process during their absence from the facility.)
   d. Loss of privileges/membership will result in the following circumstances:
      i. If, at the time of reappointment, the practitioner is found to owe outstanding fines, the application for reappointment will be considered "incomplete";
      ii. If the physician is found owing a fine for delinquent medical records for a period of 6 months or more;
         1) The practitioner will be sent a certified letter, including a copy of this Policy/ Procedure, which states that "failure to pay the outstanding fine, within twenty-one days of the date of the final notice, will result in the automatic relinquishment of his/her membership".
         2) The letter will give the practitioner an opportunity to forward a written response, within seven days of the date of the final notice, to be considered at the Medical Executive Committee meeting.
         3) The outcome of the deliberations/decision determined at the Medical Executive Committee meeting will be forwarded to the practitioner in question via certified mail. Should the practitioner fail to submit a letter for consideration at the Medical Executive Committee meeting or after consideration of such a letter, if it is determined at the Medical Executive Committee meeting that the practitioner does owe the fine, the payment of such fine is due and payable on the date identified in the first notice. A practitioner who has failed to pay the outstanding fine(s) within the

timelines as defined in this policy will be considered to have automatically relinquished his/her medical staff privileges and membership at TCHD and therefore will not be entitled to a hearing as set forth in Article VII of the Medical Staff Bylaws. If the practitioner wishes to reapply to the staff he/she will be required to pay the full application fee plus the total of any outstanding fines owed for delinquent medical record dictation.

e. The monies collected from this process will be added to the Medical Staff Checking account and used as determined by the Medical Executive Committee on behalf and in support of the Medical Staff.

D. **MEDICAL STAFF SUSPENSION MONITORING:**

1. The Medical Staff Office shall notify Medical Records/HIM, IT, Surgery, Administration, Admitting, Cardiology and Radiology of the automatic suspension.
   a. Each of these departments is responsible for enforcing the suspension.
   b. Any questions shall be directed to the Chief of Staff via the Medical Staff Office.
2. The Medical Records/HIM Department shall notify the Medical Staff Office when a suspended practitioner has completed all deficiencies.
3. The Medical Staff Office shall notify the practitioner and applicable departments that the suspension has been lifted.
4. Days on suspension shall be tracked in the Medical Staff's credentialing database and considered at the time of OPPE and reappointment.
5. The Medical Executive Committee will serve as the intermediary in resolving suspension/delinquency status questions from physicians and will assist the Medical Records Department in communications with practitioners who have disputes regarding the actions of this policy.
6. Practitioners indicating an intent to resign will be advised to complete all outstanding dictations and signatures before departure, as failure to do so will make them ineligible for "good standing" affiliation verifications.

E. **REFERENCES:**

1. Medical Staff P&P 8710-518: Medical Record Documentation Requirements
2. Medical Staff Bylaws: Article VI, § 6.4-4

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 05/01	**SUBJECT:** Temporary Privileges for Medical Staff
REVISION DATE(S): 03/08, 04/09, 09/13	**POLICY NUMBER:** 8710-515

Medical Staff Department Approval ~~Date~~:	**~~02/17~~2/20**
Credentials Committee Approval ~~Date~~:	**~~03/17~~2/20**
Pharmacy and Therapeutics Approval ~~Date~~:	**n/a**
Medical Executive Committee Approval ~~Date~~:	**~~03/17~~03/20**
Administration Approval:	**04/20**
Professional Affairs Committee Approval ~~Date~~:	**~~04/17~~ n/a**
Board of Directors Approval ~~Date~~:	**04/17**

A. **POLICY:**

1. Temporary privileges may be granted for circumstances and in accordance with procedures as outlined in the Tri-City Healthcare District (TCHD) Medical Staff Bylaws.

B. **DEFINITION(S):**

1. Temporary Privileges: May be granted to a physician who has a particular skill that is needed or desired in the organization for a period of time but not related to a disaster or emergency procedure.

C. **PROCEDURE:**

1. Temporary Privileges for Medical Staff Applicants:
   a. Refer to Medical Staff Policy #8710-543, Credentialing Policy, Processing Medical Staff Applications, for medical staff applicant credentialing criteria.
   b. In accordance with the Medical Staff Bylaws.
2. Temporary Privileges –Important Care Need and Locum Tenens
   a. The Medical Staff Office shall verify, at a minimum, the following information when temporary privileges are requested for an important patient care need and/or locum tenens:
      i. Current California license to practice
      ii. Drug Enforcement Administration registration
      iii. Current malpractice insurance and claims history
      iv. Current Competence
      v. NPDB
      vi. Peer References (at least one)
      vii. Letter(s) of Hospital Affiliation (at least one)
   b. Other verification may include:
      i. Positive identification
      ii. AMA or AOA Profile (Medicare/Medicaid exclusions)
      iii. Board Certification (Certifacts)

Tri-City Medical Center	Women's and Children's Services Manual - NICU
PROCEDURE:	**REPLOGLE TUBE INSERTION AND MANAGEMENT**
Purpose:	To provide gastric decompression and prevent vomiting and aspiration
Supportive Data:	Replogle tube insertion is used to treat a variety of gastrointestinal and multisystem disorders with gastrointestinal involvement. The largest drainage tube that can be comfortably inserted should be used to provide proper drainage and decompression of the stomach: 8-fr tube for infants <1,500 gms and a 10-fr tube for infants > 1,500 gms. Decreasing the risk of emesis and the potential for aspiration helps to prevent further complications.
Equipment:	1. Dual lumen Replogle tube (8-fr or 10-fr) 2. Suction canister and tubing 3. Drainage trap 4. Hydrocolloid dressing 5. Transparent dressing 6. Sterile water or water-based lubricant

A. **PROCEDURE:**

1. Insertion:
   a. Obtain order from physician/~~allied health professional (AHP)~~ for placement of replogle tube insertion.
   b. Perform hand hygiene and apply non-sterile gloves.
   c. Assemble appropriate equipment.
   d. Confirm patient identity using two-identifier system. Refer to Patient Care Services Policy: Identification, Patient
   e. Immobilize the patient using developmentally appropriate containment (e.g. swaddling, facilitating tucking) and use nonpharmacologic techniques (e.g. swaddling, facilitative tucking, nonnutritive sucking) for comfort as appropriate:
   f. Determine length of replogle tube to be inserted by measuring the tube from the tip of the nose to the earlobe, and **then** from the earlobe to **midway** ~~a space halfway~~ between the umbilicus and the termination of the xiphoid process.
   g. Make note of the pre-printed centimeter measurement on the tubing.
   h. Place an appropriate sized piece of hydrocolloid dressing on skin where tube is to be secured
   i. Lubricate the distal end of the tube with sterile water or water-soluble lubricant.
   j. Slowly and gently insert the tube through the mouth or nares, aiming down and back and advance until the pre-measured length is at the tip of the nostril or at the lip.
   k. If there appears to be resistance, do not force. Try rolling the tube gently. If still unable to pass the tube, remove it and try the other nostril. Remove tube at once if there are signs of distress, coughing, gasping, apnea, bradycardia or cyanosis.
   l. Allow the patient to stabilize and resume insertion procedure.
   m. Verify placement of the tube in stomach by listening with a stethoscope over the epigastric area while injecting small amount (1-3 ml) of air and/or aspirate gastric contents.**The second lumen of a dual lumen tube is not to be flushed with anything but air. Water or saline will prevent adequate intake of air to relieve pressure.**
   n. Secure the replogle tube in place on top of hydrocolloid dressing with transparent dressing.
   o. Connect the replogle tube to the drainage trap then connect the drainage trap to suction as ordered. Continuous or low intermittent suction should be set to 40-60mm Hg unless specified differently by the physician/~~AHP~~.

Department Review	Perinatal Collaborative Practice	~~Division of Neonatology~~	Pharmacy & Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
07/14, 02/17, **02/20**	04/17, **03/20**	~~n/a~~	n/a	8/14, 05/17, **03/20**	**04/20**	10/14, 06/17, **na/**	11/14, 06/17

p. Place a small label (tape or patient label) with insertion date on replogle tubing just below the hub.
q. Discard used supplies and gloves in appropriate receptacle.
r. Perform hand hygiene.
s. Document the following in the patient's medical record:
   i. Date, time, tube size, tube location, and length of the tube at the mark located at the mouth or nostril.
   ii. Tolerance of procedure.

2. Management:
   a. Ongoing proper placement is verified by:
      i. Measuring the distance from nares to the distal end of the gastrostomy tube every shift.
      ii. Verifying proper placement through auscultation or aspiration
      iii. Whenever an x-ray is obtained.
   b. Evaluate and document color and amount of aspirate and notify physician of any change in drainage color or quantity.
   ~~c. Replogle tubes should be changed every 72hrs~~.
   ~~d.~~**c.** ~~If~~ secretions are extremely thick and drainage has stopped, the replogle may be irrigated to prevent or clear plugging. Consult with the physician~~/AHP~~ prior to irrigating the replogle tube. Irrigate with 1-5ml of normal saline **or water**. If the tube cannot be irrigated, discontinue it and insert a new tube.
   d. Change drainage trap at end of shift and document output ~~When charting output,~~ subtract the amount of normal saline used as irrigant from the total output.
   e. **Replace replogle tube every 72 hours**
3. Removal:
   a. Disconnect suction (if attached) and drainage trap.
   b. Remove transparent dressing.
   c. Pinch replogle tube closed as the tube is slowly withdrawn to prevent aspiration of contents into the pharynx.
   d. Discard in appropriate receptacle.
   e. Document the procedure **and infant's tolerance** in the patient's medical record.

B. **REFERENCE(S):**

~~1. Gomella, Tricia Lacy, M. Douglas Cunningham, and Fabien G. Eyal, eds. Neonatology: management, procedures, on-call problems, diseases, and drugs. 7th. New York: McGraw Hill Education Lange, 2013.~~
~~2. Ikuta, Linda M., and Sandra S. Beauman, eds. Policies, Procedures, and Competencies for Neonatal Nursing Care. Glenview, IL: National Association of Neonatal Nursing Care, 2011.~~
~~Merenstein, G.G. & Gardner, S.L. (2011). Handbook of neonatal intensive care, 7th. St. Louis, MO: Mosby~~.

1. **Beauman, S. S., & Bowles, S. (2019). Policies, procedures, and competencies for neonatal nursing care. Chicago, IL: National Association of Neonatal Nurses.**

2. **McDonald, M. (2013). Atlas of procedures in neonatology. Philadelphia, PA: Wolters Kluwer.**

Tri-City Medical Center
Oceanside, California

WOMEN'S AND NEWBORN~~CHILDREN'S~~ SERVICES ~~MANUAL –~~
NEONATAL INTENSIVE CARE UNIT (NICU)

SUBJECT: Weaning From Thermal Support

ISSUE DATE: 02/09
REVISION DATE: 06/11, 8/12, 06/13

NICU Department Approval:	03/20
Perinatal Collaborative Practice Approval:	03/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	03/20
Administration Approval:	04/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	06/13

A. **PURPOSE:**

1. To provide guidelines for transferring an infant into an **open crib from an** isolette.

~~1. to maintain NTE (Neutral Thermal Environment) and low stimulation environment as well as provide guidelines for transition from an isolette to a crib. A hybrid isolette is inclusive of both radiant warmer and isolette environment modalities.~~

~~2. Will have a normal temperature maintained in an NTE.~~

~~3. Will have the adverse effects of hypothermia or hyperthermia minimized.~~

B. DEFINITIONS:

1. **Neutral Thermal Environment (NTE) – The temperature required to maintain the core temperature while minimizing metabolic needs and oxygen consumption.**

~~B. POLICY:~~

~~1. At least one warmer will be set at 25% power or to "pre-heat" mode at all times. The power will be increased to 100% in anticipation of a delivery.~~

~~2. When supplemental humidity is used, the minimal setting is 50%. Humidity is used in hybrid beds only. Refer to VLBW (Very Low Birth Weight) guidelines for humidity use.~~

~~C. DEFINITIONS:~~

~~1. NTE (Neutral Thermal Environment) is the sum total factor at which an infant with a normal body temperature has a minimal metabolic rate and therefore minimal oxygen consumption.~~

~~D. RESPONSIBILITIES:~~

~~1. The RN will monitor infants per NICU (Neonatal Intensive Care Unit) Standards of Care to ensure adequate temperature control to maintain neutral thermal regulation.~~

~~E. FAMILY INVOLVEMENT:~~

~~1. Educate parent(s) on the need for temperature control and weaning process.~~

~~F.~~C. **PROCEDURE:**

~~1. Assessments:~~

~~a. Assess for signs of hypothermia:~~

~~i. Cool skin temperature~~
~~ii. Pallor~~
~~iii. Mottling of extremities~~
~~iv. Decreased pulses~~

v. Prolonged capillary refill time
vi. Apnea
vii. Heart rate changes
viii. Decreased motor activity

b. Assess for signs of hyperthermia:
i. Increased heart rate
ii. Increased respiratory rate
iii. Ruddy coloring
iv. Extended posture
v. Skin warm to touch with brisk capillary refill
vi. Apnea
vii. Diaphoresis
viii. Decreased motor activity or restlessness

2. Indicators for Servo Control: Set the temperature-controlled radiant warmer or isolette to maintain abdominal skin temperature at 36ºC – 36.5ºC and axillary temperature at 36.6ºC – 37.5ºC.
a. Infants ≤ 1000 grams.
b. Acutely ill infants.
c. Any infant with temperature instability in an isolette.
d. Any infant on a radiant warmer that is turned on.

3. Use of clothes on infants in isolettes:
a. Infants on servo control will not be dressed in anything other than a hat.
b. Infants should ideally be moved from radiant warmer to isolette *within four hours of admission.*
c. Infants weighing more than 1000 grams may be started on air temperature control if demonstrating temperature stability.

4. Before switching to non-servo control:
a. Infant's skin temperature must consistently correlate by 0.5ºC with his axillary temperature.
b. Infant's axillary temperature has been stable in an isolette with an air temperature of ≤34ºC with no large fluctuations.

5. Non-servo control in isolette:
a. Refer to appendix A to determine environmental temperature that is appropriate for infant's chronological age and gestational age.
i. Adjustments of isolette air temperature may be required and should not be made in greater than 1.0ºC increments.

G. PREVENTING HEAT LOSS:

1. To prevent conductive loss:
a. Provide pre-heated (100% maximum heat) warmer at delivery.
b. Maintain warm surface for care (warmer or isolette).
c. Cover items that come in contact with infant (scale, x-ray plates).
d. Warm caregiver's hands and equipment, such as stethoscope.
e. Special considerations:
i. Heat lamp or overhead warmer may be used when weighing.
ii. Chemical blanket will promote heat gain by conduction. They should be covered with receiving blanket only for maximal effect. (Refer to Thermoregulation policy for use of chemical blanket).
iii. Do not place a heat lamp over isolette.

2. To prevent convective loss:
a. Keep isolette temperature within NTE (refer to appendix A) unless adjustments are required to maintain an axillary temperature of 36.6°C – 37.5°C, or use Servo Control.
b. Keep radiant warmer sides up.
c. Keep isolettes/warmers in areas that are draft-free.
d. Be aware of cooling effects of blow-by oxygen that is not warmed.

3. To prevent evaporative loss:
a. Dry infant thoroughly immediately after delivery, especially the head.

~~i. For infants ≤ 32 weeks gestation, place in polyethylene bag/wrap and on a port-a-mattress. (Refer to Thermo-Regulation policy).~~
~~ii. For infants ≤ 28 weeks gestation, drying is not recommended except for the head before placing in bag/wrap.~~

~~b. Maintain dry linens.~~
~~c. Keep diapers dry, especially while on radiant warmer.~~
~~d. Use a warmed, humidified environment for infants at risk for increased insensible water loss. Higher levels of humidity may be ordered depending on skin condition and serum electrolytes. (Follow ELBW/VLBW guidelines).~~
~~e. Use only warmed solutions for irrigations.~~
~~f. Administer warmed humidified gases with endotracheal tubes, CPAP, or supplemental high-flow oxygen.~~
~~g. Delay bathing until infant's temperature is stable and cardio-respiratory stability is assured. Bathe in a warm environment that is free of drafts.~~

~~H. MOVING TO OPEN CRIB FROM ISOLETTE:~~

1. Criteria to begin weaning infants from isolette to open cribs in collaboration with physician:
   - **a. Before switching to non-servo control, Infant's axillary temperature should be stable in an isolette with an air temperature of ≤34°C with no large fluctuations**
   - ~~a.~~**b.** Infant is medically stable and is in a condition that permits use of clothing and blankets.
   - ~~b.~~**c.** Infant weighs ≥ 1500 grams with stable axillary temperature and consistent weight gain for three days.
   - ~~c.~~**d.** There have been no episodes of apnea/bradycardia/desaturation requiring vigorous stimulation for the past 72 hours.
   - ~~d.~~ Infant is tolerating enteral feedings and is gaining weight daily. ~~in an amount that is acceptable to the care team, (15 to 20 g/Kg/day is ideal).~~
   - ~~e. Infant is showing an interest in oral feeds or increased ability of oral feeds.~~
2. **Dress the infant in a shirt, hat and swaddle in blanket.** ~~Every four to eight hours, turn the~~ **Wean** temperature of the isolette down **in** 0.5 - 1°C **increments**. ~~While dressed in a shirt, hat and swaddled in one or two blankets, the infant is able to maintain an axillary temperature between 36.6°C and 37.5°C in an isolette heated to 32°C or less.~~
   - a. Monitor the infant's temperature **with care**~~every 2-3 hours~~ for stability during weaning.
   - b. An infant should be placed in an open crib when **the infant has demonstrated temperature stability for at least two consecutive readings at an** ~~the~~ ambient isolette temperature of 28°C.~~ has been maintained for eight to twenty-four hours.~~
   - c. If the infant's temperature falls below normal while in the crib (axillary temperature **below**~~of~~ 36.5°C,) add extra blankets as needed to assist the infant in maintaining temperature.
   - d. Stop weaning or place infant back in isolette if infant's temperature falls below normal in spite of hat/t-shirt/extra blanket, or if infant displays signs of cold stress, including mottling, irritability, lethargy, poor feeding, tachycardia, or poor weight gain.
   - **e.** If an infant is placed back in the isolette, a repeat trial of weaning to an open crib should be considered **after**~~within~~ 48-hours if ~~criteria for weaning continues~~**criteria for weaning continue** to be met.
   - ~~e.~~**f. Do not bathe the infant on the first day the infant is placed in an open crib.**
3. ~~For the term/near term infant in an isolette for reasons other than thermoregulation (i.e., phototherapy):~~
   - ~~a. Dress infant in t-shirt and hat (if warranted) and swaddle in 1 to 2 blankets.~~
   - ~~b. Turn down the isolette temperature 1 degree per hour.~~
   - ~~c. Monitor infant's temperature prior to each wean. A Servo probe may be placed in lieu of taking a manual temperature, however a manual temperature should be done at least with routine vital signs.~~
   - ~~d. Stop weaning or place infant back in isolette if infant's temperature falls below normal in spite of hat/t-shirt/extra blanket, or if infant displays signs of cold stress, including mottling, irritability, lethargy, poor feeding, tachycardia, or poor weight gain.~~

~~I. MOVING TO AN OPEN CRIB FROM RADIANT WARMER:~~

~~1. An infant not requiring an isolette may be weaned directly to an open crib.~~

~~a. Dress infant appropriately.~~

~~b. Remove Servo probe and turn warmer off.~~

~~c. If the infant's temperature falls below normal (36.5°C), add extra blankets as needed.~~

~~J. GENERAL MAINTENANCE:~~

~~1. Isolettes/hybrid/open cribs will be wiped down by RN at beginning of each shift and changed every two weeks.~~

~~2. Clean isolettes will be stored covered in plastic.~~

~~K. SAFETY:~~

~~1. Maintain skin temperature 36.1° - 37°C (dependent on weight, gestational age, postnatal age).~~

~~2. Secure the temperature probe on the neonate's abdomen using a foil-backed shield in accordance with the manufacturer's guidelines. Choose a site that is away from bony areas and brown fat deposits,~~

~~3. Keep skin probe exposed – do not cover with diaper or lay infant on probe.~~

~~4. Clothing, hats, and/or blankets should not be used on infants when radiant warmer is used. These interfere with heat gain from the radiant warmer. The exception to this would be the neurologically impaired infant who is stable but needs a slightly warmer environment as a buffer against wide fluctuations in temperature. Temperature should be monitored every 4 hours and PRN when warmer is used in this manner.~~

~~5. The warmer may be turned off in preparation of transfer to open crib. Infant must be bundled in t-shirt, hat and blankets.~~

~~L.~~D. DOCUMENTATION:

1. Document procedure and tolerance of process in patient's medical record.

~~M. EXTERNAL LINKS:~~

~~N.~~E. REFERENCES:

~~1. American Heart Association. (2011). Neonatal Resuscitation Program, 6th Edition.~~

~~2. Merenstein, G. B. & Gardner, S. L. (2011). *Handbook of neonatal intensive care, 7th ed.* St. Louis, MO. :Mosby Elsevier.~~

1. **Beauman, S.S. & Bowles, S. (2019). Policies, procedures, and competencies for neonatal nursing care, 6th edition. Chicago, IL: National Association of Neonatal Nurses.**
2. **Gardner, S. L., Carter, B. S., Enzman-Hines, M., Hernandez, J. A., & Merenstein, G. B. (2011). Merenstein & Gardners handbook of neonatal intensive care. St. Louis: Mosby Elsevier.**
3. **Verklan, T., Walden, M. (2015). Core curriculum for neonatal intensive care nursing (5th ed.,pp. 290-299). St Louis, MO: Saunders**

~~3. National Association Neonatal Nurses (NANN) Guidelines. (2006). Neonatal Nursing Policies, Procedures, Competencies, and Clinical Pathways.~~

~~4. New, K., Flenady V., & Davies M. (2004).Transfer of preterm infants from incubator to open cot at lower versus higher body weight. Cochrane Database Systematic Review; (2); 1-14.~~

~~5. Verklan, M.T., & Walden, M. (Eds.). (2009). *Core curriculum for neonatal intensive care nursing (4th ed.).* St. Louis: Saunders.~~

~~O. APPROVAL PROCESS:~~

~~1. Clinical Policies & Procedures Committee~~

~~2. Nurse Executive Council~~

~~3. Medical Executive Committee~~

~~4. Professional Affairs Committee~~

~~5. Board of Directors~~

APPENDIX A

NEUTRAL THERMAL ENVIRONMENTAL TEMPERATURES

Age and Weight	Starting Temperature (°C)	Range of Temperature (°C)
0-6 hr		
Under 1200 g	35.0	34.0-35.4
1200-1500 g	34.1	33.9-34.4
Over 2500 g (and >36 wk)	33.9	32.0-33.8
>6-12 hr		
Under 122 g	35.0	34.0-35.4
1200-1500 g	34.0	33.5-34.4
1501-2500 g	33.1	32.2-33.8
Over 2500 g (and >36 wk)	32.8	31.4-33.8
>12-24 hr		
Under 1200 g	34.0	34.0-35.4
1200-1500 g	33.8	33.3-34.3
1501-2500 g	32.8	31.8-33.8
Over 2500 g (and >36 wk)	32.4	31.0-33.7
>24-36 hr		
Under 1200 g	34.0	34.0-35.0
1200-1500 g	33.6	33.1-34.2
1501-2500 g	32.6	31.6-33.6
Over 2500 g (and >36 wk)	32.1	30.7-33.5
>36-48 hr		
Under 1200 g	34.0	34.0-35.0
1200-1500 g	33.5	33.0-34.1
1501-2500 g	32.5	31.4-33.5
Over 2500 g (and >36 wk)	31.9	30.5-33.3
>48-72 hr		
Under 1200 g	34.0	34.0-35.0
1200-1500 g	33.5	33.0-34.0
1501-2500 g	32.3	31.2-33.4
Over 2500 g (and >36 wk)	31.7	30.1-33.2
>72-96 hr		
Under 1200 g	34.0	34.0-35.0
1200 -1500 g	33.5	33.0-34.0
1501-2500 g	33.4	32.8-33.8
Over 2500 g (and >36 wk)	31.3	29.8-32.8
>4-12 days		
Under 1500 g	33.5	33.0-34.0
1501-2500 g (and >36 wk)	32.1	31.0-33.2
4-5 days	31.0	29.5-32.6
5-6 days	30.9	29.4-32.3
6-8 days	30.6	29.0-32.2
8-10 days	30.3	29.0-31.8
10-12 days	30.1	29.0-31.4
>12-14 days		
Under 1500 g	33.5	32.6-34.0
1501-2500 g	32.1	31.0-33.2
>2-3 wk	33.1	32.2-34.0
Under 1500 g	33.1	32.2-34.0
1501-2500 g	31.7	30.5-33.0
>3-4 wk	32.6	31.6-33.6
Under 1500 g	32.6	31.6-33.6
1501-2500 g	31.4	30.0-32.7
>4-5 wk		
Under 1500 g	32.0	31.2-33.0
1501-2500 g	30.9	29.5-32.2
>5-6 wk		
Under 1500 g	31.4	30.6-32.3
1501-2500 g	30.4	29.0-31.8

Tri-City Medical Center
Oceanside, California

OUTPATIENT FORENSIC CLINIC

ISSUE DATE: 05/11 **SUBJECT:** Acuity Classification System

REVISION DATE:

Department Approval:	03/20
Medical Staff Department or Division:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval;	04/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. The acuity classification system has been designed as a component of the productivity standard that was established to safely and effectively manage and staff the outpatient clinic. In addition, it also plays an important role in the plan of care for each patient for the following reasons:
   a. It defines the extent of care the patient requires with each visit.
   b. It clarifies and validates the resources/time needed for the patient's care for each visit, as well as the time needed to support the requirements for the continuum of care activities.

B. **POLICY:**

1. All patients seen in the Clinic will be assessed for acuity and documented in their chart under clinical care notes.
2. As the needs/resources/time may vary from visit-to-visit, the assessment is performed at each encounter for each patient.
3. The clinician assigned to the patient will perform the acuity assessment at the conclusion of each visit.
4. The clinician will determine the level of acuity using the hospital approved acuity system.
5. The system is comprised of:
   a. Scoring Grid
   b. Tabulation Tool
   c. Acuity Level

C. **PROCEDURE:**

1. The indicators used to assess acuity are defined as follows:
   a. Mobility – indicates the aid/support the patient requires when moving from one area to another and on/off the treatment chair/bed.
   b. Complexity of prep for treatment/exam - e.g. the number of wounds to be assessed, number and complexity of dressing to be removed, or any other preparation activities aside from routine activity such as vital signs.
   c. Complexity of aftercare - e.g. numbers and types of dressings, and wraps
   d. Teaching required during visit - to include the need for an interpreter.
   e. Extent of the necessary assessment and/or follow-up needed - includes time necessary for planning care taking into consideration the continuum of care.
2. The following steps are taken to determine the patient acuity:
   a. The Scoring Grid is used to assign acuity points to each indicator. (Attachment A)
   b. The appropriate points from the Scoring Grid are applied to each indicator in the Tabulation Tool. (Attachment B)
   c. The total is then computed to determine the final acuity level as defined in the Acuity Level table (Attachment A)

d. Acuity levels are recorded in the database by the clinical manager for periodic and annual review and subsequently utilized for staffing and productivity standard determination.

3. The level of acuity should directly correspond to the time spent caring for patient. Levels of care are delineated as follows:
   a. Level I (0-2): The patient requires little or no assistance or care. The patient presents with a minor affliction, few symptoms and is independently mobile. Very little time, less than 11 minutes is required for this type of visit.
   b. Level II (3-5): This type of visit requires 20 minutes or less to evaluate the patient and provide any necessary care. The patient may present for a 2nd opinion/consult or may be nearing the end of their treatment period and may require minimal assistance w/ mobility and very little or no planning, teaching and follow-up.
   c. Level III (6-9): A moderate amount of time is required for this type of patient visit (21-31 minutes). They may require more complex type of care, which may include managing uncomplicated and/or multiple dressings and wound assessments. Preparation for exam & aftercare may be moderately time consuming & the patient may require minimal to moderate assistance w/ mobility. An interpreter may be necessary to discuss1-2 topics. Planning, follow-up, and time needed for support for the continuum of care is moderately time-consuming.
   d. Level IV (10-12): This patient requires a significant amount of time per visit (31-45 minutes). They may have more complex issues to be addressed or increased care time, and prolonged aftercare or patient may require moderate to significant assistance with mobility. An interpreter may be used to discuss several topics, adding more time to effectively care for the patient. Also, the time dedicated to the continuum of care is significant.
   e. Level V (13-15): This patient typifies the very complex case, requiring the maximum amount of time for the patient's visit (>45 minutes) to address the care, evaluation and follow-up. This may include very complex and time-consuming care including multiple complex dressings, multiple compression wraps, HBOT consultation, comprehensive H&P and assessment. The patient may require full assistance for the mobility requiring 2 or more staff members to transfer from one area to another. A severe learning deficit is identified requiring additional time to address the education needs of the patient and a significant amount of time may be needed for planning and addressing the continuum of care.

~~Attachments:~~
~~Acuity Class Scoring Grid & Tabulation Tool~~

Tri-City Medical Center
Oceanside, California

PULMONARY SERVICES

ISSUE DATE: 08/06 **SUBJECT: RCP Staffing Guidelines in the NICU**

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

Pulmonary Department Approval ~~Date(s)~~:	**~~2/15,~~02/20**
Division of Neonatology Approval ~~Date(s)~~:	**n/a**
Pharmacy and Therapeutics Approval ~~Date(s)~~:	**n/a**
Medical Executive Committee Approval ~~Date(s)~~:	**n/a**
Administration Approval:	**04/20**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~4/15~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**4/15**

A. **POLICY:**

1. To be qualified to work as a Respiratory Care Practitioner (RCP) in the Neonatal Intensive Care Unit (NICU), the RCP must be licensed by the state of California and have evidence of current successful Neonatal Resuscitation program (NRP) certification. Also, these RCP's must have completed additional education requirements as demonstrated by the following: 1) Completion of a formal neonatal respiratory therapy course at an approved school of respiratory therapy that includes didactic and clinical course work; or 2) Completion of a minimum of 20 hours of didactic and four weeks of precepted neonatal clinical experience in a hospital-based course at a facility with a NICU equivalent to a Community or Regional NICU
2. One RCP qualified to work in NICU will be assigned to cover that area every shift, 7 days/week.
3. If there is a neonate on ventilator support, one qualified RCP will be dedicated entirely to the NICU. That is, they will be immediately available to the NICU at all times.
4. If the NICU respiratory patient workload increases (based on acuity of patients or numbers of patients in the NICU) to the point where additional Respiratory staff are needed, the NICU RCP will notify the Lead RCP and/or the Pulmonary manager to obtain the extra staff. The need for additional staff will be determined by the NICU RCP in consultation with the neonatologist, as appropriate. The Lead RCP will reassign other qualified RCPs (those that have a NRP card) to the NICU and/or call in additional staff as needed.

D. **REFERENCES:**

1. **California Children's Services** (CCS) Policy and Procedure requirements for a Community NICU. California Children's Services Manual of Procedures, 1999.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 07/09 **SUBJECT:** ~~Anesthseia~~**Anesthesia Equipment**

REVISION DATE(S): 11/12

Surgical Services Department Approval:	**02/20**
Department of Anesthesiology Approval:	**n/a**
Operating Room Committee Approval:	**02/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**03/20**
Administration Approval:	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/13**

A. **PURPOSE:**

1. To provide guidelines for the cleaning and ~~p~~**P**reventative ~~m~~**M**aintenance **(PM)** of anesthesia equipment located in Surgical Services and other departments ~~as determined by management~~**in which anesthesia services are provided**~~.~~ (~~i.e.~~**including, but not limited to,** Emergency Department, **Interventional** Radiology, Cath Lab and PACU).

B. DEFINITIONS:

1. **Critical Equipment: Devices that enter sterile tissue or the vascular system; must be processed by sterilization.**
2. **Semicritical Equipment: Devices or items that contact mucous membranes or non-intact skin; must be processed by sterilization, or, at a minimum, high-level disinfection.**
3. **Noncritical Equipment: Devices or items that come into contact with only intact skin. Intermediate-level or low-level disinfectants may be used to process noncritical items at the point of use.**

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

1. **Anesthesia equipment shall be cleaned according to manufacturer's instructions for use (IFU).** Cleaning procedures shall follow all perioperative and infection control policies and procedures for Universal Precautions.
2. All ~~cleaning, disinfection and cold sterilizing~~**disinfectants** ~~solutions~~ utilized **to clean anesthesia equipment** shall be hospital approved.
3. ~~2.~~**Biomedical Engineering (Biomed) department is responsible for the PM and service of all anesthesia equipment, per manufacturer's IFU. PM and service records are maintained in the Biomed department.**
4. ~~3.~~ Anesthesia machine safety:
   - a. **Daily testing of anesthesia machines is performed by the anesthesia technician per manufacturer's IFU. Documentation of anesthesia machine daily testing is performed by the anesthesia technician and records are maintained in the Surgery Department for 3 years.**
   - ~~a.~~**b.** Gas Scavenger: All anesthesia waste gases are vented through the hospital vacuum system that pumps exhaust to the atmosphere. Trace gas analysis is done on an annual basis by a contract service **as part of medical gas testing, per Building Engineering department**.
   - ~~b. Oxygen Analyzers: The Oxygen analyzer is calibrated prior to use daily by the anesthesia technician, and as required throughout the day.~~

~~c. CO2 ANALYZERS: The CO2 analyzer is calibrated prior to use daily by the anesthesia technician, and as required throughout the day.~~

~~d. ALARMS:~~

~~i. The NARKOMED and APOLLO anesthesia machines have built-in alarm systems which are checked two times per year by a contract service.~~

~~1) Documentation of this service is located in the Biomedical Engineering Department.~~

~~2) The following alarm systems are checked:~~

~~a) Low oxygen delivery alarm~~
~~b) Pipeline pressure alarm~~
~~c) Oxygen-nitrous oxide ratio alarm~~
~~d) Apnea alarm~~
~~e) Continuous pressure alarm~~
~~f) Inspiratory flow alarm~~
~~g) Automatic shut-off of gases other than oxygen when hypoxic mixtures are delivered~~
~~h) Disconnect alarm~~

~~ii. In the event of an alarm malfunction, the service contractor will be called to correct the problem or the machine will be rendered inactive.~~

~~e.~~**c.** Pin Index:

i. All cylindered gases have specific pin connection system, to avoid interchanges.
ii. The cylindered gases with PIN index system are Oxygen, Nitrous Oxide, and Compressed Air.

~~f.~~**d.** Portable Cylinders:

i. Portable cylinders may be stored together, but never with flammable gases or liquids.
ii. Do not allow oil, grease, or flammable materials to come into contact with oxygen equipment, such as valves, regulators, fittings or gauges.
iii. Oxygen cylinders should not be draped with any combus~~til~~ble materials.
~~iv. Only properly trained personnel are to repair defectibe oxygen equipment.~~
~~v.~~**iv.** All cylinders must be adequately secured to protect against accidental falls. ~~Cylinders may not be placed unsecured on a bed mattress or on the floor.~~

~~g.~~**e.** Vaporizers:

i. Only the anesthesia technician or anesthesiologist is permitted to fill vaporizers.
~~ii. Spills are to be avoided when filling the vaporizers. Vaporizer caps must be screwed on tightly to prevent spills or a sudden gush of gas.~~
~~iii.~~**ii.** The vaporizer ~~interlock~~ **safety lock-out** system ~~shall be~~**is** used.

~~h.~~**f.** Medical gas hoses and adapters ~~shall be~~**are** color-coded.

~~C.~~D. PROCEDURE:

1. Cleaning of anesthesia equipment ~~between cases~~**after each use**:
   a. Don ~~all~~ appropriate personal protective equipment **(PPE).**~~and discard all disposable items propr to leaving the room.~~
   b. **Discard trash, sharps, and linen into appropriate containers.**~~Place all surface towels in the linen hamper prior to leaving the room.~~
   c. **Cover used critical and semicritical reusable equipment for transport to the dirty utility area.** ~~Place all non-disposable anesthesia items in an emesis basin, cover basin and transport the items to the cleaning/work area and place them in the dirty sink for cleaning.~~ ~~Non-disposable~~**Reusable critical and semicritical** anesthesia ~~items~~**equipment** include**s,** but ~~are~~ **is** not limited to: **bronchoscopes, Glide Scope handles and Glide Scope stylets.**~~laryngoscope handles, McGill forceps, etc.~~
   ~~d. Put all sharps in the sharps container. When the container is ¾ filled, seal the container and place in the appropriate bio-hazardous waste container.~~
   ~~e.~~ Clean **and disinfect reusable noncritical equipment** ~~head straps, plastic containers, precordial stethoscopes, and monitor cables~~ with a ~~germicide solution~~**hospital-approved**

disinfectant according to manufacturer's instructions for use (IFU). ~~and replace on anesthesia cart after dried.~~

~~f.~~**d.** Clean all surfaces of the anesthesia machine, monitors and carts with a ~~germicide solution~~**hospital-approved disinfectant, according to manufacturer's IFU**.

~~g. Any non-disposable portions of the patient breathing system that becomes internally contaminated with blood or other body fluids shall:~~

~~i. Be completely disassembled~~

~~ii. Be cleaned thoroughly with a germicide solution according to manufacturer's recommendations~~

~~iii. Remain wet for at least then minutes~~

~~iv. Be rinsed thoroughly with water~~

~~v. Dried~~

~~vi. Reassembled~~

~~h.~~**e.** ~~Remove gloves and r~~**R**estock the machine and cart **as necessary**.

~~i. Set up for the next case per request~~

~~2. Cleaning of anesthesia equipment during each shift:~~

~~a. The flexible fiber optic intubation scopes shall be cleaned with Endozyme soap and a sponge brush before being disinfected with a Steris unit, then tower dry.~~

~~i. Fully immersible scopes shall be cleaned as above; in addition use a syringe to inject disinfectant into the suction/irrigation channel.~~

~~ii. The suction/irrigation channel shall be dried with compressed air, not to exceed 5L/minute~~

~~b. Clean (non-disposable) airways, laryngoscopes blades, stylettes, airway adapters, connectors and all other non-disposable items as follows:~~

~~i. Use Endozyme soap and a brush~~

~~ii. Disinfect by using the Steris unit~~

~~iii. Air dry~~

~~c. Clean reusable Laryngeal Mask Airways (LMA) as follows:~~

~~i. Use only Endozyme soap concentrate.~~

~~ii. Wash the LMA thoroughly using a soft brush to clean the lumen. Be careful not to wet the fill valve.~~

~~iii. Inspect the LMA for signs of damage prior to sterilization.~~

~~iv. Peel pack the LMA for steam sterilization after fully deflating the cuff.~~ ~~**NOTE: LMA's may also be Immediate Use Sterilized (IUS) for three (3) minutes gravity cycle after fully deflating the cuff.**~~

~~d. Clean (non-disposable) airways, laryngoscope blades, stylettes, airway adapters, connectors and all other non-disposable items as follows:~~

~~i. Clean with Endozyme soap and brush~~

~~ii. Rinse with water~~

~~iii. Flush the internal lumen with water to remove any traces of medication (s)~~

~~iv. Dry internal lumen with air~~

~~v. Dry the entire atomizer~~

~~vi. Reassemble~~

~~e. Batteries shall be checked daily and replaced as necessary on all nerve stimulators, laryngoscopes, and the anesthesia machine reserve power.~~

~~3. Clean all anesthesia machines every four (4) weeks.~~

~~a. Clean all external surfaces of the machine with germicide solution.~~

~~b. Clean the carbon dioxide absorber.~~

~~i. Disassemble the carbon dioxide (CO_2) absorber.~~

~~ii. Clean all surfaces with germicide solution and dry before reassembling.~~

~~iii. Clean the respirometer per manufacturer's written instructions.~~

~~iv. Lubricate the respirometer with manufacturer's oil in each of the four lubrication points.~~

~~v. Using the air hose adapter, test the turbines to assure smooth motion.~~

~~c. Function test the completed breathing system.~~

~~i. Pressurize the breathing circuit and absorber to at least 40 cm/water fir fifteen (15) seconds. Locate and correct any leaks.~~
~~ii. Test the ventilator on and observe for a smooth rise and fall of the bellows. Replace bellows as necessary.~~
~~d. Remove the contents from each drawer.~~
~~i. Clean each drawer with a germicide solution.~~
~~ii. Inspect, clean and replace all items as necessary.~~
~~e. Clean all gas cylinder yokes and ceiling lines with a germicide solution.~~
~~i. Do not wet the sintered metal filter.~~
~~ii. Make sure there is only one washer on each cylinder yoke.~~
~~iii. Check the index pins on each cylinder yoke and tighten any loose pins.~~
~~f. Clean the exterior of all monitors on the anesthesia machine.~~
~~i. Clean all cables and power cords with a germicide solutions.~~
~~ii. Inspect all cables and power cords for proper function.~~
~~iii. Replace dirty blood pressure cuffs.~~
~~iv. Replace the carbon dioxide sample line.~~
~~g. Remove all debris from the wheels and clean them with a germicide solution.~~
~~h. Maintenance of anesthesia machines is coordinated through the Biomedical Department.~~
~~i. Malfunctions shall be reported to Biomed for repairs.~~
~~ii. Each anesthesia machine shall be maintained per manufacturer's guidelines.~~
~~4. Anesthesia carts are cleaned every four (4) weeks.~~
~~a. Clean the exterior of the cart with a germicide solution.~~
~~b. Remove the contents from each drawer.~~
~~i. Clean the inside with a germicide solution.~~
~~ii. Inspect and clean all items in the drawer for proper function and replace as necessary.~~
~~c. Remove all debris from wheels, and then clean them with a germicide solution.~~
~~5. Anesthesia stocking carts are cleaned every four (4) weeks.~~
~~a. Remove all items from each compartment and clean with germicide solution.~~
~~b. Remove all debris from wheels, and then clean them with a germicide solution.~~
~~6. Anesthesia workroom is cleaned every four (4) weeks.~~
~~a. Empty each shelf, cupboard, or drawer and wipe with a germicide solution.~~
~~b. Clean counter tops at least once each shift.~~
~~Maintenance of anesthesia monitors is done per manufacturer's recommendations.~~

E. REFERENCES:

1. **AORN, Inc. (2020). *Guidelines for Perioperative Practice.* Denver.**
2. **Rothrock, J. C. & McEwen, D. R. (2019). *Alexander's Care of the Patient in Surgery, 16th Edition.* St. Louis, MO: Elsevier.**

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 6/09 **SUBJECT: Bumping Surgery Procedures**

REVISION DATE(S): 11/10, 09/12, 4/15, 02/17

Surgical Services Department Approval:	**~~10/16~~02/20**
Department of Anesthesiology Approval:	**n/a**
Operating Room Committee Approval:	**~~10/16~~02/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~01/17~~03/20**
Administration Approval:	**04/20**
Professional Affairs Committee Approval:	**~~02/17~~ n/a**
Board of Directors Approval:	**02/17**

A. **PURPOSE:**
1. To provide guidelines for "bumping" of a surgical procedure

B. **DEFINITIONS:**
1. **Bumping:** The process of superceding a scheduled case with an emergency/emergent/urgent procedure
2. **Emergency Surgical Procedure:** Any procedure requiring surgical intervention immediately upon presentation to preserve life or limb. Emergency procedures are performed in the first available operating room, or may require staffing an additional operating room (OR) immediately to care for the patient (i.e., trauma).
3. **Emergent Surgical Procedure:** Any procedure requiring surgical intervention within approximately one hour of presentation. Emergent procedures are performed in the first available time in the OR schedule.
4. **Urgent Surgical Procedure:** Any procedure which requires surgical intervention within approximately 4-6 hours of presentation. Urgent procedures are placed in an available time on the OR schedule.

C. **POLICY:**
1. Emergency/emergent procedures will take priority and will be performed before a scheduled procedure that is not in progress. The OR **Supervisor/designee**~~charge nurse/~~ **and Charge** Anesthesiologist ~~running the schedule~~ will advise the bumping surgeon of the affected surgeon to be contacted, based on the criteria listed below.
2. When a surgeon deems to bump another surgical procedure, the bumping surgeon must inform the affected surgeon of their intent.
3. The surgical case to be bumped will be determined by the OR ~~Charge Nurse~~**Supervisor/designee** and Anesthesiologist based on the following criteria:
   a. Time of case
   b. Length of case
   c. Condition of patient
   d. Availability of equipment
   e. Least disruptive to entire schedule
   f. Date/time the case was scheduled (last scheduled may be bumped first)
   g. Choosing of surgeons within the same group will not be a determining factor
4. Urgent procedures may require surgical intervention within a specific time period and may require a scheduled procedure to be bumped.

5. Every effort will be made to accommodate the bumped procedure in a timely manner, and the bumped procedure will take first priority for any open time.
6. When a surgeon elects to bump his/her own elective scheduled case, the bumped case will be placed in the order to be rescheduled based on availability of rooms and staff to accommodate the case.
7. Disagreement between surgeons in the above process will be arbitrated by the OR Medical Director, Chief of Surgery or Chief of Staff.
8. Requests for bumping may be referred to the appropriate surgical ~~D~~division for review.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 04/94 **SUBJECT:** Disaster a~~A~~nd Emergency Preparedness

REVISION DATE(S): 2/05, 6/09, 11/10, 9/12, 5/15; 02/17

Surgical Services Department Approval:	~~10/16~~02/20
Department of Anesthesiology Approval:	n/a
Operating Room Committee Approval:	~~10/16~~/02/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~01/17~~03/20
Administration Approval:	04/20
Professional Affairs Committee Approval:	~~02/17~~ n/a
Board of Directors Approval:	02/17

A. **~~POLICY~~PURPOSE:**
1. To provide guidelines for Perioperative Services (**including Pre-Operative** ~~Pre-op~~ Education **[POE]**, **Pre-Operative** ~~Pre-op~~ Hold **[POH]**~~/SPRA~~, ~~OR~~ **Surgery** and **Post-Anesthesia Care Unit** [PACU**]**) personnel in the event of a disaster.
2. To maintain adequate availability of personnel and supplies during a disaster.

B. **PROCEDURE:**
1. Due to the varying types and magnitudes of emergency events, Tri-City Healthcare District (TCHD) has adopted the command structure of Hospital Incident Command System (HICS). Once the decision has been made to activate the disaster plan, the HICS becomes the standard operating procedure. The complete plan is located in the TCHD Disaster Plan Manual located in each department.
2. French Rooms 1 and 2 are designated as the Incident Command Center (ICC).

C. **NOTIFICATION:**
1. In the event of a disaster (Code Orange or Code Yellow), departments will be notified via the overhead paging system.
2. Management staff is to be notified by their respective area lead staff via pager/phone 24 hours per day, 7 days per week.
3. ~~Manager/Supervisor/designee~~**Management** responsibilities following the activation plan for a disaster or drill:
   a. The Surgical Services ~~Clinical Manager(s)~~**Director/Assistant Director/Supervisor/**designee ~~from their respective areas~~ will:
      i. Review the HICS form, located in the disaster manual.
      ii. Assess number of patients currently in department(s).
      iii. Assess anticipated time of discharge from department**(s).**
      iv. Assess number of available staff.
      v. Complete HICS form and submit to the **ICC**~~Incident Command Center~~.
   b. Dependent upon the type and severity of the disaster, the **ICC**~~Incident Command Center~~ may direct the departments to:
      i. Delay or cancel elective surgeries/procedures
      ii. Discharge patients

iii. Call in on-call staff
iv. Initiate the disaster recall list
v. ~~Post Anesthesia Care Unit~~**PACU** may be directed to discharge all patients capable of returning to the nursing units, and clearing this department for holding area of disaster victims if necessary.
vi. ~~OR~~ **Surgery** staff will obtain emergency case carts and pick extra supplies for emergency procedures:
1) Extra Lap, Chest, and Extremity custom packs
2) Six (6) extra cases of **laparotomy sponges (**~~L~~laps**)** and ~~4x4 sponges~~**raytex**
3) IV solutions and tubing
4) Blood administration sets
5) Irrigation: water and saline
6) Antibiotics
7) Morgue packs

4. Employee's Responsibilities:
a. Employees at work but away from the department are to return immediately to their home department.
b. In the event that the department is in the location of the disaster, employees will report to the Labor Pool.
c. Personnel will take direction from the ~~OR/PACU Clinical Managers~~**Director/Assistant Director/Supervisor**/designee in each area.
i. ~~Operating Room~~**Surgery**:
1) Registered Nurses will circulate/scrub with surgical procedures, picking of supplies and instruments of following cases.
2) Anesthesia technician will assist anesthesiologist with line placement and intubations as directed.
3) OR Technicians will scrub surgical cases or assist with instrument processing and ~~running errands~~**duties as assigned**.
4) Endoscopy Suite personnel will assist with minor surgical care and in Pre-Op holding area.
5) Perioperative Aides will assist with transporting patients from the ~~ER~~ **Emergency Department** and discharging cancelled elective surgical patients, as well as ~~routine duties of cleaning~~**OR turnovers and duties as assigned**.
6) OR Secretaries will answer the telephones~~, take messages,~~ and ~~run errands as needed~~**perform duties as assigned**.
ii. ~~Post Anesthesia Care Unit~~**PACU**:
1) ~~Registered Nurses~~**RN's** will assist with the delayed surgery patients~~.~~**,** ~~Some of these patients may require resuscitation or monitoring. They will also~~ assist in **recovering patients in** ICU ~~nursing units~~ if patients are sent directly ~~back~~**to ICU**~~,~~ **(**bypassing PACU**),** if staffing allows.
2) Acute Care Technicians (ACTs) will assist with transporting patients and patient care as directed.
~~2)~~**3) PACU Secretary will answer telephones and perform duties as assigned.**

D. **EVACUATION OF THE OPERATING ROOM:**
1. In the event the Surgical Services is directed to evacuate:
a. Evacuation routes are posted in each specific department
b. Hallways are to be cleared, moving ~~any~~ **all** carts/equipment to the closest storage areas.
~~i. Storage Room 1 and 2~~
~~ii. Dirty Utility Room~~

~~iii. Case Cart Room~~
~~iv. Back hallway by the windows~~
~~v. Any open Operating Room~~
~~vi. Forensic Pre-Op Hold~~
~~vii.~~i. ~~PACU cubicles~~

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 07/09 **SUBJECT:** Food and Drink, Surgery

REVISION DATE(S): 11/12, 01/13

Surgical Services Department Approval:	**02/20**
Department of Anesthesiology Approval:	**n/a**
Operating Room Committee Approval:	**02/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**03/20**
Administration Approval:	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/13**

A. **PURPOSE:**

~~B.~~**1.** To provide guidelines for the consumption of food and drink in surgical areas.

~~C.~~**B. DEFINITION(S):**

1. Restricted areas: **Areas which are accessible only from semi-restricted areas. Wearing of surgical attire is required and masks are required in the presence of open sterile supplies or scrubbed personnel. Restricted areas include the Operating Rooms (OR's) and sub-sterile rooms.**~~Surgical suites and clean core areas.~~
2. Semi-restricted areas: **Areas which are accessible from unrestricted, other semi-restricted, or restricted areas. Wearing of surgical attire is required. Semi-restricted areas include corridors leading to the Operating Rooms, sterile storage rooms, Anesthesia workroom,** ~~P~~peripheral support areas, ~~and storage~~ and processing areas.~~, and corridors; areas in which sterile supplies are stored.~~
3. ~~Non-restricted~~**Unrestricted** areas: **Areas which are accessible from the exterior of the building, other unrestricted areas or semi-restricted areas. Wearing of surgical attire is not required. Unrestricted areas include Pre-Op Hold, PACU, OR desk, offices, and hallways leading to these areas.**~~All areas established to monitor the entrance of patients, personnel, and materials.~~
4. ~~OSHA: Occupational Safety and Health Administration~~

~~D.~~**C. POLICY:**

1. Food and drink must not be taken into the semi-restricted or restricted areas of the perioperative suite.~~Food will only be consumed in non-restricted areas.~~

~~1.~~**2. Food and drink must not be kept in refrigerators, freezers, cabinets, or on shelves, countertops, or workspaces where blood or other potentially infectious materials are present.**

2. ~~Beverages will only be consumed non-restricted areas.~~
   a. ~~Beverages, such as orange juice, for hypoglycemia, may be consumed in restricted areas.~~
   b. ~~Water may be consumed in areas ONLY when necessary.~~
   c. ~~Beverages consumed in non-restricted areas must be covered and kept away from hazardous or infectious agents, electrical and other equipment (telephones, computers, etc.).~~

~~E.~~**D. REFERENCE(S):**

1. ~~OSHA regulation 29 CFR 1910.1030. Paragraph (d) (2) (ix) of this regulation prohibits the consumption of food and drink in areas in which work involving exposure or potential exposure to blood or other potentially infectious material exists, or where the potential for contamination of work surfaces exists. The prohibition against eating and drinking in such a work area is consistent with other OSHA standards and is good industrial hygiene practice.~~**AORN, Inc. (2020). *Guidelines for Perioperative Practice*. Denver.**

~~1.~~2. **Rothrock, J. C. & McEwen, D. R. (2019). *Alexander's Care of the Patient in Surgery, 16th Edition*. St. Louis, MO: Elsevier.**

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES POLICY & PROCEDU

DELETE
Use Elsevier Online Clinical Skills: Laser Safety (Perioperative)

ISSUE DATE: 04/94 **SUBJECT:** LASER SAFETY

REVISION DATE(S): 02/05; 08/09; 11/12

Surgical Services Department Approval:	**02/20**
Department of Anesthesiology Approval:	**n/a**
Operating Room Committee Approval:	**02/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**03/20**
Administration Approval:	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/13**

A. PURPOSE:
To provide guidelines for safe laser practices within the Perioperative and clinical settings which comply with the American National Standards Institute's recommendations.

B. DEFINITIONS:
1. Laser: Light Amplification by Stimulated Emission of Radiation; a device which produces an intense, coherent, directional beam of light by stimulating electronic or molecular transitions to lower energy levels.
   a. Argon - Produced by Argon gas, visible blue-green wavelength of 488 to 514 nanometers (nm).
   b. Candella- Pulsed dye laser, visible green wavelength of 504 nm.
   c. CO2- Produced by clear carbon dioxide gas, invisible at a wavelength of 10600nm.
   d. Diode-810nm class IV, URAM E2 by Endo Optics 2 watt max output
   e. He-Ne- Helium/Neon aiming beam, visible red wavelength at 633nm.
   f. Holmium Yag Chromium thulium - Yttrium Aluminum garnet, invisible at 2100nm pulsed.
   g. KTP/532 - Potassium Titanyl Phosphate, visible green operating at 532nm.
   h. NdYag- Yttrium Alluminum Garnet "doped" with neodymium, invisible operating at 1064nm.
   i. Krypton- Krypton, visible red at 647 to 676nm.
2. Laser Safety Officer(LSO): A staff member who is trained on the potential hazards, control measures, applicable standards, medical surveillance and any other pertinent information pertaining to laser safety and applicable standards. The LSO's responsibilities shall include, but not be limited to:
   a. Developing and reviewing policies and procedures
   b. Staff education and training programs
   c. Appropriate and safe operation of lasers
   d. Reporting problems, concerns, or incidents immediately to the Charge Nurse
   e. Ensuring that routine and preventive maintenance is performed according to manufacturer's written instructions.
3. Designated Laser Person (DLP): A person who shall operate a laser during a procedure/treatment, under physician direction. The DLP shall have received

documented training in laser science, laser safety, clinical applications, operating and trouble shooting of the specific laser to be used.

C. POLICY:

1. Patients and healthcare workers shall be protected from the hazards associated with the use of lasers in their practice settings.
   a. There shall be a LSO designated for TCMC.
   b. There shall be a DLP for the operation of a laser, whose sole responsibility during the procedure is to operate the laser. The DLP may be the technician employed by the laser rental company, or a trained TCMC employee
      i. Ophthalmic surgery procedures are permitted to have the circulating registered nurse act as the DLP in addition to their circulating duties.
   c. Healthcare workers shall be aware of areas of laser use and controlled access to these areas shall be maintained.
      i. A master control key is necessary for the operation of any laser.
      ii. The key shall be labeled, removed when the laser is not in operation, and stored in the Main OR Pyxis.
      iii. Signs shall be posted on all doors entering the operating room to be used for a laser procedure.
      iv. The signs shall state the type and class or the laser to be used, and type of eye protection required.
      v. All doors to the operating room shall be completely closed and all windows in the room shall be covered with laser shades during the laser procedure.
      vi. Room traffic shall be kept to a minimum.
   d. The eyes of patients and healthcare workers shall be protected from laser beams.
      i. Personnel, including the anesthesiologist, surgeon, staff members, and observers, shall wear laser optical grade goggles, specific to the laser in use.
      ii. These goggles shall be labeled with the specific laser wavelength that is to be filtered.
      iii. It is recommended for these goggles to have an elastic strap to prevent them from being dislodged.
      iv. During the use of a microscope/endoscope, an eye safety filter shall be attached and used by the surgeon.
      v. If the patient is awake, he or she shall wear appropriately labeled eyewear.
      vi. If the patient is undergoing a general anesthetic, they should be provided eye protection, such as saline moistened eye pads or specifically manufactured eye shields for laser use.
      vii. During Ear, Nose and Throat (ENT), and facial cases when the laser goggles would interfere, non-petroleum based ophthalmic ointment and saline moistened gauze pads/towels shall be placed over the patient's eyes or specifically manufactured eye shield for laser use.
      viii. During certain ophthalmology laser treatment and/or surgical procedures, the eyes may not need to be covered.
      ix. Laser specific eye wear shall be available outside the room for personnel needing entry during a laser procedure.

e. Skin and other tissues of patients and healthcare workers shall be protected from aberrant and reflected laser beams.
   i. The laser shall remain in the "OFF/STAND-BY" mode when not in use.
   ii. Laser settings, power, and the changes from standby to active mode shall be confirmed verbally by the laser physician and the DLP.
   iii. During laser operation, the laser shall be placed in **standby** when the use of other instrumentation or foot pedals is required.
   iv. Only the operating physician shall operate the laser foot pedal.
   v. Exposed tissue around the operative site shall be protected with saline or water saturated, nonflammable material, when thermally intensive lasers are being used.
   vi. Dull, ebonized, or non-reflective anodized instruments shall be used near the operative site.
   vii. Backstops or guards shall be used during laser surgery, when applicable.

f. Patients and healthcare workers shall be protected from inhaling the plume associated with laser use.
   i. A smoke evacuation system and/or in line filter shall be used to remove plume during laser cases producing plume.
   ii. The system used shall be appropriate for the amount of plume generated.
   iii. In-line filters shall be changed according to manufacturer's written instructions.
   iv. Laser filters for the Neptune system are single patient use only.
   v. High filtration surgical masks shall be worn for all procedures involving condyloma and are highly recommended for cases producing large amounts of laser plume.

g. Patients and healthcare workers shall be protected from fire hazards associated with laser use.
   i. Flammable or combustible anesthetics, prep solutions, drying agents, petroleum based ointments, plastic resins, or plastics shall not be used near the laser site.
   ii. Flame resistant drapes or moistened, reusable fabric shall be used to drape the operative site.
   iii. A basin of water or saline and a fire extinguisher shall be readily available.
   iv. A laser safe endotracheal tube shall be used during laser surgery of the nasal/oral pharyngeal areas, and have the cuff inflated with saline (EXCEPTION: Ophthalmologic laser procedures do not require special endotracheal tubes).

h. Patients and healthcare workers shall be protected from electrical hazards associated with laser use.
   i. Electrical circuitry shall have adequate amperage to meet the power requirements of the specific laser.
   ii. Liquids shall not be placed on the laser unit.
   iii. The laser foot pedal shall be protected from liquids.

i. The laser operative record shall include:
   i. All personnel present
   ii. Laser safety checklist
   iii. Laser type, power, duration, and mode
   iv. Type of evacuation system used
   v. Use of any special or specific equipment for the case
   vi. Patient protective eye wear used

~~j. Personnel working in a laser treatment area shall obtain basic orientation to laser technology and safety.~~

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

SUBJECT: Loaner Trays

ISSUE DATE: 07/09
REVISION DATE(S):

DELETE – incorporated into Sterile Processing Procedure: Sterilization of Packaging System

Department Approval Date(s):
Department of Anesthesiology Approval Date(s):
Operating Room Committee Approval Date(s):
Pharmacy and Therapeutics Approval Date(s):
Medical Executive Committee Approval Date(s):
Administrative Approval: 04/20
Professional Affairs Committee Approval Date(s): n/a
Board of Directors Approval Date(s): 11/12

A. **PURPOSE:**
1. To outline the procedure for the use and return of loaner instruments and equipment from suppliers/facilities to Tri-City Medical Center, Department of Surgical Services.

B. **DEFINITIONS:**
1. High-Level Disinfection: Chemical high-level disinfection is achieved by immersing an item for a specified period in a chemical agent that has been cleared by the FDA as a disinfectant/sterilant.

C. **POLICY:**
1. All communication from the vendor/supplier of loaner equipment will follow the outlined procedure:
a. Incoming Instruments/ Equipment from Vendors
i. All loaners must be arranged through the onsite SPD Manager or designee.
ii. If an individual surgeon contacts a supplier directly to request a loaner, the supplier must contact the onsite SPD Manager makes arrangements for the loan.
iii. Loaners not approved in advance will be evaluated on an individual basis by Management with consultation with the requesting physician.
iv. All loaners must have a complete, accurate inventory list with associated dollar values.
v. Loaners shipped to the hospital receiving dock will have an entity specific "No Charge" Purchase Order (PO) issued for tracking purposes as necessary (i.e. trial equipment, etc).
1) Items shipped without a PO will be returned to the sending party.
vi. All loaners brought in must have a signature of receipt by a TCMC representative, preferably a SPD staff person, or if after hours, a Charge Nurse or designee.
vii. All loaners must be clean, in good repair and in good working order.
viii. BioMed shall perform an electrical safety check and/or functional test on the equipment prior to use.
ix. TCMC does not accept any loaner wrapped sterile instruments from other facilities.
1) Loaner instruments shall be processed through the washer/sterilizer and terminally sterilized in SPD. Immediate Use Sterilization shall only be used in emergency situations.
x. Surgeon, procedure and expected date of use must accompany all loaners.
xi. Any charges associated with the "loaners" must be **pre-authorized** by SPD Manager prior to the surgical procedure.
1) TCMC will not be responsible for any charges which are not pre-authorized.

b. Returns of Instruments/Equipment from Vendors:

i. ***All loaners must be cleaned and terminally sterilized or be high level disinfected prior to return.***

ii. All loaners **must** be picked up within 48 hours of use, unless other arrangements are made at the time of delivery.

1) All loaners that the vendor/supplier pick up must have a signature of a TCMC representative, preferably an SPD person, or if after hours, a Charge Nurse.

iii. Prior to leaving the facility, the supplier must check all loaners for completeness.

1) TCMC will not be responsible for any reports of missing/damaged items made after the loaner has left the facility.

iv. Any individual item/part removed from loaner set/equipment must be logged out through the SPD Manager.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 04/05 **SUBJECT: ON CALL SCHEDULING GUIDELINES**

REVISION DATE(S): 06/09; 10/12

Department Approval:	02/20
Department of Anesthesiology Approval:	
Operating Room Committee Approval:	
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	
Administration Approval:	
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **SCHEDULING MECHANICS:**

1. ~~DAILY SCHEDULE: Schedule is automated with the program being located in the Staffing Office.~~ A**The on-call** ~~master~~ schedule is **posted for staff to sign up at least two months in advance of the start of the schedule. The finalized call schedule is posted three weeks before the start of the schedule.**~~produced 4 weeks in advance and is updated with requests for vacations, planned absences, schedule changes new and terminated employees by the Director or designee. Two weeks prior to start, it is returned to the nursing staffing office to be finalized in the computer and a new updated schedule is sent to the department. A separate schedule is completed by an assigned staff scheduler reflecting a global staffing structure. Based on this schedule, room assignments are made by the Assistant Nurse Manager (ANM)/Charge Nurse for the scheduled cases.~~
2. ~~CALL SCHEDULE:~~ Standby and Call Back will be utilized to staff **the department as deemed by Surgical Services Director/Assistant Director/designee.** ~~shifts that have minimal staffing in-house. The following are guidelines to use, and illustrates how standby~~ **On call** staffing is ~~assigned and provided~~**established in the following manner**:
   a. **The on-call schedules for the main Operating Room, Heart Team, Endoscopy and Anesthesia Techs are established by the staff with final approval by Surgical Services Assistant Director/designee.**~~In the Operating Room the staff on duty initiates the Call Back by contacting the on-call person to return to the department within 30 minutes.~~
   b. **All finalized call schedules are posted at the OR desk.**~~The call schedules for the Main Operating Room, Heart Team, Endoscopy and Anesthesia Techs are done by the staff. A copy of the call schedules are available at the OR desk. The Endoscopy call schedule is located in the Endoscopy room.~~
   c. All full-time,~~ and~~ part-time**, and per diem staff members** ~~RNs and OR techs will be~~**are** expected to cover standby/**on-call shifts** with call back on a rotational basis.
      i. **Per diem staff members will take two (2) shifts of call per month.**
   d. Personnel covering "heart call" will not be expected to take additional **main OR** call, but may volunteer to do so.
   e. Weekend Only personnel will not be expected to cover call except on a voluntary basis.
   f. Weekend personnel are not expected to take call, but may volunteer to do so. Weekend personnel are expected to be in the holiday rotation.
   ~~ii.~~

B. **WEEKENDS:**

1. There are two types of Weekend Professionals:
   a. WEEKEND ONLY: personnel work only the weekend; 8 or 10 hour shifts.
      i. Weekend Only and Per Diem personnel will not be expected to cover call except on a voluntary basis. They must work a minimum of 4 shifts per month in order to participate in the call rotation.
      ii. Weekend only and Per Diem personnel are required to fulfill their regularly scheduled shift if it falls on the holiday. They will work the major or minor holiday unless request to be off as vacation. Only one person at a time may request each holiday off.
   b. WEEKEND PERSONNEL: (either full-time or part-time) also work other days of the week and work at least two full weekends per month.
      i. Weekend Personnel are not expected to take weekend call. Weekend Personnel will fill their call obligation by taking call during the week or voluntarily taking weekend call during off duty hours.
      ii. These individuals whose normal working hours routinely encompass part or all of a weekend are required to participate in holiday coverage. When hired or changed to this shift, this is a one-time option to be decided by choosing one of the following methods of compliance:
         1) Elect to work the minor/major holidays that are in conjunction with their regularly scheduled weekends. If the individual works both Saturday and Sunday, these shifts will count as call shifts. If the individual's worked shift is only one day, this person will sign up for call on their off day.
         2) Elect to work a major/minor holiday (1 major and 2 minor), then stays in these groups as they are rotated every year.
      iii. The method the individual chooses must be communicated to the Unit call scheduler(s). Those who choose method (1) will submit in writing the holidays they are working for the year.
2. Weekend Coverage begins at 2300 hours on Friday and ends at 2300 hours on Sunday.
   a. Friday
      i. 2300-0700 hours:
         1) 1 RN/Tech (in-house)
         2) 1 RN/Tech (on-call) first call
      ii. 2nd Call:
         1) 1 RN, 1 Tech/RN
   b. Saturday
      i. 0630-1700 hours:
         1) 2 OR Teams (weekend personnel)
      ii. 0630-1500 hours:
         1) 1 OR Team (2nd Call backup)
      iii. 1500-2300 hours:
         1) 1 OR Team (in-house)
         2) 1 OR Team (2nd Call)
      iv. 2300-0700 hours:
         1) 1 Tech/RN (in-house)
         2) 1 Tech/RN (on-call)
         3) 1 OR Team (2nd Call)
   c. Sunday
      i. 0630-1700 hours:
         1) 2 OR Teams (weekend personnel)
      ii. 0630-1500 hours:
         1) 1 OR Team (2nd Call backup)
      iii. 1500-2300 hours:
         1) 1 OR Team (in-house)
         2) 1 OR Team (2nd Call)

~~iv. 2300-0700 hours:~~
~~1) 1Tech/RN (in-house)~~

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

1. ON CALL POLICY:
   a. Full-Time personnel ~~assigned to Night duty~~**working the night shift** will not be expected to cover call except on a voluntary basis.
   b. Per Diem Personnel are required to work 1 ~~minor~~ **winter and 1 other** holiday per year.
   c. The number of call shifts **an individual will be responsible for in any month will be determined by the number of shifts** needing coverage divided by the number of personnel covering call.
      ~~c.~~**i.** RN's may ~~be expected to cover some~~ **sign up for** scrub role coverage.
   d. The response time from the time an individual receives the call unit they must arrive at the hospital is 30 minutes.
   e. Pagers may be used if the on-call person is away from their phone. When using a pager, check in with the operating room personnel (in-house) to let them know you are "on pager". Check to make sure they have the correct pager number and ask for a pager check while checking in.
   f. Employees who wish to be in-house must place an "H" next to their name. In-house call is first come, first served.
      ~~e.~~**i. If two people are scheduled (first call team) and neither one wishes to be in-house, it is the responsibility of the individuals to decide between themselves how they will cover the in-house responsibility.**
   g. If the "first call" person is unable to fulfill the call responsibility due to illness/injury, it will be the responsibility of the "second call" person to move into the "first call" slot.
      i. The ~~ANM or charge nurse~~**Supervisor/designee** on duty will be responsible for finding a replacement to fill the "second call" standby position.
      ~~f.~~**ii.** The list of personnel who have signed up for extra call will be utilized first, and if unable to fill the position, then the staffing book.
      ~~g.~~**iii.** It is not acceptable to call into the OR and expect the OR Aide or Nurses on call back duty to find a replacement. The OR ~~ANM~~**Supervisor/designee**~~, Administrative Coordinator, or Administrative person on-call may be reached through the TCMC Operator in the event that the OR weekend charge cannot be reached~~ **or management team member shall be reached to find a replacement**.
   h. Call Rotation/Give-away:
      i. Rotational call schedule
      ii. Unwanted call will be ~~starred (*)~~**colored burnt-orange** for giving away
      iii. Extra call group list is posted for sign-up in Google drive. Group 1 signs up for extra call first and then the extra call sign-up rotates through all call groups.
      ~~ii.~~
      ~~iii. Person with least amount of call for the week, will have first rights~~
   ~~iv. Next in line would be by seniority (full-time, part-time, then per diem)~~
   i. Endoscopy Call:
      i. When cases are finished for the day, ~~T~~the Endoscopy nurses go on-call.
      ii. Evenings, nights and weekends are covered by on-call staffing.
      iii. The Endoscopy Unit Registered Nurses are contacted by the OR main desk after receiving a call from the physician ~~needing to perform the~~**scheduling a** procedure.
      iv. Responsibilities of the Endoscopy Nurses:
         1) Maintain an accurate call schedule, including correct telephone and pager numbers, in the designated Endoscopy Call Schedule Folder.
         2) Updated the Operating Room on any changes in on-call personnel on the present working day.

3) Inform the Operating Room of changes in status (i.e. ~~Leaving present phone location and going on pager~~**changes to preferred contact number**)

~~v. OR Back-up: The OR will have a select group of personnel on-call to provide backup assistance for Endoscopy during the evening hours, from 1500 to 2200 hours, and on Saturdays from 0700 to 1500 hours.~~

~~j. Operating Room on-call personnel will cover Endoscopy call should the need arise for backup personnel.~~

~~k. There will be 2 rooms available for holidays and staffed as follow:~~

~~i. Day Shift:~~

~~1) 1 OR team (in-house)~~

~~2) 1 OR team (on-call)~~

~~ii. PM's and Night Shifts:~~

~~1) 2 OR teams (on-call)~~

~~l.~~**j.** Holiday call is divided into two categories:

i. **Winter**~~Major~~ holidays (Thanksgiving, Christmas **Day** and New Year's **Day**)

1) **Winter**~~Major~~ holiday~~s~~ **call** will go in rotation (i.e. If an employee **was on-call**~~had~~ Thanksgiving last year, they ~~would rotate~~**are on-call** ~~to~~ Christmas **Day** this year, or if they ~~had~~ **were on-call** Christmas ~~off~~**Day last year**, they ~~would have~~**are on-call** New Year's **Day** ~~the following~~**this** year~~, and then Call assignment would continue to rotate thereafter~~)

2) When new personnel are added to the call schedule they will be put in the holiday slot ~~that~~ **for which call coverage** is needed and that ~~would~~**will** begin their rotation.

ii. **Other**~~Minor~~ holidays (President's Day, Memorial Day, July 4th, and Labor Day)

1) **Other**~~Minor~~ holiday~~s~~ **call** will go in rotation (i.e. if an employee ~~had~~ **was on-call** President's Day ~~off~~ last year, they ~~would then rotate to~~**will be on-call** Memorial Day ~~for the current~~**this** year~~, and if they had Memorial Day off, they would have July 4th off the following year, and so on for Labor Day, and then Call assignment would continue to rotate thereafter~~)

2) When new personnel are added to the call schedule they will be put in the holiday slot ~~that~~ **for which call coverage** is needed and that will begin their rotation.

~~2)~~**iii. Number of holidays required is dependent on department business needs, as determined by the Director of Surgical Services/Assistant Director/designee.**

~~iii.~~**iv.** Holiday Call ~~will be covered~~**is assigned** on an 8-hour shift basis.

~~1) There will be 2 teams available for 7AM-3PM and 2 on-call teams available for the other two shifts.~~

~~2) Personnel that will be responsible for covering a holiday and weekend call will have the opportunity to sign up for their holiday and weekend call shifts in advance of the regular staff. They will be allocated certain slots for the actual holiday (based on seniority), as well as a number of weekend shifts they are responsible for. They will pick in the order of the group they are in.~~

~~iv.~~**v.** ~~These p~~**P**ersonnel assigned to holiday shifts during an approved vacation will be responsible for finding a replacement.

~~v.~~**vi.** If a holiday falls in the middle of the week, the holiday personnel are not required to cover the weekend with the exception of Thanksgiving. However, if the holiday is a three-day weekend, they are responsible to cover the weekends call shifts in addition to their holiday call.

~~vi.~~**vii.** ~~Holiday p~~**P**ersonnel that are ~~responsible for~~**assigned call for** ~~covering~~ a holiday that falls in the middle personnel that are responsible for covering a holiday that falls in the middle of the week will be ~~allocated certain slots that they must sign up for~~**required to cover on-call shifts** in addition to their regular call. They will pick in order of the group they are in.

~~vii.~~**viii.** If individuals wish to trade their holidays they must submit the trade in writing before the schedule is made ~~up for that~~**for the** month. The **holiday** rotation ~~(if it is a major holiday)~~ remains unchanged.

~~m. Holiday call for OR Aides/Instrument Aides~~

~~i. There will be one person on call for 16 hours for each holiday.~~

~~ii. The four (4) major holidays (Fourth of July, Thanksgiving, Christmas, and New Years) will be on a rotational basis and the minor holidays will be drawn on the first Monday of November at 2:00pm.~~

~~n. Holiday Call for Anesthesia Techs~~

~~i. Any holiday falling a weekend.~~

C. **PROCEDURE:**

1. **PROCEDURE FOR CALL ASSIGNMENTS:**
   - a. **Call sign up will be through Google Drive under the email of tcmcsurgicalservices@gmail.com.**
   - b. **Staff personnel assigned to the Group List will specify how many and what kind of shifts each person must take (i.e., scrub, circulate, first, second, etc.).**
   - c. **OR personnel will be assigned to call on a rotational basis in groups. Each group member will be assigned an AM or PM designation.**
     - i. **Anyone scheduled at 0630 will be scheduled as the AM and all others will be scheduled as PM.**
   - d. **AM and PM will rotate each month based on which designee signs up first.**
   - e. **Call sign up will begin with Group 1 on the Sunday at 1800 that the Staff Schedule is completed. The first group will be activated to edit the schedule. After 12 hours the staff member will revert back to a view only status.**
   - f. **If the staff member does not sign up after 12 hours, the call will be assigned by the management team.**
   - g. **The remaining groups will follow this protocol.**
   - h. **Any individual with an approved vacation of one week or more will be allowed to sign up within the second group's rotation for that month, unless they are already assigned to group 1.**
   - i. **All personnel assigned to call are responsible to cover the amount of shifts designated regardless of circumstances. If the slots that are vacant are conflicting, they must still sign up and either trade their call or try to give it up.**
   - j. **Staff selecting to "give away" their call can denote this by changing the box color from white to a burnt orange color.**
   - k. **After all groups have signed up for call, the burnt orange shifts will then be available for those who added their name to the Extra Call box in the Group list. All individuals will be able to select two (2) shifts in the group rotation for that month. Only two (2) shifts at a time will be allowed to be picked up.**
   - l. **Any call shift that has become vacant due to lengthy unexpected illness, disability, or resignation, will be posted for coverage. If after ten (10) days it is not covered, it will be assigned by management personnel.**
   - m. **Stand-by On-call shifts are as follows:**
     - i. **0700-1500 hours**
     - ii. **1500-2300 hours**
     - iii. **2300-0700 hours**
   - ~~D.~~n. **Stand-by/On-call personnel are responsible to relieve the preceding individual which they are replacing by five (5) minutes before their "call" shift ends (i.e., if relieving the scrub from the 1500-2300 shift, the 2300-0700 on-call scrub should relieve the previous scrub by 2255 hours).**

~~1. PROCEDURE FOR CALL ASSIGNMENTS:~~

~~a. The call sheet will be posted by the last day of the month, one month in advance of the month to be covered.~~

b. The staff personnel assigned to the call staffing duty will specify how many and what kind of shifts each person must take (i.e. scrub, circulate, first, second).
c. The unit scheduler will place all OR personnel assigned to call on a rotational basis in groups.
d. If an individual is gone longer than two weeks when a new schedule is out, they are responsible to sign up within their group order before they leave or assign another staff member to sign up for them in their absence. The call schedule cannot be held up and people will proceed in group order to pick their shifts.
e. The call schedules are located at the main desk in the OR on a clipboard.
f. Any individual with an approved vacation of one week or more will be allowed to sign up within the second group's rotation for that month unless, of course, they are in group one.
g. No individual is allowed to jump groups when picking their call except for the above mentioned.
h. All personnel assigned to call are responsible to cover the amount of shifts designated regardless of circumstances. If the slots that are vacant are conflicting, they must sill sign up and either trade their call or try to give it up.
i. Staff electing to "give away" their call can denote this by marking a star (*) by their name when they sign up. The person originally assigned will be responsible for the shift if there should be some discrepancy.
j. After all groups have signed up for call, the starred shifts will then be available for those staff members interested in extra call. There will be a list each month for the individuals that are interested in extra call to sign their name. The list will be at the bottom of the call schedule for each particular month. All starred shifts will be selected by those individuals equally in order of their group rotation for that month.
k. Any call shift that has become vacant due to lengthy unexpected illness or disability, or resignation will be posted for coverage. If after 10 days it is not assumed, it will be assigned by management personnel.
l. Standby-On-call shifts are as follows:
    i. 0700-1500 hours
    ii. 1500-2300 hours
    iii. 2300-0700 hours
        1) Standby/On-call personnel is responsible to relieve the preceding individual which they are replacing by 5 minutes before their "call" shift ends. (i.e. if relieving the scrub from 1500-2300, and are the 2300-0700 On-call person, that scrub individual should be leaving the room at 2255 hours).

2. REQUESTING SCHEDULE CHANGES OR PTO:
    a. Submit written request to ANM at least 3 weeks prior to start of the schedule in which desired vacation time occurs.
    b. Only 2 nurses will be permitted Requested Time Off per 8-hour period, as staffing permits.
    c. PTO requests will be honored on a first-come, first-serve basis, with the person having the most seniority being granted the time off in the event that 2 or more requests are submitted on the same day.
    d. Requests for PTO during winter holidays will be accepted until August 31st prior to the holiday. Requests will be granted based upon the following:
        i. Whether or not the person had PTO over the same holiday the previous year.
        ii. Whether or not the person was granted PTO over one of the other winter holidays in the current year.
        iii. The date of which request was submitted.
    e. Any employee requesting PTO must have accrued PTO on the books or the request will be approved pending adequate PTO accumulation. If adequate PTO is not accrued when the schedule is distributed, the employee will be scheduled normal working hours.

B. **RELATED DOCUMENT(S):**
1. Surgery On Call Guidelines

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 04/94 **SUBJECT: Operating Room (OR) Committee**

REVISION DATE(S): 1/05, 6/09, 10/12, 5/15; 11/15, 02/17

Surgical Services Department Approval:	**~~10/16~~02/20**
Department of Anesthesiology Approval:	**na**
Operating Room Committee Approval:	**~~10/16~~02/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~01/17~~03/20**
Administration Approval:	**n/a, 04/20**
Professional Affairs Committee Approval:	**~~02/17~~ n/a**
Board of Directors Approval:	**02/17**

A. **OPERATING ROOM COMMITTEE:**

1. Existence
   a. The chairperson of the Operating Room Committee will be either the chief of surgery or chief of anesthesia, alternating each fiscal year.
   b. Members shall consist of physician~~s~~ representation from anesthesia, surgical sub-specialties, perioperative nursing leadership and administration.
   c. The committee shall function as a liaison between Perioperative Services and the Medical Staff and shall:
      i. Conduct periodic review of operational policies (i.e., scheduling of elective and emergency cases)
      ii. Review incidents and adverse events
      iii. Review problems with the daily management of the Operating Room schedule
      iv. Review block time utilization
      v. Review late surgeons for appropriate sanctions
   d. The committee shall meet monthly in addition to any meetings called by the committee chair.
   e. The chair of the committee, with input from the Director of Surgical Services/designee and OR Medical Director,~~-~~ develops the meeting agenda.
   f. Documentation of the minutes is forwarded to the Medical Staff Office and approved by the Medical Executive Committee and Board of Directors.
2. Responsibility
   a. All surgical and anesthesia services are coordinated by the Operating Room Committee through the development of policies and protocols relating to the functioning of ~~the~~ **Pre-Operative Education (POE), Pre-Operative Hold (POH),** Operating Room, Post-Anesthesia Care Unit (PACU), and Anesthesia Department. These are coordinated in conjunction with administration and are reviewed at least every three years.
   b. The Committee determines OR availability requirements to meet the needs of the community.

B. **EXTERNAL COMMITTEES:**

1. Perioperative Services is represented on select hospital level committees in order to ~~link~~**align** surgical/anesthesia activities with other hospital-wide ~~critical situations~~**initiatives**. ~~The following lists these external committees and addresses the Operating Room/external group interactions.~~

~~1.~~**2. Members of the Perioperative Leadership team will represent Surgical Services on clinical product selection committees, patient safety committees, and regulatory compliance committees, as well as the following interdisciplinary committees, including, but not limited to:**

~~a. Clinical Value Analysis Team (CVAT)~~

~~i. The OR Materials Manager, OR Manager and the Sterile Processing Department (SPD) Operations Manager are members of this committee, which reviews products for the entire facility for compatibility, cost effectiveness, etc.~~

~~b.~~**a.** Infection Control **Committee**

~~i. The Director for Surgical Services and SPD Manager are members of the Infection Control committee, which reviews hospital-wide infection control issues.~~

~~c.~~**b.** Quality Assurance (QA)/Performance Improvement (PI) Committee

i. ~~The Director of Surgical Services attends this committee, which reviews Quality Initiatives and Outcomes.~~

c. Policy and Procedure review committees (i.e., Clinical Policies and Procedure [CPP], Administrative Policies and Procedures [APP])

d. Code Blue Committee

e. Radiation Safety Committee

~~i.~~**f. Donor Committee**

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
PERI-ANESTHESIA NURSING SERVICES POLICY ~~MANUAL~~

ISSUE DATE:

SUBJECT: PANS~~pacu & spra~~ Staffing & Scheduling ~~Practices~~ Guidelines

REVISION DATE(S): 06/18, 2/20

Department Approval:	**06/18,**
Department of Anesthesiology Approval:	**n/a**
Operating Room Committee Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**

1. To establish guidelines and staffing criteria to assure that appropriate nursing personnel are available to administer nursing care to patients recovering from surgical/special procedures, ~~and~~ anesthesia **and sedation**. Unit staffing patterns and scheduling practices determines the staffing practices for **Perianesthesia Nursing Services** (PANS).

B. **STAFFING PROCEDURE:**

1. **PANS~~PACU~~ COVERAGE:**
   - **a.** Monday through Friday ~~Days & PM's:~~ **0700 – 2300 hours.**
     - **i. Unit staffing includes registered nurses (RNs), advanced care technicians (ACTs), aides and secretaries.**
     - **ii. Staffing will reflect patient volume, acuity and comply with American Society of Perianesthesia Nurses (ASPAN) Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements.**
     - ~~i. When operating 9-12 OR rooms 0700-1500 and 3-4 OR rooms 1500-2300, CCL, Radiology and Endoscopy suites, minimum staffing will be provided as follows:~~
       - ~~1) Days: 1 charge RN; 6-7 RN's scheduled in house or On Call; 1 ACT~~
       - ~~2) PM's: 3-4 RN's scheduled in house or On Call; 1 transporter~~
       - **1)** ~~3) Staffing will be flexed based on anticipated patient volume and acuity. See Addendum K, *Acuity Guidelines*~~
   - **b. Weekday nights (2300 – 0700 hours) and weekends, see PANS Policy: PACU ON CALL COVERAGE.**
   - ~~a.~~**c. Monday through Friday- Nights:** ~~Monday through Friday - Nights~~:
     - i. PACU staff covers night shift ~~11:00 pm – 7:00~~**2300-0700** ~~am~~ on-call
   - ~~b.~~**d.** Weekends (Saturday and Sunday):
     - i. When operating 1-3 operating rooms, CCL, Radiology and Endoscopy suites (emergent cases only), minimum staffing will be provided as follows:
       - **1)** ~~Saturday/Sunday:~~ **1 RN in-house professional 0700-1900 Saturday and Sunday**
       - **2)** **2~~3~~** RN's ~~7:00 am – 7:00~~**0700-1900** ~~pm in-house or~~ on-call, **Saturday and Sunday**
       - **3)** 1 ACT~~/transporter~~ on-call ~~9:00 am~~**0900** – ~~9:00 pm,~~**1800**
       - ~~1)~~**4)** 2 RN's on-call ~~7:00 pm – 7:00 am~~**1900-0700, Saturday and Sunday**

~~**SPRA COVERAGE:**~~

~~Monday through Friday 7:30 am – 6:00 pm:~~
~~When operating CCL, Radiology and transfusion, minimum staffing will be provided as follows:~~
~~Days: 1 Charge Nurse, 2 or 3 RN's, (Fluctuations based on acuity), 1 ACT/transporter 9:00 am – 5:30 pm~~
~~Staffing will be flexed based on anticipated patient volume and acuity. See Addendum K, Acuity Guidelines~~
~~Weekends (Saturday and Sunday) and Holidays:~~
~~i. The SPRA area will be closed. SPRA patients will be cared for in PACU.~~
~~2. **ANCILLARY SUPPORT:**~~
~~a. A PACU transporter/ACT is available 7:00 am – 11:00 pm Monday through Friday to assist with patient transport to the nursing units and to perform other duties as outlined in the job description. The hours may vary depending upon patient census.~~
~~An OR transporter is on duty 16 hours a day in the operating room. Assistance with patient transport in the PACU is dependent upon OR workload.~~
~~In the event transport help to the PACU is delayed due to a heavy workload, it is requested that the PACU charge/resource nurse call the OR Charge Nurse/Resource Nurse for assistance. If none is available, call the Administrative Coordinator.~~
~~Unit secretaries are assigned to PANS to assist with secretarial duties, and to perform other duties as outlined in the job description.~~

C. **UNIT SCHEDULING SYSTEM / SCHEDULING PRACTICES**

~~1. 1. DEFINITIONS:~~
~~a. AVAILABLE SHIFTS: All scheduled shifts, extra and available call shifts due to vacation, sick time, bereavement, education time, medical LOA, LOA, and unfilled unit positions.~~
~~b. HRTO: Hospital requested time off when staffing exceeds patient census~~
~~c. OVERTIME: All employees on a 40-hour workweek are on overtime when they reach the 41st hour in a week (i.e., any time over 40 hours in a week). Time worked after 12 hours in one day is double time. NOTE: The Operations Manager/Designee must approve scheduled and unscheduled overtime. While it may not be realistic to expect approval as overtime is occurring (e.g., an unexpected busy shift), this is considered to be approved when the time card is signed by the Operations Manager. This is in accordance with payroll policies.~~
~~d. WORK WEEK: A workweek is Sunday 0001 through Saturday 2400.~~
~~2. Unit Specific Staff Scheduling Requirements:~~
~~a. **Call requirements for benefited and non-benefited staff** will be the same and will depend~~
~~i. upon the number of nurses currently on staff. Call shifts will be scheduled through self-scheduling, coordinated by the unit scheduler.~~
~~ii. NIGHT BACKUP ROTATION (Per 4 week schedule): night of backup call (2300 - 0700)~~
~~iii. FIRST CALL NIGHT ROTATION (Per 4 week schedule)~~

1. **Scheduled shift requirements for benefited staff will be required in accordance with the staff member's ~~job description~~Add Change Hire (ACH) form~~.~~.**
~~1.~~2. **Scheduled shift requirements for non-benefited (per diem) staff:**
   a. Availability of at least 4 shifts ~~per schedule~~ **in a 4 week period** to include**, at minimum, one Friday.**~~:~~
   ~~a.~~b. **Scheduled shifts do not include call shifts. Call shifts are assigned in addition to scheduled shifts.**
      ~~1) Scheduled shift on a Friday~~
      ~~2) Late evening shifts (i.e., a shift ending 2230 or 2330)~~
3. **Scheduled overtime must be approved by ~~the Manager/Director~~Management. While it may not be realistic to expect approval as overtime is occurring (e.g., an unexpected**

busy shift), this is considered to be approved when the time card is signed by Management~~the Manager/Director~~. This is in accordance with payroll policies.

~~c. . A scheduled shift on Saturday and/or Sunday meets the requirement for a scheduled day shift. This DOES NOT INCLUDE Second or Third shifts on the weekend or any other shift scheduled "On Call". If the scheduled shift is canceled or changed to an On Call status per hospital request due to change in patient volume or acuity, this time will count toward the per diem shift requirements.~~

~~**ASSIGNMENT OF CALL COVERAGE**~~

~~Assignment of call coverage for PACU will be done by Unit Scheduler in the following manner:~~

~~NIGHT BACKUP:~~

~~A night backup rotation list for the next schedule will be available on the Second Friday of the current schedule. The first person on the list will be first to choose their nights for backup; the second person will have second choice, etc. The person at the top of the list will be placed at the bottom of the list on the next schedule. The number of nights each person chooses will vary depending upon the number of staff in the rotation. First call nights and night backup for a weekday holiday will count toward the backup requirement.~~

~~WEEKEND CALL:~~

~~b.~~**a.** ~~A weekend availability list will be 4-6 weeks prior to the beginning of the next weekend rotation schedule. The schedule will cover the same number of weekends as the number of staff. Each staff member is required to indicate availability for a minimum number of weekends, currently four (4). The unit scheduler or will assign weekends according to the choices indicated on the availability list. Each staff member will be assigned **two** weekends. The completed weekend schedule will be placed in the schedule notebook. A full-time employee scheduled to work in house Saturday and/or Sunday will be given a day off during the same week.~~

D. **SCHEDULING SYSTEM**

1. ~~The draft of the new schedule and first posting will be distributed on the first Monday of the current schedule.~~**Department scheduling will be completed via an electronic scheduling system.** ~~being worked. The first posting is of available shifts for PANS. This is not an overtime shift option.~~
2. Each staff member **will** indicate~~s~~ their schedule preference**s** ~~on first posting (posted on Monday). This first posting needs to be completed by first Friday of current schedule being work on.~~
3. ~~**The** Unit **PANS** scheduler~~**Management will** make~~s~~ adjustments **to the schedule as needed** ~~and fills in the per diem staff~~ to ensure adequate daily staffing.~~.~~

~~The final schedule will be distributed by Friday of the second week of the current schedule being worked. A copy of the final schedule will be kept in OP/PACU and in the schedule notebook in PACU and a copy will be posted in SPRA.~~

~~**Management cannot make changes to the posted schedule without consent of the employee.**~~ ~~Any **staff requests for** changes after the schedule is posted must be approved by the Operations Manager/**Director or PANS Scheduler**. It is the responsibility of the staff member who needs to make a change to find coverage of his/her shift.~~

~~**Staff working extra shifts may not cancel themselves from an assigned shift unless a replacement has been found.**~~

~~1. **Any employees wishing to exchange shifts must submit the schedule changes to the PANS Scheduler on a Request for Change of Scheduled Shift. A completed request will be approved/ disapproved and posted on the final schedule.**~~

~~Once final schedule is posted staff **are** to bring inaccuracies to the attention of **the PANS** Scheduler/Manager in order for corrections to be made. From this point requests for change in schedule must be arranged with another staff member, a change of schedule slip submitted to Manager/Scheduler for approval and schedule changes made.~~

E. ~~**REDUCTION IN FORCE**~~**FLEXING**

1. ~~Reduction in force (flexing)~~ **Flexing** will be done **according to patient volume and acuity** in accordance with **policy Administrative Human Recourses: Flex/Float to Activity and with the current CNA/SEIU contract.**~~TCMC Administrative Policy #437.~~

~~Priority list for reduction of force:~~

~~First: Scheduled overtime, benefited/non-benefited staff (FT/PT)~~
~~Second: Volunteers. Priority will be given to staff members who worked the previous night on call, and staff members who have worked on call over the previous weekend or who have 2nd call over the following weekend.~~
~~Third: Non-PANS staff~~
~~Fourth: PANS per diem staff~~
~~Fifth: Benefited staff PT and FT working an extra shift that is not overtime~~
~~Sixth: Staff with the least hours flexed in the current pay period being worked. If more than one staff member has flexed the same amount of flex hours during the current pay period, the employee with the least hours flexed over the previous pay period will be flexed.~~

2. It is the responsibility of each individual nurse to document hours flexed daily on the ~~HRTO~~ flex sheet provided in the unit schedule notebook. ~~**The PANS Scheduler will ensure this is kept up to date.** The Charge Nurse is not responsible for recording hours flexed.~~

~~The route for addressing any scheduling issue is to communicate the concern to the unit scheduler, if no resolution, speak with operation manager.~~
~~Overtime: Issues involving overtime need to be approved by the Operations Manager.~~

3. **Flex documents must be approved and signed by management**
3.**4.** ~~If census is down and nurses are placed On Call for the remainder of their scheduled shift, the nurses will be called back in the order assigned by the charge nurse.~~**If staff is flexed they may be placed on call for the remainder of the scheduled shift and can be called in if needed for patient care.**

F. **REQUESTING ~~SCHEDULE CHANGES OR~~ PAID TIME OFF (PTO)**

~~Personnel from PANS will be permitted to request PTO. Submit~~ **W**Written request**s shall be submitted** to **~~the PANS Scheduler~~Management** ~~Unit Scheduler/Manager~~ at least ~~3~~ **2** weeks prior to the start of the schedule in which the ~~vacation time~~ **PTO** occurs. ~~Unit Scheduler/Manager~~ **~~The Manager/Director~~Management** will approve/disapprove **and** ~~,~~ return a copy of the request to the employee. **~~The PANS scheduler~~Management will keep the PTO calendar current~~t~~,** ~~and enters the PTO onto the PTO calendar in the schedule notebook. This will be done at least 3 weeks prior to the start of the schedule in which the vacation time occurs.~~ Staff must have **either ~~have~~** sufficient PTO **banked or** accrue **enough PTO by the time requested**~~al~~ to cover requested time off **per the HHR Administrative Resource Policy.** ~~. in order for request to be granted. At Manager's discretion PTO may be granted for staff with insufficient PTO accrual dependent on unit needs.~~

~~b. Only three nurses will be permitted to be scheduled off per 24 hour period. Only 1 nurse from POH or POT will be permitted off per 24 hour period. If a fourth nurse requests PTO for any given day, they will be given the first opportunity to flex.~~

1. PTO requests will be honored on a first-come, first-serve basis, with the person having the most seniority being granted the time off. **I**~~i~~n the event that two or more requests are submitted on the same day**, the employee that has the sufficient amount of PTO at the time of the request will be granted the time off.**
~~c.~~**2.** Requests for PTO during winter holidays will be accepted from January 1 ~~until~~ **to** August 31 of the same year.
   - **a. Winter Holidays**
     The week of Thanksgiving
   - **b. Thanksgiving day**
     The day after Thanksgiving
   - **c. The week of Christmas or New Years**
   - ~~a.~~**d. The week before or after Christmas and New Years**

~~2.~~**3.** ~~Requests~~**Requests** will be granted based upon the following:

~~d. Whether or not the person was granted PTO over one of the other winter holidays in the current year~~

~~e.~~**a.** Whether or not the person had PTO~~. ever~~ **on** the same holiday within the previous two years

~~f.~~**b.** The date on which the request was submitted

~~g.~~**c.** Seniority**, if sufficient PTO available**

~~h.~~**d.** Any requests received after August 31st will be granted on a first-come, first-serve basis as staffing permit**s and sufficient amount of PTO.**~~s.~~

~~i.~~**e.** Flexing lists for ~~major~~ Holidays:

i. Will be made from **denied** ~~ungranted~~ PTO requests~~;~~ **b**~~B~~ased on the same criteria as written above.

~~i.~~ Based on the same criteria as written above.

~~5. Any employee requesting PTO must have accrued PTO on the books or the request will be approved pending adequate PTO. If adequate PTO is not accrued when the schedule is distributed, the employee will be scheduled normal working hours.~~

~~6. Once the final schedule is posted, schedule changes are permitted only with Operations Manager approval.~~

~~Per diem staff and benefited staff working extra shifts may not cancel themselves from an assigned shift unless a replacement has been found. The employee must submit the schedule change to the Operations Manager on a Request for Change of Scheduled Shift slip signed by both the employee and his/her replacement.~~

~~Any employees wishing to exchange shifts must submit the schedule changes to the Operations Manager on a Request for Change of Scheduled Shift slip signed by both employees involved in the shift exchange. A completed request will be approved/ disapproved and posted on the final schedule by management.~~

4. ~~Planned time off~~ **PTO** can be canceled once approved ~~only~~ with management authorization.

a. Under no circumstances will PTO be replaced with **flexing**~~HRTO~~ if **the** census is low during planned time off.

b. **Previously denied requests will be reassessed by ~~the PANS Scheduler~~management.**

~~PANS Holiday Call:~~

~~a. Holiday call will be divided into major holidays (Thanksgiving, Christmas Eve/Christmas, New Year's Eve/New Year's Day), and minor holidays (President's Day, Memorial Day, July 4th, and Labor Day).~~

~~b. Major holidays will go in rotation, i.e., if an employee had Thanksgiving last year, they would rotate to Christmas this year; or if they had Christmas, they would have New Years the following year. It would continue to rotate. When new personnel are added to the call schedule they would be put in the holiday slot that was needed and that would begin their rotation.~~

~~Holidays will be covered on a 12-hour shift basis. All shifts on major holidays will be on call.~~

~~On minor holidays, the first shift will be in house. All other shifts will be on call.~~

~~There will be 3 nurses available from 0700 to 1900 hours, and 2 nurses available 1900 to 0700 hours, on call, for each holiday.~~

~~The holiday drawing will take place during the October. The Unit Scheduler/ Operations Manager /Designee will draw for those who are not present.~~

~~Minor holidays will go in rotation (i.e. if an employee had President's Day weekend the previous year they would rotate to Memorial Day this year) or if they add Memorial Day they would rotate to July 4th and so on. Each person will pull one holiday shift.~~

~~Major holidays will be drawn from a holiday specific pot. The Department will be divided into three equal groups. If there are more personnel in a group than there are holiday shifts to work, Blank slips will be added to the pot. The personnel with a blank slip will move into a shift that has been left uncovered due to changes in staffing. The slips will be numbered consecutively beginning with 1 and this is the order in which empty shifts will be filled. Most senior person draws first the following year and 2nd most senior person and so on and so on.~~

~~If the holiday falls in the middle of the week, including Thanksgiving, the holiday personnel are not required to cover the weekend. If the holiday falls on the weekend they are responsible for the entire weekend.~~

~~Those personnel assigned to holiday shifts during an approved vacation will be responsible for finding a replacement.~~
~~Those personnel covering a holiday weekend will count this as a part of their weekend rotation. Those personnel covering a holiday night or backup during the week will count this as a part of their backup rotation.~~
~~If individuals wish to trade their holidays they must submit the trade in writing to the Operations Manager.~~
~~The PANS holiday call applies to benefited and non-benefited staff, equally.~~

~~3.~~ ~~The seniority list will be updated yearly, prior to the holiday dra~~

Tri-City Medical Center
Oceanside, California

PERI-ANESTHESIA NURSING SERVICES POLICY MANUAL

ISSUE DATE: **SUBJECT: PACU ON CALL COVERAGE**

REVISION DATE (S): 06/2018, 2/20 **POLICY NUMBER:**
~~**ISSUE DATE:**~~ ~~**REVISION DATE: 06/2018**~~

Department Approval:
Department of Anesthesiology Approval:
Operating Room Committee Approval:
Pharmacy & Therapeutics Committee Approval: N/A
Medical Executive Committee Approval:
Administrative Approval: 04/20
Professional Affairs Committee Approval: n/a
Board of Directors Approval:

~~1.~~**A. PURPOSE:**

1. To establish a system for providing ~~additional~~ staffing after hours for urgent/emergent surgical cases and ~~invasive~~ procedures ~~in CCL, Endoscopy, and Radiology departments~~**requiring sedation**. ~~PACU and SPRA staff (benefited/non-benefited) provide coverage for night and weekend shifts. To establish criteria for calling in the On Call nurse and to identify the responsibilities of the On Call nurse.~~

~~2.~~**B. WEEKDAY CALL COVERAGE:**

1. **Monday – Friday ~~———~~2300 – 0700 hours ~~rs:~~ ~~———~~**
   a. **2 PACU RNS (on call)**

~~a. Night Call: Monday through Friday – RN On Call 2300-0700 hours.~~
~~b. Night Backup Call: Monday through Friday – On Call 2330 – 0700 hours.~~

~~3.~~**C. WEEKEND COVERAGE:**

1. **Saturday and Sunday ~~y~~ ~~———~~ 0700 – 1900 hours:**
   a. **1 PACU RN (in-house professional)~~or first call)~~**
   b. **~~———————————————————————~~1 PACU RN (second call) ~~——)~~**
   c. **~~———————————————————————~~11 PACU RN (third call)**
2. **Saturday and Sunday 0900-1800 hours~~———————————————————~~ :**
   a. **1 ACT/Aide (on call)**
3. **Saturday and ~~Sunday~~ Sunday ~~———~~1900 – 0700 hours:**
   a. **1 PACU RN (first call)**
   ~~II)~~
   ~~———————————————————————~~b. 1 PACU RN (second call)

~~D. a. FIRST SHIFT: Saturday and Sunday - One RN scheduled 0700-1730 if 10 hour employee; Same RN on call 1730-1930~~
~~b. FIRST CALL (NIGHTS): Saturday and Sunday - One RN On Call 1900-0730 hours.~~
~~c. SECOND CALL: Saturday and Sunday - One RN On Call 0700-1900 hours.~~
~~d. THIRD CALL:~~
~~i. Saturday - One RN On Call 0700-1900 hours~~
~~ii. Saturday Night - Same RN On Call 1900-0700 hours~~
~~iii. Sunday - One RN On Call 0700-1900 hours~~

~~iv. Sunday Night - Same RN On Call 1900-0700 hours~~

~~4. SPLIT CALL SHIFTS:~~
~~Staff who split a call shift and are called in will cover for a minimum 2 hour period before the next RN is called in and make the on-coming RN aware of the call time adjustment.~~

HOLIDAY COVERAGE:

1. 0700 – 1900 hours
   a. ~~:~~ 1 PACU RN (in-house or first call)
   b. 1 PACU RN (second call)
   c. 1 PACU RN (third call)
   d. 1 ACT/Aide (on call)
2. 1900 – 0700 hours:
   a. 1 PACU RN (first call)
   b. 1 ~~1~~ PACU RN (second call)
   ~~)~~

E. ON CALL REQUIREMENTS:

1. Benefited and non-benefited staff shall take two weekday ~~-~~calls and one weekend call every~~-~~ 4 weeks, depending on staffing levels.
   a. Staff will be in the PACU to accept patients within 30 minutes.
   b. ~~In the~~ On call shift requirements for non-benefited (per diem) staff:
      i. Scheduled shifts do not include call shifts. Call shifts are assigned in addition to scheduled shifts.
   c. In the event that PACU staffing levels decrease, due to open positions, PTO, or staff on leave, the amount of call required may increase from the stated above.

2. Holidays are divided into major and minor holidays.
   a. Major holidays consist of July 4th, Thanksgiving Day, Christmas Day and New Year's Day.
   b. Minor holidays consist of President's Day, Memorial Day and Labor Day (all holidays are three day weekends.)
   c. The weekend professional is responsible for all minor holiday call and is not required to take major holiday call.

F. CALL ASSINGMENT:

~~CALL ASSIGNMENT:~~

1. WEEKDAY CALL (Monday – Friday 2300 – 0700)
   a. A rotation list for the next schedule will be available on the second Friday of the current schedule. The first person on the list will be first to choose their shift; the second person will have second choice, etc. The person at the top of the list will be placed at the bottom of the list on the next schedule. The number of nights each person chooses will vary depending upon the number of staff in the rotation.
2. WEEKEND CALL
   a. A weekend availability list will be posted 2-4 weeks prior to the beginning of the next weekend rotation schedule. The schedule will cover the same number of weekends as the number of staff. Each staff member is required to indicate availability for a minimum number of weekends, currently four (4). ~~The PANS Scheduler~~Management will assign weekends according to the choices indicated on the availability list. Each staff member will be assigned two weekends.
3. HOLIDAY CALL
   a. The holiday drawing will take ~~place~~ place ~~during the~~in October. ~~The PANS Scheduler will~~Management will draw for those who are not present.
   b. Each staff member will pull one holiday shift.

c. **The Department will be divided into equal groups of holiday shifts. If there are more personnel in a group than there are holiday shifts to work, blank slips will be added to the pot. The personnel with a blank slip will move into a shift that has been left uncovered due to changes in staffing. The slips will be numbered consecutively and this is the order in which empty shifts will be filled.**

d. **Major holidays will rotate annually for each employee. For example, if an employee was assigned Thanksgiving the previous year, he/she would rotate to Christmas this year, then New Years the following year.**

i. **When new personnel are added to the call schedule they would be placed in the holiday slot that was vacant and would begin their rotation within that holiday shift based on terms of employment.**

e. **Minor holidays will also rotate annually for each employee. For example, if an employee was assigned President's Day weekend the previous year, he/she would rotate to Memorial Day this year, then July 4th the following year.**

f. **If the holiday falls in the middle of the week, including Thanksgiving Day, the holiday personnel are not required to cover the weekend. If the holiday falls on the weekend they are responsible for the entire weekend.**

g. **Those personnel covering a holiday weekend will count this as a part of their weekend rotation. Those personnel covering a holiday night during the week will count this as a part of their weekday rotation.**

h. **If individuals wish to trade their holidays they must submit the trade in writing to ~~the PANS Scheduler.~~Management**

The PANS holiday call applies to benefited and non-benefited staff, equally.

i. ~~5. **CALLING IN THE "ON CALL" NURSE CRITERIA:**~~

~~a. Rate of pay: All staff On Call will receive On Call pay at the prevailing hospital rate. The On Call rate will not be paid for hours worked. Hours worked when On Call are paid at a premium rate of time and a half, as call back pay.~~

~~b. Availability requirements:~~

~~i. The On Call nurse is called in to assist with the care of special procedures and post-op surgical patients in the PACU based on patient volume and acuity.~~

~~ii. The On Call nurse will be available by beeper or phone. The nurse will respond immediately by phone and will be available to accept patients in the PACU within 45 minutes. Beepers will be issued to individual benefited/non-benefited nurses upon request. The nurse will sign receipt of each beeper and will be responsible for replacement if lost.~~

~~7.~~G. **CALL COVERAGE PROCEDURE:**

1. ~~a.iii.~~ If arrangements have been made with a coworker to cover any part of the call time, it is the responsibility of the primary nurse to communicate this to **Management** ~~the **PANS Scheduler or** Operations Manager/**Director in writing**~~**and submit a change of shift form.** ~~or charge nurse and write these changes into the schedule book.~~ **The call sheet shall be updated by ~~the PANS Scheduler.~~Management.**

2. ~~b .iv.~~ In the event a call position is left unfilled due to illness, the Charge Nurse or ~~Operations Manager/**Director**~~**Management** will attempt to secure coverage of the shift by another nurse. If this cannot be done, the coverage will be as follows:

~~1) **Weekday**First Call Nights 2300 – 0700 **hours** (Mon-Fri):~~

~~a) The night backup will move up to First Call 2300 – 0700 hours~~

~~ab) Attempts will be made to find a **replacement** backup for 2300 – 0700 hours~~

a. ~~2)~~ First Call 0700-1900 hours (Saturday/Sunday):
   i. ~~a)~~ The ~~S~~second call person will move up to ~~F~~first Call
   ii. ~~b)~~ The ~~T~~third call person will move up to ~~S~~second call 0700-1900.

b. ~~3)~~ First **Call** 1900-0700 **hours** (Saturday/Sunday):

~~a) The **second** Third call person will move up to **F**first **C**call.~~

i. ~~b)~~ Attempts will be made to find a backup for 1900-0700.

c. ~~4)~~ If attempts to find a replacement for an uncovered shift are unsuccessful, the ~~Operations Manager or~~ Charge Nurse **or** ~~**Manager/Director**~~**Management** will use a lottery system to assign the call. Staff with approved PTO will not be in the lottery.

~~c.~~**3. ~~It is an expectation that if~~ a staff member cannot fulfill an assigned call ~~shift,~~shift; he/she is expected ~~will attempt~~ to repay the staff member who covered his/her call shift.~~**

~~c. Staff calling in sick for an assigned call shift will be required to make up the shift:~~

~~i. 1st Call or back-up nights will pick up a shift from the person who took their call on the next night call rotation.~~

~~ii. Weekend/holiday shifts will be re-assigned a similar make-up shift the next call rotation. The person who was most impacted by the call off will be assigned one less call shift on the next rotation.~~

~~iii. Staff on TCHD approved medical or family leave will be exempt from this amended standard.~~

~~d. Criteria for calling in backup coverage:~~

~~i. The patient will be admitted to ACCU after being recovered in PACU.~~

~~ii. The patient requires invasive monitoring and/or titration of one or more vasoactive drips.~~

~~iii. A third patient will be admitted to PACU, regardless of the status of the two other patients.~~

~~iv. The patient is a pediatric patient 9 years of age and under.~~

~~v. Any time the On Call nurse is deemed necessary by the charge/resource or staff nurses in order to provide recovery in accordance with the PACU Standards of Nursing Practice and Acuity Guidelines.~~

~~— **PROCEDURE FOR 8.**~~

F. CALLING IN THE "ON CALL" NURSES ~~PROCEDURE~~:

1. **The Operating Room (OR) will call the entire on-call team, including PACU RNs, at the time the case is booked.**
2. **Two PACU RNs will be called in for all cases.**
3. **Both PACU RNs will be present in PACU before the patient's arrival and through discharge/transfer from PACU.**
4. **Additional PACU RNs may be called in to cover departmental needs.**

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 04/94

SUBJECT: Patient Transport in the ~~OR~~perioperative Environment

REVISION DATE(S): 08/97; 04/00; 07/11; 11/12

Surgical Services Department Approval:	**02/20**
Department of Anesthesiology Approval:	**n/a**
Operating Room Committee Approval:	**02/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**03/20**
Administration Approval:	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/13**

A. **PURPOSE:**

1. To outline the process of patient transport ~~to~~**in** the ~~surgical area~~**perioperative environment**.

B. **POLICY:**

1. **Pre-Operative Hold (POH) Registered Nurse (RN), Surgery Supervisor, or other designated RN**~~OR Charge Nurse, Preoperative nurse, or designee~~ will call the nursing unit prior to transfer to receive a hand-off report **from the patient's primary RN/designee** and ensure patient's readiness **for transport to the perioperative area**.
   - **a. For ICU patients and critical/unstable patients, the perioperative nurse assigned to the case is to go to the unit and obtain bedside hand-off report from the primary RN prior to transporting the patient to Surgery. The anesthesiologist, anesthesia tech may assist with transport, as available. Intubated patients must be accompanied by the anesthesiologist during transport.**
   - ~~1.~~**b. Patients on a cardiac monitor must be transported with a transport monitor and RN, unless the physician writes an order for the patient to transport without monitoring.**
2. The following written information will be available to the transporting PeriOperative Aide:
   a. Patient's Name
   b. Room number
   c. Medical Record Number (MRN)
   d. Surgeon's name
   e. Name of patient's nurse on nursing unit
   f. Isolation precautions (yes/no, type if applicable)
   g. Restraints (yes/no, type if applicable)
   h. Falls risk (yes/no)
   i. Monitor/Nurse needed for transport (yes/no)
   j. Oxygen needs
   k. Mode of transport (i.e. bed or gurney)
   l. Location to bring patient (i.e. POH, PACU/Cubicle, X-ray Room #, Endoscopy, etc.)
3. If transporting by gurney, ~~the PeriOp Aide will~~ obtain **a** clean gurney from the Pre-Op Hold area with a sheet, blanket, and pillow.
4. ~~Two transporting personnel shall be used to transport a patient in their bed.~~
4. ~~The following p~~**P**atients will be transport**ed to Surgery in their bed at the discretion of the RN.**
   - ~~5.~~**a. Two transport personnel shall be used to transport a patient in their bed.** ~~a patient in their bed.~~

~~a. All total joints (CPM machine)~~
~~b. Anterior / Posterior Cervical Fusions~~
~~c. Lumbar laminectomies / fusions~~
~~d. Obese patients over 300 lbs. (regardless of procedure)~~
~~e. Tramflap patients~~
~~f. Other patients at the discretion of the nurse~~

~~6. Pediatric patients under 4 years of age will be transported in a crib. If patient's condition permits, the parent may sit in a wheelchair holding the baby during transport.~~

~~7. NICU patients will be transported in incubator in NICU nurse accompanying patient to OR.~~

5. Isolation precautions shall be followed during transport, when applicable.

~~8. Intubated patients from ICU will be accompanied by anesthesiologist, Perioperative nurse, and ICU nurse or anesthesia technician.~~

~~9. High acuity, non-intubated patients will be accompanied by the Perioperative nurse in charge of patients with the anesthesia technician.~~

~~10.~~**6. Upon arrival to the floor,** ~~On the floor the PeriOp Aide will~~ notify **the** patient's nurse, obtain chart and proceed to patient's room. ~~where PeriOp Aide will introduce himself/herself to patient.~~

a. Introduce self to patient.

~~a.~~**b.** ~~Patient identification will be verified by checking~~**Verify two** patient **identifiers by checking patient** ID band with the chart and confirming with patient.

~~b.~~**c.** ~~PeriOp Aide will e~~**E**nsure patient's privacy by drawing curtain and placing blanket over patient before pulling down bed linen.

~~c.~~**d.** Before transferring patient to gurney, ~~PeriOp Aide will~~ ensure ~~that~~ wheels on bed and gurney are locked.

~~d.~~**e.** A floor nurse or the lift team will assist ~~PeriOp Aide~~**with** transferring patient to gurney (if required), making sure IV and drainage bags are carefully moved with the patient and IV bag **is** hung on IV pole on gurney. **Urine drainage bags are to be hung on the bedframe below the level of the patient's bladder, avoiding dependent loops in the urinary drainage tubing.**

~~e.~~**f.** ~~PeriOp Aide will r~~**R**aise and secure side rails and make sure patient's arms and legs are ~~well~~ inside rails.

~~f.~~**g.** ~~PeriOp Aide will~~**Transporter shall** stay at the head of the gurney.

~~g.~~**h. Transport feet first, at an appropriate speed. Enter** ~~E~~elevators ~~will be entered~~ head first.

~~h.~~**i.** Upon arrival to ~~PreOp Hold~~**POH** ~~area~~ or the OR, appropriate personnel will be notified and chart given to **the RN assigned to the patient**~~PreOp Hold nurse responsible~~**. The transporter shall remain with the patient until the RN arrives to assume care of the patient.**

~~i.~~**j.** Upon arrival to ~~PreOp Hold~~**POH**, ~~the OR Aide shall~~**lock the bed/gurney, place it in lowest position and ensure side rails are up.** ~~g~~**G**ive the patient the following items:

i. Warm blanket
ii. ~~Hat~~**Hair cover**
iii. Call bell
~~iv. Bed placed in lowest position~~
~~v.~~**iv.** Pulse oximeter placed on patient's finger
~~vi.~~**v.** Blood pressure cuff placed on bed

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 06/09 **SUBJECT: Perioperative Standards of Practice**

REVISION DATE(S): 11/12;

Surgical Services Department Approval:	**02/20**
Department of Anesthesiology Approval:	**n/a**
Operating Room Committee Approval:	**02/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**03/20**
Administration Approval:	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/13**

A. **PURPOSE:**

1. To describe the responsibilities for which perioperative practitioners are accountable and to define a competent level of nursing practice and professional performance that is designed to achieve desired patient outcomes in the perioperative setting.

B. **POLICY:**

1. Structure standards were developed to guide professionals in administrative roles and to provide direction for evaluating operational systems.
   a. A philosophy, a purpose, and objectives shall be formulated to guide surgical care.
   b. An organizational plan for surgical care shall be developed and communicated.
   c. A registered nurse shall be authorized with administrative accountability and responsibility for surgical care.
   d. A registered nurse administrator shall be accountable and responsible for developing mechanisms that ensure optimal **age-appropriate** patient care.
   e. Surgical Services management team shall develop and manage the budget for surgical care.
   f. Surgical Services shall have written policies and procedures that serve as operational guidelines.
   g. Surgical Services management team shall be responsible for establishing staffing requirements, selecting personnel, and planning for the appropriate utilization of human resources.
   h. Staff development programs shall be provided for surgical care personnel.
   i. A safe surgical ~~suite~~ environment shall be established, controlled, and consistently monitored.
   j. Surgical Services ~~management~~**leadership** team shall promote the discovery and integration of new knowledge by encouraging development and use of nursing research.
   k. Surgical Services staff shall maintain appropriate documentation related to surgical activities.
   l. Surgical Services ~~management~~**leadership** team shall recognize professional responsibility to promote, provide, and participate in a learning environment for students in health care disciplines.
   m. Surgical Service shall establish methods for continuous assessment, measurement, and improvement in the quality of patient care and departmental functions, in conjunction with the organization's Quality Plan.

2. Standards of perioperative clinical practice focus on the process of providing nursing care that is population specific (i.e. culturally and age specific).
   a. The perioperative nurse collects patient health data.
   b. The perioperative nurse analyzes the assessment data in determining diagnosis.
   c. The perioperative nurse identifies expected outcomes unique to the patient.
   d. The perioperative nurse develops a plan of care that prescribes interventions to attain the expected outcomes.
   e. The perioperative nurse implements the interventions identified in the plan of care.
   f. The perioperative nurse evaluates the patient's progress toward attainment of outcomes.
3. Standards of perioperative professional performance focus on the process of performing professional role activities.
   a. The perioperative nurse systematically evaluates the quality and appropriateness of nursing practice.
   b. The perioperative nurse evaluates his or her practice in the context with professional practice standards and relevant statutes and regulations.
   c. The perioperative nurse acquires and maintains current knowledge in nursing practice.
   d. The perioperative nurse contributes to the professional growth of peers, colleagues, and others.
   e. The perioperative nurse's decisions and actions on behalf of the patients' are determined in an ethical manner.
   f. The perioperative nurse collaborates with the patient, significant others, healthcare providers, and others in providing care.
   g. The perioperative nurse uses research findings in practice.
   h. The perioperative nurse considers factors related to safety, effectiveness, efficiency, environmental concerns, and cost in planning and delivering patient care.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 04/94

SUBJECT: **Protective Barriers: Materials for Gowns and Drapes**

REVISION DATE(S): 02/05; 06/09; 11/12

Surgical Services Department Approval:	**02/20**
Department of Anesthesiology Approval:	**n/a**
Operating Room Committee Approval:	**02/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**03/20**
Administration Approval:	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/13**

A. **PURPOSE:**

1. To provide guidelines for the evaluation, selection, and use of protective barrier materials used as surgical gowns and drapes.

B. **POLICY:**

1. Surgical gowns and drapes **shall be disposable and** should be made of materials that minimize the passage of microorganism from non-sterile to sterile areas.
   a. Materials (including seams) shall be resistant to penetration by blood and other liquids
   b. Materials shall be resistant to tears, punctures, strain and abrasion.
   c. Manufacturers shall provide data concerning the ability of each material to prevent bacterial transfer in relation to time, pressure and strike through.

~~2. Reusable fabrics shall maintain a protective barrier through multiple processing.~~
   ~~a. Manufacturer's written guidelines for suggested number of processing shall be followed~~
   ~~b. Heat sealed patches made of the same material shall be used for mending reusable fabrics.~~

~~3.~~**2.** Gowns and drapes shall be safe and comfortable for use in the practice setting.
   a. Materials shall resist ignition and have a low rate of flame spread.
   b. Materials shall be as lint-free as possible.
   c. Materials shall be nonabrasive and free of toxic ingredients.
   d. Materials shall be non-glare and of a color that minimizes distortion from reflected light.
   e. Materials shall maintain integrity over the expected life as claimed by the manufacturer.
   f. Materials shall maintain an environment appropriate to body temperature.
   g. Materials shall allow freedom of movement.

3. Select the surgical gown by task and anticipated degree of exposure to blood, body fluids, or other potentially infectious materials, as determined by the following factors:
   a. Team member's role
   b. Type of procedure (e.g., minimally invasive versus open, superficial incision versus deep body cavity incision)
   c. Procedure duration
   d. Anticipated blood loss
   e. Anticipated volume of irrigation fluid
   f. Possibility of handling hazardous medications
   g. Anticipated patient contact (e.g., splash, soaking, leaning)

4. **Select the surgical gown needed for the procedure according to the barrier performance class as stated on the product label.**
~~g.~~5. **Select and wear surgical gowns that wrap around the body and completely cover the wearer's back. The gown sleeves should conform to the shape of the wearer's arms, be of sufficient length to allow gloves to completely cover the cuffs, and be of sufficient length to prevent the gown cuffs from being exposed when the wearer's arms are extended.**
6. **Scrubbed personnel may wear a surgical helmet system when splashes, spray, splatter, or droplets of blood or other potentially infectious materials may be generated and facial contamination can be reasonably anticipated.**
7. Sterile drapes **shall be used to establish a sterile field. Sterile drapes provide a barrier that minimizes the passage of microorganisms from unsterile to sterile areas.**
~~4.~~8. **Sterile drapes** should be placed on the patient**, furniture, and equipment in the sterile field in a manner that prevents contamination.** ~~according to procedure, and all furniture and/or equipment to be included in the sterile field appropriate to the case.~~
~~5.~~9. **Sterile** ~~D~~**d**rapes should be handled as little as possible
~~6.~~10. In the draping process, the **drape** material should be held above waist level, in a compact position, draping from operative site to periphery. **Sterile drapes should be placed in a manner that does not require scrubbed team members to lean across an unsterile area and that prevents the sterile gowns from contacting an unsterile area.**
~~7.~~11. ~~In placing drapes~~**During draping**, the gloved hands should be ~~protected~~**shielded** by cuffing **the interior portion of the drape** ~~draping~~ material over the ~~hands~~**sterile gloves**.
12. Once placed ~~in position~~, sterile drapes should note be moved or ~~shifter~~**shifted**.
~~8.~~13. **Surgical equipment (e.g., tubing, cables) should be secured to the sterile field with non-perforating devices.**
~~9.~~14. ~~Drapes should not be resting on the floor~~**Consider only the top surface of the sterile drape to be sterile. Consider items that fall below the level of the sterile field to be contaminated.**

C. **REFERENCES:**

1. **AORN, Inc. (2020). *Guidelines for Perioperative Practice*. Denver.**

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 04/94 **SUBJECT: SANITATION: PERIOPERATIVE**

REVISION DATE(S): 02/05; 01/06; 06/09; 11/09; 01/10; 10/12

Department Approval:	**02/20**
Department of Anesthesiology Approval:	**n/a**
Operating Room Committee Approval:	**n/a**
Infection Control Committee Approval:	**03/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To control and reduce the possibility of cross contamination of the surgical patient and personnel in the surgical suite, cleaning will be comprehensive enough to provide a bacteriologically safe environment regardless of the procedure being performed or the condition of the patient.

B. DEFINITIONS:

1. **Clean: The absence of visible dust, soil, debris, or blood.**
2. **Contact time: The specific length of time a disinfectant must remain in contact with a microorganism to achieve disinfection.**
3. **Disinfection: A process that kills pathogenic and other microorganisms by physical or chemical means.**
4. **Scheduled cleaning: Periodic cleaning (i.e., weekly, monthly) of areas and equipment that are not cleaned daily or after every use.**
5. **Terminal cleaning: Thorough environmental cleaning that is performed at the end of each day the room or area is used.**

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

1. **Cleaning chemicals used in Surgical Services must be approved by Infection Prevention.**
2. **Cleaning chemicals are prepared, handled, used, stored, and disposed of according to manufacturer's instructions for use (IFU).**
   a. **If a cleaning chemical is dispensed or removed from the original container, the secondary container must immediately be labeled with the chemical name, concentration, and expiration date.**
3. **Before applying a disinfectant, remove visible soil (e.g., dust, debris) from the surface.**
4. **Spray bottles may not be used to apply disinfectants to environmental surfaces in the perioperative setting. Poured solutions or ready-to-use wipes shall be used.**
5. **Apply disinfectants for the contact time required per manufacturer's IFU. Reapply the disinfectant as needed to ensure the surface remains wet for the duration of the contact time.**
6. **Cleaning materials (i.e., microfiber mop heads, cloths and ready-to-use wipes) shall be disposable and low-linting.**
7. **Brooms with bristles may not be used to sweep the floor in the semi-restricted and restricted areas.**

8. Cleaning materials, tools and equipment (i.e., cleaning carts, floor scrubber) are dedicated for use in specified areas and may not be taken out of dedicated areas or to other areas of the hospital (i.e., OR dedicated equipment, SPD dedicated equipment).
9. Before storage and re-use, cleaning equipment must be disassembled, cleaned, disinfected, and dried, per manufacturer's IFU.
10. High-touch objects and surfaces in the OR must be cleaned and disinfected after each procedure. High-touch areas are, including but not limited to:
    a. OR table: controller, side rails, mattress, base
    b. Light switch and surgical light switches
    c. Front door handles and side door push-plates
    d. Anesthesia machine and Pyxis
    e. IV poles
    f. Prep stands
    g. Handles on warmers
    h. Surgical lights
    i. Phones
    j. Trash hamper lids
    k. Neptune
    l. Bovie
11. Clean in a methodical pattern to limit the transmission of microorganisms.
    a. Use a new ready-to-use wipe to clean each area/equipment.
    b. When cleaning with the same cleaning material (i.e., mop head), progress from clean to dirty areas.
    c. Clean from top to bottom.
12. Do not return used cleaning materials (i.e., mop heads) to the cleaning solution container.
13. Discard disposable cleaning materials after each use, according to manufacturer's IFU.
14. Consider the floors in the perioperative practice setting to be contaminated.
    a. Consider items that contact the floor for any amount of time to be contaminated.
    b. Clean and disinfect noncritical items (i.e., positioning devices) per the manufacturer's IFU after the items contact the floor.
15. Mop floors with damp or wet mops. Do not dry mop in semi-restricted or restricted areas.
16. After each patient use, clean and disinfect reusable noncritical, nonporous surfaces (e.g., mattress covers, positioning devices) and equipment per manufacturer's IFU.
    a. Before cleaning, inspect mattresses and padded positioning devices (e.g., OR beds, arm boards, gurneys) for any moisture, stains, or damage.
    b. Remove and replace damaged or worn mattress coverings according to manufacturer's IFU.
17. Discard single-use items after each patient use.
18. Clean and disinfect equipment that is stored outside the surgical suite before bringing it into the semi-restricted area.
19. Standard precautions must be followed when cleaning to prevent contact with blood, body fluids, or other potentially infectious materials.
    a. Personal protective equipment (PPE) must be worn during handling of contaminated items or cleaning of contaminated surfaces, to reduce the risk of exposure to blood, body fluids, and other potentially infectious materials.
    b. Gloves must be worn when it is reasonably anticipated that there may be contact with blood, body fluids, or other potentially infectious materials during handling or touching of contaminated items or surfaces.
    c. Masks, eye protection, and face shields must be worn whenever contact with splashes, spray, splatter, or droplets or blood, body fluids, or other potentially infectious materials is anticipated.
    d. Wear respiratory protection (i.e., N95 or powered air-purifying respirator [PAPR]) if cleaning procedures are expected to generate infectious aerosols.
    e. Perform hand hygiene after PPE is removed and as soon as possible after hands are soiled.

20. When visible soiling by blood, body fluids, or other potentially infectious materials appears on surfaces or equipment, the area must be cleaned and disinfected immediately or as soon as feasible.
21. Clean spills of blood or body fluids in the following manner, to minimize risk to personnel during cleanup:
    a. Apply an EPA-registered disinfectant that is effective against bloodborne pathogens to the spill.
    b. Soak up the spill with an absorbent material and discard.
    c. Clean and disinfect the surface.
22. Items that are saturated with blood, body fluids, or other potentially infectious materials (i.e., would release the fluids in a liquid or semi-liquid state if compressed), and items caked with dried blood, body fluids, or other potentially infectious materials must be placed in a red bag labeled biohazardous waste.
23. Contaminated liquid waste may be suctioned into Neptune or solidified in a canister using solidifying powder.
24. Immediately or as soon as possible after use, contaminated sharps (e.g., needles, blades) must be discarded in a puncture-resistant red sharps container.
    a. Contaminated single-use instruments must be discarded in the puncture-resistant recycle collection bins.
    b. Bins must not be overfilled.
25. Laundry contaminated with blood, body fluids, or other potentially infectious materials must be handled as little as possible. Contaminated laundry is placed in blue bags.

D. <u>OR AND PROCEDURE ROOM CLEANING</u>:
1. All horizontal surfaces (e.g., furniture, surgical lights, booms, equipment) must be damp dusted before the first scheduled surgical or other invasive procedure of the day.
    a. Damp dusting is performed before case carts, supplies, and equipment are brought into the room.
    b. A clean, low-linting cloth moistened with disinfectant (i.e., Sanicloth AF3 ready-to-use wipes) is used to damp dust.
2. Operating and procedure rooms must be cleaned and disinfected after each patient procedure.
    a. Do not begin environmental cleaning, including trash and contaminated laundry removal, until the patient has left the OR or procedure room.
    b. Remove trash and used linen from the room.
    c. Clean and disinfect all high touch areas and items used during patient care according to manufacturer's IFU, including, but not limited to:
        i. Anesthesia carts, including the top and drawer handles
        ii. Anesthesia equipment (e.g., IV poles, IV pumps)
        iii. Anesthesia machines, including dials, knobs, and valves
        iv. Patient monitors, including cables
        v. OR beds and attachments (e.g., arm boards, stirrups, head rests)
        vi. Reusable table straps
        vii. Positioning devices (e.g., chest rolls, axillary rolls, bed clamps)
        viii. Patient transfer devices (e.g., roller board)
        ix. Overhead procedure lights
        x. Tables and Mayo stands
        xi. Mobile and fixed equipment (e.g., sitting stools, standing stools, tourniquets, bovie, microscope, robot)
        xii. Light switches
        xiii. Door handles and push plates
        xiv. Telephones
        xv. Computer accessories (i.e., keyboard, mouse)
        xvi. Chairs, stools, and step stools
        xvii. Trash and linen receptacle lids

d. The OR bed/lights is considered the dirtiest part of the OR after the procedure and should either be cleaned last, or be cleaned as a separate area (i.e., remove gloves and perform hand hygiene after cleaning this area; don clean gloves before proceeding with cleaning the rest of the OR).
e. Clean and disinfect the floor with a mop after each surgical or invasive procedure when visibly soiled or potentially soiled by blood or body fluids (i.e., splash, splatter, dropped item).
f. Spot clean and disinfect the walls and ceiling after each surgical or invasive procedure when visibly soiled.

3. Terminally clean operating and procedure rooms each day the rooms are used.
   a. Clean and disinfect the exposed surfaces, including wheels and casters, of all items, including:
      i. Anesthesia carts, including the top and drawer handles
      ii. Anesthesia equipment (e.g., IV poles, IV pumps)
      iii. Anesthesia machines, including dials, knobs and valves
      iv. Patient monitors, including cables
      v. OR beds and attachments (e.g., arm boards, stirrups, head rests)
      vi. Reusable table straps
      vii. Positioning devices (e.g., chest rolls, axillary rolls, bed clamps)
      viii. Patient transfer devices (e.g., roller board)
      ix. Overhead procedure lights
      x. Tables and Mayo stands
      xi. Mobile and fixed equipment (e.g., sitting stools, standing stools, tourniquets, bovie, microscope, robot)
      xii. Storage cabinets, supply carts, and furniture
      xiii. Light switches
      xiv. Door handles and push plates
      xv. Telephones
      xvi. Computer accessories (i.e., keyboard, mouse)
      xvii. Chairs, stools, and step stools
      xviii. Trash and linen receptacles
   b. Clean and disinfect the entire floor, including areas under the bed and mobile equipment.
   c. Spot clean and disinfect the walls and ceilings.
4. Terminally clean unused rooms weekly.
~~Clean walls and ceilings in each OR monthly.~~
5. Terminally clean the Endoscope Storage Room and Endoscope Processing Room daily.

E. PRE-OPERATIVE HOLD (POH), ~~AND~~ POST ANESTHESIA CARE UNIT (PACU), AND PHASE II:
1. Preoperative and postoperative patient care areas must be cleaned after each patient has left the area.
   a. Clean and disinfect equipment that is used during patient care according to manufacturer's IFU, including, but not limited to:
      i. Patient monitors, including cables
      ii. IV pumps and IV poles
      iii. Patients beds/gurneys
      iv. Over-bed tables
      v. Bedside tables and drawer handles
      vi. Call lights
      vii. Suction regulators
      viii. Medical gas regulators
      ix. Warming equipment
   b. Clean and disinfect the floor with a mop when visibly soiled or potentially soiled by blood or body fluids (e.g., splash, splatter, dropped item).
   c. Spot clean and disinfect the walls when visibly soiled.

2. Terminally clean the preoperative and postoperative patient care areas each day the areas are used.
   a. Clean and disinfect the exposed surfaces, including wheel and casters, of all items in the area, including:
      i. Patient monitors
      ii. Patients beds/gurneys
      iii. Over-bed tables
      iv. Call lights
      v. Mobile and fixed equipment (e.g., suction regulators, medical gas regulators, warming equipment)
      vi. Storage cabinets, supply carts and furniture
      vii. Light switches
      viii. Door handles and push plates
      ix. Telephones
      x. Computer accessories (e.g., keyboard, mouse)
      xi. Chairs, stools and step stools
      xii. Trash and linen receptacles
   b. Clean and disinfect the entire floor, including areas under mobile equipment, using a mop.

F. STERILE PROCESSING DEPARTMENT (SPD):
1. Damp dust all horizontal surfaces in the sterilization packaging area (e.g., countertops, workstation) at least daily. Use a clean, low-linting cloth moistened with disinfectant, or ready-to-use disinfectant wipe, to damp dust.
2. Terminally clean sterile processing areas each day the areas are used.
   a. Receiving Room
   b. Equipment Room
   c. GUS Room
   d. Sterrad/V-Pro Room
   e. Sterilizing Room
   f. Prep and Pack
   g. Sterile Instrument Storage
   h. Bundle Room
   i. Dirty Utility
   j. Decontamination Room
   ~~a.~~k. Clean Storage near Decontamination Room
3. Clean and disinfect the clean work areas, such as the packaging area and sterile storage area, before the dirty work areas, such as the decontamination area, to reduce the possibility of contaminating the clean areas.
4. When feasible, avoid terminal cleaning when personnel are actively decontaminating instruments.
5. Clean and disinfect all work surfaces and high touch objects in the clean work areas and decontamination areas using a clean, low-linting cloth or ready-to-use disinfectant wipe.
6. Remove trash from receptacles in sterile processing areas at least daily and when they are full.
~~2.~~7. Clean and disinfect all floors in sterile processing areas each day the areas are used.

G. SCHEDULED CLEANING:
1. Cleaning schedule for areas of Surgical Services that are not terminally cleaned:
   a. The following areas shall be cleaned daily:
      i. OR hallways
      ii. All substeriles
      iii. Clean Core
      iv. Specimen Room
      v. Elevators

vi. OR Dirty Utility Room
vii. POH waiting room
viii. Patient restroom in PACU
ix. Patient restroom in ~~PCU POH~~Phase II
x. Patient restroom in POH
xi. Anesthesia lounge/sleeprooms/restroom
xii. Physician lounge
xiii. Staff lounges
xiv. Female staff restrooms
xv. Male staff restrooms
xvi. Male physician restroom

b. The following areas shall be cleaned weekly:
~~1)~~i. ~~Vents in all OR's~~OR Vents, Walls and Ceilings
ii. Anesthesia Workroom
iii. Pump Room
~~ii.~~iv. ~~Dirty utility room~~EVS Closets in Surgery, PACU, and SPD
v. Specimen room
vi. Women's locker room
vii. Male staff locker room
viii. Male physician locker room

c. The following areas shall be cleaned monthly:
~~OR walls and ceilings~~
i. Storage rooms, including Equipment Room, Storage Room 1, Storage Room 2, and ~~and~~ Storage Room Between OR's 3 and ~~4the Central Core~~
ii. Stairs and stairwells
~~EVS closets in Surgery, PACU, and SPD~~
~~1)~~iii. Shelving, drawers, and storage bins in OR's and storage areas shall be cleaned in conjunction with monthly outdates.

H. SPECIAL CONSIDERATIONS:
~~3.~~1. Following the care of a patient diagnosed with or suspected of infection with C. Difficile, use a bleach-based disinfectant product (i.e., Dispatch) to clean.
~~4.~~2. Cleaning and disinfection procedures shall be implemented after construction, renovation, repair, demolition, and disaster remediation.
~~5.~~3. Preventative measures shall be taken to prevent pest infestation in the perioperative environment, including removing food, containing biological waste, and keeping windows and doors closed.
a. If preventative measures fail to eliminate the cause of a pest infestation, a pest control specialist shall be consulted.
b. Terminally clean affected areas after the pest infestation is resolved.

I. EDUCATION AND TRAINING:
1. Personnel responsible for perioperative sanitation shall be provided education upon hire and annually. Perioperative sanitation competency shall be verified upon hire and annually.

J. QUALITY ASSURANCE:
1. Cleaning practices shall be monitored through audits using fluorescent marking.

K. DOCUMENTATION:
~~6.~~1. Terminal and scheduled cleaning shall be documented in appropriate logs.
~~7. PERIOPERATIVE SANITATION:~~
~~a. Perioperative aides will receive training on the proper cleaning of the surgical suite and a copy of the policy before they are assigned to the operating room (OR).~~

b. All horizontal surfaces within the OR (furniture, surgical lights, equipment) should be damp dusted before the first scheduled procedure of the day with a clean, lint free cloth moistened with hospital-approved agent.
c. Rooms will be cleaned between each surgical procedure.
d. All surgical procedures will be considered contaminated and will follow the same cleaning procedure.
e. Clean mop heads will be used in the restricted and semi-restricted areas. Brooms will NOT be allowed in the surgical suite.
f. OR nursing personnel will be responsible for confining and disposing of all disposable drapes, instruments and sharps.

8. OR SUITE CLEANING PROCEDURE:
   a. Prepare all equipment necessary for between case cleaning:
      i. Mop bucket with clean water and proper amount of hospital approved cleaning agent, prepared for each shift.
      ii. Clean mop head mounted on mop handles (always have two prepared)
      iii. Wet mop heads in disinfecting solution and placed in clean, small plastic bags to bring to area to be cleaned
      iv. Clean cloths for damp dusting
      v. Pour bottle of hospital approved disinfectant
      vi. Gloves
      vii. Plastic blue linen bags and red and clear trash bags
   b. Don a clean pair of gloves.
   c. Carry trash and linen bags, touching outside of bags, to entrance of the OR room, leaving tops of bags open.
   d. Pick up any trash, linen or other debris off of floor and place in appropriate bag
   e. Remove disposable safety strap from OR table and discard in trash bag.
      i. Disposable safety straps are one time use only
   f. Moisten a clean, lint-free cleaning cloth with hospital approved disinfecting agent.
      i. Do not spray surfaces directly.
   g. Damp dust both surfaces of the surgical lights with disinfectant solution. Wipe the OR table, back table (top and second shelf), mayo stands, ring stands, anesthesia machine, and any other flat surfaces that come in direct contact with the patient.
      i. Equipment such as monitors, cautery machines, blood warmer, and all cords and non-disposable tubing must be wiped.
      ii. After wiping, place dirty cloths in appropriate plastic bag.
      iii. Clean all high-touch areas after each case, including, but not limited to:
         1) OR table: controller, side rails, mattress, base
         2) Light switch and surgical light switches
         3) Front door handles and side door push-plates
         4) Anesthesia machine and pyxis
         5) IV poles
         6) Prep stands
         7) Handles on warmers
         8) Surgical lights
         9) Phones
         10) Trash hamper lids
         11) Neptune
         12) Bovie
   h. Mop the floor of the OR suite.
      i. Mop one side of the floor next to the bed.
      ii. Unlock bed and move to clean area.
      iii. Continue to mop the rest of the floor around the surgical field and any other area that has been contaminated by blood or body fluids.
      iv. Return bed to center of room under lights and lock the bed.

v. If the room is especially soiled, a second mopping may be necessary and a second clean mop head must be used.
vi. Never place a soiled mop head back in the mop water bucket.
i. Remove mop head and place it in a plastic trash bag.
j. Remove gloves and place in a plastic trash bag after all cleaning procedures are completed.
k. Perform hand hygiene
l. Return all furniture to its proper place in the OR room
m. Place clean sheets and safety strap on OR table
n. Place clean plastic bags on trash and linen receptacles
o. Stock warmers with fluids and/or linen when the room is clean.
p. Close OR door and take bags to proper receptacles

9. CLEANING SCHEDULE
a. Daily Cleaning (i.e. End of Day Cleaning)
i. OR rooms are cleaned every 24 hours after the last case of the day.
ii. Mechanical friction and an approved detergent/disinfectant are used to clean equipment and areas including, but not limited to:
1) Surgical lights (including sides and arms)
2) Orbiters
3) Equipment (anesthesia machine, cautery machine, etc.)
4) Tables, ring stand, mayo stands, IV poles, computer stands
5) Suction canister stands
6) Tubing of all kinds, cords, (suction tubing) compression sleeve tubing, gas lines, electrical cords
7) All equipment wheels
8) All flat surfaces
9) Damp dust OR table removing all pads and table pieces
10) Position OR table in highest height position and clean table column
11) Push plates and handles of doors/cabinets
12) Computer keyboards (with Sanicloth)
13) Scrub rooms and substerile rooms
a) Remove all items from horizontal surfaces (i.e. shelves and counter tops)
b) Wipe all horizontal surfaces with disinfectant solution
c) Re-stock supplies
14) Wet Vac is used to clean floor in the OR; mops are used to clean floors in substeriles
iii. Other Daily Cleaning (including floors and horizontal surfaces)
1) Anesthesia workrooms
2) Sleep Rooms
3) Lounges
4) Locker Rooms
5) Desk
6) Hallways
7) Other Flooring and support areas, including Sterile Processing Department and the elevators between SPD and OR
8) Pre-Op
9) PACU
10) Cath Lab
11) Pain Clinic
12) Bronch Room
13) Specimen Room
b. WEEKLY CLEANING (i.e. Weekly Terminal Cleaning)
i. All daily cleaning duties with the addition of :
1) Walls and ceilings

2) Face plates/grills on ventilation ducts
3) Floor Mats
   a) Substeriles
   b) "Zone of Silence" mats in front of medication Pyxis and in Case Cart Room

ii. Areas to be terminally cleaned weekly include:
1) OR Rooms 1-12
2) All substerile rooms
3) Cath Labs 1-3
4) Utility rooms
   a) Clean and dirty utility rooms
   b) EVS closet
   c) Specimen room
5) Locker rooms
   a) Doctor's locker room
   b) Female staff locker room
   c) Male staff locker room
6) Lounges
   a) Anesthesia lounge
   b) Doctor's lounge
   c) Staff lounge
7) Other areas
   a) PreOp Hold
   b) OR Hallways
   c) Pain Management
   d) Bronch Room

iii. Sterilizers are to be cleaned weekly by night staff on duty

c. MONTHLY CLEANING (i.e. Monthly Terminal Cleaning)
i. Monthly cleaning includes all daily and weekly cleaning duties with the addition of cleaning inside storage bins, cabinets and shelves
ii. Areas to be terminally cleaned monthly include:
1) Storage rooms
   a) Storage Room 1
   b) Storage Room 2
   c) Case Cart Room
   d) Ortho Storage Room (between OR 3&4)
   e) Clean Central Care
2) Work Rooms
   a) Anesthesia Workroom
   b) Forms Room
   c) X-Ray Room
3) Offices
   a) Director's Office
   b) OR Manager's Office
   c) PACU Manager's Office
   d) Educator/Shift Supervisors' Office
   e) Coordinators' Office
   f) Department Secretary's Office
4) Storage bins/shelves/inside/cabinets
   a) In OR 1-12

d. Air filter changes are the responsibility of Facilities Engineering Department. Proper documentation will be kept by Facilities Engineering Department.

C.L. **REFERENCE(S):**

1. ~~AORN Perioperative Standards and Recommended Practices, 2011 edition.~~**AORN, Inc. (2020). *Guidelines for Perioperative Practice*. Denver.**

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 04/94

SUBJECT: ~~STAFFING~~STAFF SCHEDULE AND ASSIGNMENT PRACTICES IN SURGERY

REVISION DATE(S): 02/05; 06/09; 10/12

Department Approval:	02/20
Department of Anesthesiology Approval:	n/a
Operating Room Committee Approval:	
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	04/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. Scheduling policies are written to ensure quality patient care, continuity, optimal utilization of resources, and fairness and consistency throughout the organization in a cost-effective and accountable manner.

B. **POLICY:**

1. General Staffing Guidelines:
   a. Manager/Supervisor/designee schedules nursing personnel according to Collective Bargaining Agreements (CBA), personnel policies and established standards of staffing patterns for surgery. Flexible staffing patterns may be utilized as a method to meet patient care needs.
      i. Using approved staffing requirements for surgery and in accordance with state regulation and Tri-City Medical Center Collective Bargaining Agreement and Tri-City Surgery Department practices.
2. The Surgery Department is staffed with direct and non-direct care providers in sufficient numbers to provide quality care.
3. Each position has a job description which identifies essential job duties, minimum job requirements/competencies, organizational expectations, necessary skills and licensure requirements (when applicable).
4. A minimum of two direct care providers are assigned to each surgical procedure/patient:
   a. The role of circulator is always assigned to a Registered Nurse (RN).
   b. The role of the scrub may be assigned to a Surgical Technologist/Endoscopy Technologist (as applicable) or an RN.
5. Staff work schedules are for a four (4) week period and are posted in accordance with CBA prior to the beginning of the defined period.
6. Schedule is developed and approved by the Manager/Supervisor/designee.
7. Schedule is expected to provide uniform coverage throughout the scheduled period.
8. The schedule is developed with consideration to:
   a. Contractual agreements
   b. Approved PTO requests
   c. Staff requests

d. Established staffing levels
e. Staff skill mix
f. Number of planned operating rooms as determined by the OR Committee.

9. Staff are required to fulfill benefited status and shift scheduling requirements.
10. Staff must fulfill weekend and holiday call requirements.
11. It is the responsibility of the individual employee to check their schedule at the time it is posted and forward any concerns immediately to the Manager/Supervisor/designee.
12. Changes to the posted staff schedule will be recorded on the schedule (i.e., cancellations, absent/ill, PTO, trades).
13. Completed staff schedules are maintained in the department for a minimum of six (6) months, with remaining stored in an approved off-site storage facility for six (6) years.
14. Students in the OR are not to be considered staff and are not to be left alone to perform tasks or provide patient care.
    a. TCMC employee must remain scrubbed with a scrub student (Surgical Technician student or RN student) during the entire surgical procedure.
    b. RN Externs may perform activities for which they have demonstrated competency, under the supervision of their RN preceptor.
    c. RN students are observers only.
    d. Paramedic students may observe and perform intubations as permitted by the anesthesiologist.

C. <u>TIME OFF REQUESTS</u>:
1. Requests for time off prior to the schedule being posted:
    a. Staff special requests and/or PTO requests are to be submitted no later than two (2) weeks prior to the posting of the schedule.
    b. While every effort is made to accommodate requested days off, no "set" schedules are guaranteed.
    c. Requested time off is considered when minimum staffing requirements are met.
    d. If several requests are submitted for the same dates, skill set, unit needs, and date of submission will be considered.
    e. Final approval of all schedules rests with the Manager/Supervisor/designee.
2. Requests for time off/schedule changes after the schedule is posted:
    a. Written notification is required to change the schedule after it is posted.
        i. Staff shall submit a schedule change form.
    b. All involved parties must sign the schedule change request form.
    c. Schedule changes should not reduce staffing coverage.
    d. Schedule changes should be between like job codes, skill mix, and shift hours (i.e., 8, 10, or 12 hour shifts).
    e. Schedule changes/trades cannot place an employee into overtime hours.
    f. All schedule changes must be approved by the Manager/Supervisor/designee prior to the change.
    g. Once the schedule change has been approved, the shift becomes the responsibility of the staff member who has agreed to work.

D. <u>ASSIGNMENT OF STAFF</u>:
1. Staffing review is completed prior to the start of the shift by the Manager/Supervisor/designee.
    a. Staff assignments are made with the following considerations:
        i. RN is assigned as the circulating role
        ii. Surgical Technologist or RN is assigned as the scrub
        iii. Documented specialty education/training
        iv. Need for specialty education/training

v. Availability of resources/including technical assistance
vi. Experience with special procedure/equipment/patient population
vii. Request of staff/surgeon/patient

b. Additional personnel may be assigned as indicated by procedure or patient needs, for example:
i. Complexity of surgical procedure
ii. Complexity of patient care
iii. Surgeon or staff request

c. Additional staffing may be decreased as:
i. Patient condition stabilizes
ii. Procedure is in progress with all equipment/instruments/supplies in place
iii. Primary staff no longer need assistance

2. Staffing is planned to allow for breaks and meals, without disruption of surgical procedures.

3. Staffing Reductions (flexing)
a. Staff reductions (flexing) may be made dependent upon case volume and skill mix.
~~1.~~b. Follow TCMC policies and CBA agreements.

~~C. FORM(S):~~
~~1.~~

~~D. RELATED DOCUMENT(S):~~
~~1.~~

~~E. EXTERNAL LINK(S):~~
~~1.~~

~~F. REFERENCES:~~
~~1.~~

~~A. PURPOSE:~~
~~To facilitate the availability of necessary qualified and competent staff to provide quality care.~~

~~B. POLICY:~~
~~1. Surgical Services is staffed with direct and non-direct care providers in sufficient numbers to provide quality care.~~
~~2. Staffing is a mixture of fixed staffing and volume/acuity staffing.~~
~~3. The following categories of staff are assigned to Surgical Services:~~
~~a. Senior Director of Nursing~~
~~b. Managers (OR, PreOperative Education; PACU, SPRA, PreOperative Hold; SPD)~~
~~c. Assistant Nurse Managers (ANM in OR, PACU)~~
~~d. Supervisor (SPD)~~
~~e. Registered Nurses (RN)~~
~~f. Surgical Technologists (ST)~~
~~g. Endoscopy Technicians~~
~~h. Anesthesia Technicians~~
~~i. Perioperative Aides~~

j. Sterile Processing Technicians
k. Surgery Schedulers
l. Surgery Support Clerks (Billing, Scheduling, Desk)
m. Clinical Nurse Educator
n. Informatics Coordinator (Surgery IT System)
o. Administrative Assistants

4. Each position has a job description, which identifies essential job duties, minimum job requirements/competencies, organizational expectations, necessary skills and licensure requirements (when applicable).
5. A minimum of two direct care providers are assigned to each Surgical Suite in which cases are scheduled:
   a. The role of circulator is always assigned to a registered nurse.
   b. The role of the scrub may be assigned to a Surgical Technologist or a Registered Nurse.
6. One Registered nurse is assigned as Charge nurse, to coordinate delivery of care in the department. This person may be the manager, supervisor or designated staff nurse.
7. Surgical Support Clerks or others may assist with answering phones, taking message, preparing charts, communicating information, entering orders into the computer system or other activities to assure the smooth flow of patient care.
8. Staff members are assigned to cases with the following considerations:
   a. Documented specialty education/training
   b. Need for specialty education/training
   c. Availability of resources/including technical assistance
   d. Experience with special procedures/patient population
   e. At the request of staff/surgeon/patient
9. In addition to in house staff, employees are also assigned on call, to allow for staffing an increased number of rooms as needed.
10. Staffing is planned to allow for breaks and meals without disruption of cases.
11. Additional personnel, above routine staffing, are assigned as indicated by procedural or patient needs.
12. Procedural indicators for increased staffing are:
   a. Large amounts of equipment
   b. New procedures
   c. Use of lasers where the control is not immediately accessible to the surgeon
   d. Surgeon request
   e. Extended procedures with separate sterile fields, position, equipment or procedural changes
13. Patient indicators for increased staffing include: hemodynamic instability, emotional instability, local anesthesia procedures requiring intense physiological monitoring, extreme positioning considerations, of threatening condition, rapid change of condition, or as identified by the perioperative RN.
14. Sources of additional staff are immediate (Director, Manager, ANM, Supervisor, Educator, Charge nurse, float nurse(s), and unassigned staff on duty) or planned (registry, and routine staffing adjusted to meet planned needs, decrease in the number of surgical suites with scheduled cases).
15. Additional staffing may be decreased if the patient condition stabilizes, if the procedure is in progress with all equipment/instruments/supplies in place, if the

primary staff no longer needs assistance, or if scheduled surgical procedures are cancelled.

16. The routine staff schedule is developed by the Manager or designee. Staff schedules are posted every month per hospital policy, two weeks prior to the beginning of the schedule, and are developed with consideration to:
    a. Contractual agreements
    b. Established staffing levels
    c. Requests from staff
    d. Staffing mix
    e. Planned number of operating rooms
17. Changes in the posted staff schedule will be recorded on the schedule (i.e., cancellations, absent/ill, PTO, trades). Completed staff schedules are maintained in the department for a minimum of six months, with remaining stored in an approved off-site storage facility.
18. The call schedule is developed by a designated separate staff nurse, assigned to this responsibility.
19. Routine staffing is planned to provide patient care consistent with established block times and the agreed upon availability of surgical suites. Routine staffing levels are as follows:
    a. Monday through Friday
        7am to 3pm = 8 rooms
        3pm to 7pm = 6 rooms
        7pm to 11pm = 2 rooms
        11pm to 7am = 1 room
    b. Saturday
        7am to 3pm = 2 rooms
        3pm to 11pm = 1 room
        11pm to 7am = 1 room
    c. Sunday/Holidays
        7am to 7am = 1 room
20. Sufficient Staffing
    a. Staffing will be sufficient at all times in terms of numbers, skill mix, and competency to meet the needs of patients in the OR.
    b. Staffing patterns will also be designed to allow staff to participate in Nursing Services and Operating Room staff meetings, performance improvement/standards development activities, and continuing education events.

C. STAFFING PRACTICES:
1. UNIT STAFFING PATTERNS
    a. Determining staffing patterns
        i. Volume as a basis for staffing
            The numbers/ratios used in staffing are as follows:
            1) Two people per room minimum:
                a) At least one person shall be an RN to circulate
                b) One RN/OR Technician shall scrub
            2) OR Aides (dependant upon case volumes):
                a) Day Shift, Monday Friday (4)
                b) Evening Shift, Monday Friday (3)

~~c) Night Shift (3)~~
~~d) Weekends/Days (2)~~
~~e) Weekends/Evenings (1) on call~~
~~3) Two secretaries for OR:~~
~~a) One shall start at 6:30am~~
~~b) The second person shall start mid-shift at 12:30pm to 9:00pm, Monday through Friday~~
~~4) The number of Float RN's shall be determined on a daily basis after assignments are made on the day shift. He/she shall help in the rooms, turn rooms over, relieve for breaks and lunches, pull cases, and check supplies and equipment.~~
~~5) Anesthesia Technicians:~~
~~a) Monday through Friday, 2 technicians work a split shift. The first technician arrives at 5:00am. The second routinely comes in at 9:00am unless the schedule requires a second technician for first cases (i.e., a heart plus a AAA). The shifts are 10 hours with call.~~
~~b) Holidays and weekends have one technician on duty.~~
~~6) Perfusionists: two full-time perfusionists are available. They are on call if no heart cases are scheduled. After 5:00pm and on weekends, one is on call.~~
~~7) Surgical Instrument Coordinator: one available Monday through Friday, to assist in OR rapid turnaround and delicate instrumentation.~~
~~ii. Acuity as a basis for staffing~~
~~1) A Patient Classification System is not used in the Operating Room. Patient acuity is assessed by the severity of the procedure, the anticipated blood loss, and the amount and type of equipment required. When staffing permits, three personnel are assigned to abdominal aortic aneurysms, total joint cases, large spine cases, robotic cases and craniotomies.~~
~~2) The Manager/ANM or designee completes the staffing pattern based on the numbers of rooms that will be opened. This is done on a master schedule two weeks in advance of the beginning of the four-week schedule.~~
~~3) Per Diem staff are scheduled to fill gaps for vacations, etc. Traveling nurses may be employed to cover staffing needs not able to be filled by regular staff.~~
~~b. Responsibilities~~
~~i. Unit staffing patterns are the ultimate responsibility of the Chief Nurse Executive and are the product of the Nursing Services master staffing plan.~~
~~ii. The unit staffing pattern is operationalized on a daily basis by the Manager/designee.~~
~~c. Purpose~~
~~i. The unit staffing patterns define what constitutes staffing in the OR and identify the current fiscal variables on which the current patterns are based.~~
~~2. UNIT SCHEDULING PRACTICES~~

a. Definition

Unit scheduling practices are based on the unique needs of the OR. Content is in concert with Human Resources Department requirements related to use of call time, attendance, use of scheduled/unscheduled time off, use of time cards, employee status change, and use of compensation time.

b. Purpose

Unit scheduling practices exist to define the precise mechanisms used by the Director to build time schedules (automated or manual) which provide appropriate OR coverage and facilitate fairness and consistency in scheduling staff.

3. STAFFING ADJUSTMENTS

a. Staffing adjustments will be made by the Manager or designee during off-shifts and weekends.

b. Generally short term adjustments on a shift-to-shift basis are made in situations of changing patient acuity and/or additional cases when existing staffing is either inadequate or in excess of what is required. On call personnel will be called in for these changes if necessary.

c. Staffing inadequate to meet required needs:

i. If the staffing is inadequate to meet the required needs for the next day, the schedule is:

1) Per Diem nurses are brought in
2) Manager works in a room
3) Rearrange schedule (six rooms become five, etc.)
4) The time is shifted

ii. If staffing needs are inadequate at the last minute (i.e., sick calls, emergency):

1) Attempt to call Per Diem or scheduled off personnel
2) Manager works in room
3) Attempts are made to rearrange, but this sometimes impossible due to physician's already planned day

d. Staffing in excess to meet required needs:

For excess staff a rotation flex list is initiated after staff has been informed that schedule is light. Frequently someone wants the day off; this is accomplished on a first-come volunteer basis.

D. STAFFING LEVELS:

1. REGULAR STAFF

a. Definition

As defined in the Nursing Services Generic Structure Standards, Element VIII, Staffing, regular staff is the designation given to nursing personnel who are hired as part/full time or per diem and permanently assigned to a unit.

b. Personnel

The regular staff who work in the Operating Room are as follows:

i. OR Aide
ii. Anesthesia Technician
iii. OR Technician
iv. Instrument Aide
v. Perioperative Clinical Educator
vi. Perfusionist
vii. RN's

viii. Secretaries
ix. Schedulers
x. Surgical Instrument Coordinator

2. NON-REGULAR STAFF
   a. Definition
      Non-regular staff is the designation given to nursing personnel who are hired as part/full time or "as needed" basis and are not permanently assigned to the Operating Room.
   b. Personnel
      Non-regular staff are not used in the OR, but may be used in the Pre-Op Hold area.
3. STUDENTS IN THE OR
   a. To provide nursing students an opportunity to observe and gain an understanding of the intraoperative experience, students will be permitted access to the Surgical/Endoscopic Services suites. The student will not assist with patient care and must meet guidelines set out in Addendum P – "Visitor to OR".
   b. OR tech students will be used in the OR. They will be second scrubbed with a hospital employee until deemed competent by staff and instructor to scrub alone.

E. MANAGING THE OR BOARD:
1. The operating room schedule board is used by the Day and Evening shifts Monday through Friday, to assist with the flow of the OR schedule.
2. The schedule board is written the night before by the secretary or designee, following the printed schedule.
3. Written in dry-erase marker for each scheduled procedure are the following:
   a. Operating Room number
   b. Scheduled surgery start time
   c. Patient's initials and age
   d. Type of admission, (i.e., Same Day Surgery, AM Admit), or in-patient room number
   e. Surgeon and assistant
   f. Length of operation (in minutes)
   g. Procedure scheduled
   h. Assigned anesthesiologist
4. The OR staff is assigned to the rooms, and their names are written in dry-erase marker.
5. Cases scheduled after the final schedule is printed are added to the "Add-on board" in Red dry-erase marker. All the above information is added to the board and written in numerical order as added by the surgeons.
6. Magnetic squares are placed above the staff's name indicating if they have had a break and/or lunch.
   a. The brown magnetic square indicates 15-minute break
   b. The yellow magnetic square reflects 30-minute lunch
7. As cases are completed, they are erased from the board.

F. OR UNIT SPECIFIC STAFF SCHEDULING PRACTICES:
1. SCHEDULING MECHANICS
   a. Daily Schedule

i. Scheduling is automated with the program being located in the Staffing Office.
ii. A master schedule is produced 4 weeks in advance and is updated with requests for vacation, planned absences, schedule changes, new and terminated employees by the Manager or designee.
iii. Two weeks prior to start, it is returned to the nursing staffing office to be finalized in the computer and a new updated schedule is sent to the department. A separate schedule is completed by an assigned staff scheduler reflecting a global staffing structure.
iv. Based on this schedule, room assignments are made by the ANM/Charge Nurse for the scheduled cases.

b. Call Schedule

Standby and Call Back will be utilized to staff those shifts which have minimal staffing in-house. The following are guidelines to use, and illustrates how standby staffing is assigned and provided:

i. In the Operating Room, the staff on duty initiates the Call Back by contacting the on-call person to return to the department within 30 minutes.
ii. The call schedule for the Main Operating Room and Endoscopy is done by the staff. A copy of the call schedule is available at the OR desk.
1) All full-time and part-time RNs and OR techs will be expected to cover standby with call back on a rotational basis.
2) Personnel covering "heart call" will not be expected to take additional call, but may volunteer to do so.

c. Weekends

i. Weekend personnel definition (there are two types):
1) Weekend Only are personnel who work only the weekend, 8 or 10 hour shifts.
a) Weekend Only and Per Diem personnel will not be expected to cover call except on a voluntary basis. They must work a minimum of 4 shifts per month in order to participate in the call rotation.
b) Weekend Only and Per Diem personnel are required to fulfill their regularly scheduled shift if it falls on the holiday. They will work the major or minor Holiday unless request to be off as vacation. Only one person at a time may request each holiday off.
2) Weekend personnel (either full-time or part-time) that also work other days of the week and work at least two full weekends per month.
a) Weekend Personnel are not expected to take weekend call. Weekend Personnel will fill their call obligation by taking call during the week or voluntarily taking weekend call during off duty hours.
b) These individuals whose normal working hours routinely encompass part or all of a weekend are required to participate in holiday coverage. When hired or changed to this shift, this is a one time option to be decided by choosing one of the following methods of compliance:

i) Elect to work the minor/major holidays that are in conjunction with their regularly scheduled weekends. If the individual works both Saturday and Sunday, these shifts will count as call shifts. If the individual worked shift is only one day, this person will sign-up for call on their off day.

ii) Elect to work a major/minor holiday (1 major and 2 minor), then stays in these groups as they are rotated every year.

c) The method the individual chooses must be communicated to the Unit call scheduler(s). Those who choose method (i) will submit in writing the holidays they are working for the year.

d) Weekend Coverage begins at 2300 hours on Friday and ends at 2300 hours on Sunday.

Friday	2300-0700 hours:	1 RN/Tech (in-house)
		1 RN/Tech (on-call) first call
	2nd Call:	1 RN, 1 Tech/RN
Saturday	0630-1700 hours:	2 OR Teams (weekend personnel)
	0630-1500 hours:	1 OR Team (2nd Call backup)
	1500-2300 hours:	1 OR Team (in house)
		1 OR Team (2nd Call)
	2300-0700 hours:	1 Tech/RN (in house)
		1 Tech/RN (on call)
		1 OR Team (2nd Call)
Sunday	0630-1700 hours:	2 OR Teams (weekend personnel)
	0630-1500 hours:	1 OR Team (2nd Call/backup)
	1500-2300 hours:	1 OR Team (in house)
		1 OR Team (2nd Call)
	2300-0700 hours:	1 Tech/RN (in house)

d. Full Time personnel assigned to Night duty will not be expected to cover call except on a voluntary basis.

e. Per Diem Personnel are required to work 1 major and 1 minor holiday per year.

f. The number of call shifts an individual will be responsible for in any month will be determined by the number of shifts needing coverage divided by the number of personnel covering call. RN's will be expected to cover some scrub role coverage.

g. The response time from the time an individual receives the call until they must arrive at the hospital is 30 minutes.

h. Beepers may be used if the on-call person is away from their phone. When using a beeper, check in with the operating room personnel (in house) to let them know you are "on beeper". Check to make sure they have the correct beeper number and ask for a beeper check while checking in.

i. If the "first call" person is unable to fulfill the call responsibility due to illness/injury, it will be the responsibility of the "second call" person to move into the "first call" slot. The ANM or charge nurse on duty will be responsible for finding a replacement to fill the "second call" standby position. The list of personnel who have signed up for extra call will be utilized first, and if unable to fill the position, then the staffing book.
   i. It is not acceptable to call into the OR and expect the OR Aide or Nurses on call back duty to find a replacement.
   ii. The OR ANM, Administrative Coordinator, or Administrative person on "call" may be reached through the TCMC Operator in the event that the OR weekend charge cannot be reached.

j. Call Rotation/Give away:
   i. Rotational call schedule
   ii. Unwanted call will be starred (*) for giving away
   iii. Person with least amount of call for the week will have first rights
   iv. Next in line would be by seniority (full time, part time, then per diem)

k. Endoscopy Call
   i. When cases are finished for the day, the Endoscopy nurses go "on call".
   ii. Evenings, nights and weekends are covered by on-call staffing.
   iii. The Endoscopy Unit Registered Nurses are contacted by the OR main desk after receiving a call from the physician needing to perform the procedure.
   iv. Responsibilities of the Endoscopy nurses:
      1) The Endoscopy Nurses will maintain an accurate call schedule, including correct telephone and beeper numbers, in the designated Endoscopy Call Schedule Folder.
      2) Update the Operating Room on any changes in On Call personnel on the present working day. Inform the Operating Room of changes in status. RE: Leaving present phone location and going on beeper.
   v. OR Back-up: The OR will have a select group of personnel on-call to provide backup assistance for endoscopy during the evening hours, from 1500 to 2200 hours, and on Saturdays from 0700 to 1500 hours.

l. Operating Room "On-call" personnel will cover Endoscopy Call should the need arise for backup personnel.

m. There will be 2 rooms available for holidays and staffed as follows:
   Day Shift: 1 OR team (in-house)
   1 OR team (on-call)
   PM's and Night Shifts: 2 OR teams (on-call)

n. Holiday call is divided into two categories:
   i. Major holidays (Thanksgiving, Christmas and New Years)
      1) Major holidays will go in rotation, i.e., if an employee had Thanksgiving last year, they would rotate to Christmas this year, or if they had Christmas off, they would have New Years the following year, and then Call assignment would continue to rotate thereafter.
      2) When new personnel are added to the call schedule they would be put in the holiday slot that was needed and that would begin their rotation.

ii. Minor holidays (President's Day, Memorial Day, July 4, and Labor Day)
1) Minor holidays will go in rotation, i.e., if an employee had President's Day off last year, they would then rotate to Memorial Day for the current year, and if they had Memorial Day off, they would have July 4th off the following year, and so on for Labor Day, and then Call assignment would continue to rotate thereafter.
2) When new personnel are added to the call schedule they would be put in the holiday slot that was needed and that would begin their rotation.

o. Holiday Call will be covered on an 8-hour shift basis.
i. There will be 2 teams available for 7 am – 3 pm and 2 (on call) teams available for the other two shifts.
ii. Personnel that will be responsible for covering a holiday and weekend call will have the opportunity to sign up for their holiday and weekend call shifts in advance of the regular staff. They will be allocated certain slots for the actual holiday (based on seniority), as well as a number of weekend shifts they are responsible for. They will pick in the order of the group they are in.
iii. Those personnel assigned to holiday shifts during an approved vacation will be responsible for finding a replacement.
iv. If a holiday falls in the middle of the week, the holiday personnel are not required to cover the weekend with the exception of Thanksgiving. However, if the holiday is a three day weekend, they are responsible to cover the weekend call shifts in addition to their holiday call.
1) Holiday personnel that are responsible for covering a holiday that falls in the middle of the week will be allocated certain slots that they must sign up for in addition to their regular call. They will pick in order of the group they are in.
v. If individuals wish to trade their holidays they must submit the trade in writing before the schedule is made up for that month. The rotation (if it is a major holiday) remains unchanged.
vi. Holiday call for OR Aides/Instrument Aides
1) There will be one person on call for 16 hours for each holiday. The four (4) major holidays, Fourth of July, Thanksgiving, Christmas, and New Years will be on a rotational basis and the minor holidays will be drawn on the first Monday of November at 2:00 pm.
vii. Holiday call for Anesthesia Techs
1) Any holiday falling on a weekend.

p. Procedure for Call Assignments:
i. The call sheet will be posted by the last day of the month, one month in advance of the month to be covered.
ii. The staff personnel assigned to the call staffing duty will specify how many and what kind of shifts each person must take (i.e., scrub, circulate, first, second).
iii. The unit scheduler will place all OR personnel assigned to call on a rotational basis in groups.

iv. If an individual is gone longer than two weeks when a new schedule is out, they are responsible to sign up within their group order before they leave or assign another staff member to sign up for them in their absence. The call schedule cannot be held up and people will proceed in group order to pick their shifts.

v. The call schedules are located at the main desk in the OR on a clipboard.

vi. Any individual with an approved vacation of one week or more will be allowed to sign up within the second group's rotation for that month unless, of course, they are in group one.

vii. No individual is allowed to jump groups when picking their call except for the above mentioned.

viii. All personnel assigned to call are responsible to cover the amount of shifts designated regardless of circumstances. If the slots that are vacant are conflicting, they must still sign up and either trade their call or try to give it up.

ix. Staff electing to "give away" their call can denote this by marking a star (*) by their name when they sign up. The person originally assigned will be responsible for the shift if there should be a discrepancy.

x. After all groups have signed up for call, the starred shifts will then be available for those staff members interested in extra call. There will be a list each month for the individuals that are interested in extra call to sign their name. The list will be at the bottom of the call schedule for each particular month. All starred shifts will be selected by those individuals equally in order of their group rotation for that month.

xi. Any call shift that has become vacant due to lengthy unexpected illness or disability, or resignation will be posted for coverage. If after 10 days it is not assumed, it will be assigned by management personnel.

xii. Standby/On call shifts are as follows: 7 am-3 pm; 3 pm-11 pm, and 11 pm-7am.

1) The Standby/On call personnel is responsible to relieve the preceding individual which they are replacing by 5 minutes before their "call" shift ends, i.e., if relieving the scrub from 3-11, and are the 11-7 On call person, that scrub individual should be leaving the room at 10:55 pm.

q. Requesting Schedule changes or PTO:

i. Submit written request to ANM at least 3 weeks prior to start of the schedule in which desired vacation time occurs.

ii. Only 2 nurses will be permitted Requested Time Off per 8 hour period, as staffing permits.

iii. PTO requests will be honored on a first-come, first-serve basis, with the person having the most seniority being granted the time off in the event that 2 or more requests are submitted on the same day.

iv. Requests for PTO during winter holidays will be accepted until August 31st prior to the holiday. Requests will be granted based upon the following:

1) Whether or not the person had PTO over the same holiday the previous year.

2) Whether or not the person was granted PTO over one of the other winter holidays in the current year.
3) The date of which request was submitted.

v. Any employee requesting PTO must have accrued PTO on the books or the request will be approved pending adequate PTO accumulation. If adequate PTO is not accrued when the schedule is distributed, the employee will be scheduled normal working hours.

r. Vacation request guidelines:

Vacation requests must be submitted on the appropriate form. It is essential that your request be dated. Consideration for approval will be based initially on a first-come basis. All written requests are to be submitted to your Manager.

i. The specific number of employees who can be off at the same time are as follows:

Weekdays	Scrub/Circulate	Support Personnel
0630-1500	3	1
1430-2300	2	1
2230-0700	1	0
ES	1	1
Weekends		
0630-1700	1	1

ii. If your duty hours fall on two different shifts, the 2 appropriate Clinical Managers will jointly approve your request.

iii. Please follow the call schedule policy in relation to your call obligation during your vacation.

iv. Before submitting your request, please check the vacation calendar first. If the time you desire is available, tender your written, dated request as soon as possible. If the dates you are interested in are already taken by the maximum number allowed, it is still possible to obtain approval for your request. The 3rd person who provides his own coverage after the schedule is out cannot provide someone on an overtime basis unless approved by ANM. Final approval of your request will come from your ANM.

v. Vacation requests submitted for the same week or next day worked schedule must be handed to ANM directly so she/he is aware of need.

vi. Vacation requests that include a major holiday:

In order to insure a fair distribution of vacation time that includes any of the three (3) major holidays, Thanksgiving, Christmas, and New Years, a deviation from the established guideline is necessary. An employee who has taken requested time off over any of these three (3) specific holidays will not be considered for the same holiday the following year until three (3) months prior to that holiday. If at this point there is time available, you may submit your request.

vii. Only one of the major holidays may be requested up to 3 months prior to that holiday. After the 3 month deadline, extra holidays may be requested on a first-come first-serve basis.

viii. If it is your intention to request vacation over a different holiday than one taken the previous year, you may submit your request at any time.

ix. If a conflict arises between two (2) employees' requests for the identical time, approval will be based on date of the request and employee seniority.

x. Vacation requests and scheduled time off is noted in the calendar kept at the desk for monitoring the number of personnel already granted time off. If requests are made after the schedule is posted it is the decision of the ANM based on staffing available whether or not to grant the time off request.

xi. Granted time off will be covered by per diem or part time staff to provide adequate coverage.

xii. RN's may not be covered by a tech unless the 75/25 staffing ratio of RN's to techs has not been reached. Secretaries and instrument aides may be relieved by RNs or techs. Perioperative aides may be relieved by instrument aides, secretaries, or OR techs.

2. CHANGE OF SHIFT:

a. Personnel are expected to be in the department at the time their shift begins. A five-minute grace period is allowed to change clothes.

b. Shift Report is given at 0635, 1435, and 2235 hours. Ten minutes is allowed for each report.

c. Personnel are expected to be in rooms to relieve at 15 minutes before the hour, so that adequate time is available to do counts, etc., and to get the out going personnel off duty in a timely manner, and to keep overtime to a minimum.

E. UNIT SPECIFIC ACUITY BASED STAFFING PATTERNS:

1. The OR averages 13,500 cases annually including In patient, Outpatient, and Endoscopic procedures. The average case length is 150 minutes. Add on cases comprise approximately 1850 of those cases and emergencies are about 500. The impact on scheduling nursing assistance is heavy. Enough nurses/techs are scheduled on Monday Friday to open 9 rooms of surgery, and 1 for Endoscopy. If caseloads remain low, personnel are permitted to flex off, leaving enough personnel to open one additional room.

2. The types of cases generally assigned extra personnel are abdominal aortic aneurysms, open heart, laser cases, local only, total joints, and craniotomies.

3. Generally there is one float nurse if staffing permits who may assist getting difficult cases started and assist in room turnover.

4. The average annual caseload for Endoscopy is 1350 cases of approximately 1 hour in length. Of those cases, 400 are emergency or add-ons having significant impact on planning the schedule. There are 2 RNs scheduled from Monday through Friday. When cases are finished the nurses go on call. There are per diem nurses available to call for a heavier case load. The ANM/designee also assists in covering the unit during the day. The Operating Room will do add-ons on Tuesday, Wednesday, and Thursday to provide call relief for the nurses in Endoscopy. Otherwise evenings, nights, and weekends are covered by call.

5. SHIFTS:

Most shifts in the OR are 8 hours for days, evenings and nights. Weekend shifts for the day are 10 hours, evening and nights 8 hours. During the week, there is a mid shift of 10 hours beginning at 8:30 am on Wednesday, Thursday, and Friday. There is a mid shift of 8 hours beginning at 10:00 am on Monday through Friday and a 10 hour shift

beginning at 11:00 am on Monday, Tuesday, and Friday. These help cover the busiest days and the heavy parts of lunch, shift changes, and dinner breaks.

6. PERSONNEL PER SHIFT:

Day shift - Monday through Friday	9 Rooms
1 ANM or Charge Nurse	1
2 RNs or 1 RN/1 Tech per room	18
1 Extra RN for heavy cases and/or total joints	2
2 RN mid shift 10-6:30	1
2 RN float	1
1 Extra RN for heart room	1
2 Anesthesia Techs, staggered (1 early, 1 late)	2
3 Staggered Perioperative aides	3
2 Equipment/Supply Coordinator staggered	2
1 Secretary	1

Four RNs/Techs are allowed to go on vacation at any given time.

Evening shift - Monday through Friday	5 - 8 Rooms (1500-1700)
1 AUM or Charge Nurse	1
2 RNs or 1 RN/1 Tech per room	10 - 16
1 Float RN	1
1 Anesthesia Aide, staggered (midshift)	1
2 Perioperative Aides	2
1 Secretary	1
1 Float ORT	1

Evening shift - Monday through Friday	3 Rooms (1700-2000)
1 AUM or Charge Nurse	1
2 RNs or 1 RN/1 Tech per room	6
1 Float RN	0
1 Anesthesia Aide, staggered (midshift)	1
2 Perioperative Aides	1
1 Secretary	1

Evening shift - Monday through Friday	2 Rooms (2000-2300)
1 AUM or Charge Nurse	1
2 RNs or 1 RN/1 Tech per room	4
1 Float RN	0
1 Anesthesia Aide, staggered (midshift)	0
2 Perioperative Aides	1
1 Secretary	0

Night shift
1 RN and 1 Tech, Sunday through Thursday
1 RN or Tech, Friday and Saturday
3 OR Aides to terminal clean

If a regular scheduled Tech or RN is ill or on vacation, call is moved up. One person will always be in house.

Weekends
Days: 1 AUM or Charge Nurse
2 Techs
1 RN
1 Secretary
1 Aide

Evenings: 1 RN
1 Tech

These are ideal staffing patterns. Occasionally the float nurse and the Charge Nurse are the same person. There is call coverage for the night shift and for running extra rooms on the weekend (up to 3 plus the heart room).

The philosophy of this OR is to have RNs competent to scrub, therefore, the RN/Tech ratio is 75% RN/25% Tech.

F. OFF HOURS COMMUNICATION WITH SPECIALTY COORDINATORS:

1. Coordinators are available for phone calls during their off-duty hours in accordance with the following guidelines. Calls should be regarding:
   a. Emergent cases relating to individual patients, and after all other resources have been exhausted regarding:
      i. Check with SPD
      ii. MDC
      iii. Case Carts
      iv. Specialty Carts
      v. Storage areas
      vi. Coordinators Carts (SPD)
   b. Materials and equipment (availability/non-availability) for next day or emergent cases or requests from other facilities to borrow equipment from TCMC.
   c. Special Requests from Surgeons.
      i. These guidelines pertain to all coordinators with the exception of Open Heart Coordinator, who requested to be called or paged with any / all questions and information. When not available, the most senior Open Heart Team member is to be contacted.
      ii. It should be noted that coordinators are not on 24-hour call, and are not mandated to be available at all times. If you are unable to reach the coordinator, it is at the discretion of the charge nurse to do what is necessary to facilitate a positive patient outcome.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 06/09 **SUBJECT: Standard Precautions in Surgery**

REVISION DATE(S): 11/12; 07/15

Department Approval:	**~~03/18~~02/20**
Department of Anesthesiology Approval:	**n/a**
Operating Room Committee Approval:	**~~03/18~~02/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~05/18~~03/20**
Administration Approval:	**04/20**
Professional Affairs Committee Approval:	**~~06/18~~ n/a**
Board of Directors Approval:	**06/18**

A. **PURPOSE:**

1. To identify those practices used by surgical personnel in addition to the hospital Standard Precautions policy, to protect both patients and personnel from exposure to bloodborne pathogens. **The perioperative setting is a high-risk environment for exposure to bloodborne pathogens from percutaneous injuries due to the presence of large quantities of blood and other potentially infectious body fluids, prolonged exposure to open surgical sites, frequent handling of sharp instruments, and the requirement for coordination between team members while passing sharp surgical instruments.**

B. **DEFINITIONS:**

1. **Standard Precautions: The primary strategy for successful infection control and reduction of worker exposure. Precautions used for care of all patients regardless of their diagnosis or presumed infectious status.**
2. **Engineering Controls: Safety-engineered devices designed to prevent or reduce the incidence of worker injury and the risk of bloodborne pathogen exposure to the worker.**
3. **Neutral Zone: A work practice control technique used to ensure the surgeon and scrub person do not touch the same sharp instrument at the same time. This technique is accomplished by establishing a designated neutral zone on the sterile field and placing sharp items within the zone for transfer of the item between scrubbed personnel.**
4. **Perforation Indicator System: A double-gloving system comprising a colored pair of surgical gloves worn beneath a standard pair of surgical gloves. When a glove perforation occurs, moisture from the surgical field seeps through the perforation between the layers of gloves, allowing the site of perforation to be more easily seen.**

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

1. Standard precautions shall be used ~~for all invasive procedures~~**when caring for all patients**.
2. Blood and body fluids from all patients shall be considered infectious.
3. Protective barriers shall be made available to all personnel to reduce the risk of exposure.
4. Personal protective equipment (PPE) shall **be worn whenever the possibility exists for exposure to blood, body fluids, or other potentially infectious materials. PPE shall** depend upon the degree of exposure anticipated and may include:
   a. Goggles
   b. Glasses with side barriers
   c. Face shields
   d. Masks

e. Gowns (including impervious)
f. Shoe covers
g. Gloves

5. **Remove PPE before leaving the work area and place used PPE in designated receptacle for disposal. Perform hand hygiene after PPE removal.**

~~5.~~**6.** Eye protection shall be worn by all scrubbed personnel.

~~6.~~**7.** Scrubbed personnel ~~are strongly encouraged to~~**should** double glove **(i.e., wear two pairs of sterile surgical gloves) and use a perforation indicator system.**~~for added personal protection.~~

~~7.~~**8.** Perioperative personnel shall take precautions to prevent injuries caused by scalpels and other sharp instruments.

a. Perioperative personnel shall use engineering controls when feasible (i.e., sharps with engineered sharps injury protection), such as blunt needles, safety scalpels, safety needles and needeless systems.

b. The "hands-free, Neutral Zone" technique shall be used when possible, to transfer sharps between personnel.

i. Identify and designate the neutral zone before beginning the surgical procedure.
ii. Use an instrument mat, magnetic pad, basin or designated area as the neutral zone.
iii. Give verbal notification when a sharp is in the neutral zone.
iv. Place one sharp at a time in the neutral zone.
v. Orient the sharp for easy retrieval by the surgeon or fist assistant.
vi. Ensure the sharp is handled by only one team member at a time.
vii. Place sharp items in the neutral zone after use.

~~a.~~**c.** Used needles shall not be sheared, bent, broken, or recapped by hand. If recapping is necessary, an instrument, or the one-handed scoop technique shall be used.

~~b.~~**d.** Knife blades shall be loaded and removed using an instrument.

e. Sharp devices must be contained, transported, and disposed of safely. Disposable sharps shall be placed in a puncture resistant, labeled, or color-coded leak proof container.

~~c.~~**f. The scrub person should account for and confine all sharps on the sterile field.**

~~d.~~**g.** Reusable sharps shall be placed in a puncture resistant container, isolated from other surgical instruments.

~~e.~~**h.** Use gloves and an instrument to pick up sharp items that have fallen on the floor.

~~8.~~**9.** ~~Perioperative personnel shall handle specimens as potentially infectious material~~**Standard Precautions shall be used when transferring specimens from the sterile field**.

a. All specimens shall be placed in a **labeled** container which prevents leakage during collection, handling, processing, storage, transport or shipping.

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

~~9.~~**10.** Perioperative personnel shall control work practices to minimize the risk of exposure to bloodborne pathogens. This includes prohibition of eating, drinking, applying cosmetics, and handling of contact lenses in restricted and semi-restricted areas.

~~10.~~**11.** Perioperative personnel ~~who have~~ **with dermatitis, infections,** exudative lesions or ~~weeping dermatitis~~**non-intact skin** shall refrain from providing direct patient care or handling of medical devices used in performing invasive procedures.

~~11.~~**12.** Perioperative personnel ~~who participate in invasive procedures are encouraged to receive Hepatitis B immunization~~**should be immunized against vaccine-preventable diseases**.

~~12.~~**13.** Perioperative personnel shall adhere to Employee and Occupational Health Service (EOHS) policies regarding work restrictions for personnel with infectious diseases.

~~13.~~**14.** ~~Patients requiring Isolation Precautions shall be placed in a private cubicle in Pre-Op and Post-Op, when possible~~**Infection control policies for Standard and Transmission based precautions shall be followed**.

a. Transport gurneys will be cleaned **and fresh linen applied** as soon as the patient is transferred to the operating table.~~, prior to leaving the surgical suite.~~

b. ~~The post-operative receiving unit shall be notified of patient diagnosis as soon as possible~~**Patient's isolation status shall be communicated during hand-off report**.

c. Patients on Airborne Precautions, including those with suspected or active pulmonary tuberculosis shall be recovered in a private cubicle with a portable high efficiency particulate air (HEPA) filter.

~~14. Unopened supplies may be returned to stock after the surgical procedures if there has not been contamination or compromise in the packaging.~~

~~C.~~D. REFERENCES:

1. ~~Conner, R. (2017). Guidelines for Perioperative Practice, 2017 Edition. Denver, CO: Association of PeriOperative Registered Nurses.~~ AORN, Inc. (2020). ***Guidelines for Perioperative Practice***. Denver.

~~1.~~

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
POLICY MANUAL

ISSUE DATE: 06/07 **SUBJECT: Acuity Class System**

REVISION DATE(S):

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administrative Approval:	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE**

1. The acuity classification system has been designed as a component of the productivity standard that was established to safely and effectively manage and staff the multi-service outpatient center. In addition, it also plays an important role in the plan of care for each patient for the following reasons:
   a. It defines the extent of care the patient requires with each visit.
   b. It clarifies and validates the resources/time needed for the patient's care for each visit, as well as the time needed to support the requirements for the continuum of care activities.

B. **POLICY**

1. All patients seen in the Center will be assessed for acuity.
2. As the needs/resources/time may vary from visit-to-visit, the assessment is performed at each encounter for each patient.
3. The clinician assigned to the patient will perform the acuity assessment at the conclusion of each visit.
4. The clinician will determine the level of acuity using the hospital approved acuity system.
5. The system is comprised of:
   a. Scoring Grid
   b. Tabulation Tool
   c. Acuity Level

C. **PROCEDURE**

1. The indicators used to assess acuity are defined as follows:
   a. Mobility – indicates the aid/support the patient requires when moving from one area to another and on/off the treatment chair/bed.
   b. Complexity of prep for treatment/exam - e.g. the number of wounds to be assessed, number and complexity of dressing to be removed, preparation for Hyperbaric Oxygen Therapy (HBOT), or any other preparation activities aside from routine activity such as vital signs.
   c. Complexity of aftercare - e.g. numbers and types of dressings, wraps, etc.
   d. Teaching required during visit - to include the need for an interpreter.
   e. Extent of the necessary assessment and/or follow-up needed - includes time necessary for planning care taking into consideration the continuum of care.

2. The following steps are taken to determine the patient acuity:

Step 1: The Scoring Grid is used to assign acuity points to each indicator.

PATIENT ACUITY SCORING GRID					
ACUITY POINTS	**MOBILITY**	**COMPLEXITY OF PREP**	**COMPLEXITY OF AFTERCARE**	**TEACHING REQUIRED**	**ASSESSMENT/ CONTINUUM OF CARE**
0	Independent; no assistance required	No prep required other than routine, such as vital signs, etc.	No aftercare required	No teaching necessary	**Not applicable** All patients require assessment with each encounter
1	Minimal assistance for mobility (guided by 1 person)	Minimal prep required such as removal of simple dressing, 1-2 wounds to assess/ prepare, etc.	Minimal aftercare required such as simple dressing	Reinforcement of a few simple topics	Simple assessment and or follow-up required
2	Moderate assistance for mobility	Moderate prep time required, such as removal of several dressings, removal of single-layer com-pression wraps, 3-6 wounds to assess, etc.	Aftercare is moderately complicated, such as uncomplicated multiple dressings, single-layer compression wrap	Requires reinforcement of several issues/ problems and/or 1 or 2 additional topics	More extensive assessment and follow-up with several issues/ problems required
3	Maximal assistance required (2 or more patient lift)	Time-consuming or complicated prep such as HBOT, removal of multiple or compli-cated dressings, removal of multiple-layer compression wraps, etc.	Time-consuming and/or complicated such as multiple complicated dressings, multi-layer compression wrap	Learning deficit identified requiring constant reinforce-ment and follow-up or several new issues/problems discussed and/or lengthy/time-consuming discussion or interpreter required	Comprehensive assessment and planning required

Step 2: The appropriate points from the Scoring Grid are applied to each indicator in the Tabulation Tool.

PATIENT ACUITY TABULATION TOOL				
MOBILITY	**COMPLEXITY OF PREP**	**COMPLEXITY OF AFTERCARE**	**TEACHING REQUIRED**	**ASSESSMENT/ CONTINUUM OF CARE**

TOTAL POINTS

Step 3: The total is then computed to determine the final acuity level as defined in the Acuity Level table below:

ACUITY LEVELS	
POINT RANGE	**ACUITY LEVEL**
0-2	I
3-5	II
6-9	III
10-12	IV
13-15	V

Step 4: Acuity levels are recorded in the database by the clinical manager for periodic and annual review and subsequently utilized for staffing and productivity standard determination.

Note: The level of acuity should directly correspond to the time spent caring for patient.

3. Levels of care are delineated as follows:
   a. Level I (0-2): The patient requires little or no assistance or care. The patient presents with a minor affliction, few symptoms, and is independently mobile. Very little time (*less than 11 minutes),* is required for this type of visit.
   b. Level II (3-5): This type of visit requires *20 minutes or less* to evaluate the patient and provide any necessary care. The patient may present for a second opinion/consult or may be nearing the end of their treatment period and may require minimal assistance with mobility and very little or no planning, teaching, and follow-up.
   c. Level III (6-9): A moderate amount of time is required for this type of patient visit *(21 to 30 minutes).* They may require more complex type of care, which may include managing uncomplicated and/or multiple dressings and wound assessments. Preparation for exam and aftercare may be moderately time consuming and the patient may require minimal to moderate assistance with mobility. An interpreter may be necessary to discuss 1 or 2 topics. Planning, follow-up, and time needed for support for the continuum of care is moderately time-consuming.
   d. Level IV (10-12): This patient requires a significant amount of time per visit *(31-45 minutes).* They may have more complex issues to be addressed or increased care time including multiple and/or complex dressings, multiple compression wraps, HBOT, and prolonged aftercare or patient may require moderate to significant assistance with mobility. An interpreter may be used to discuss several topics, adding more time to effectively care for the patient. Also, the time dedicated to the continuum of care is significant.
   e. Level V (13-15): This typifies the very complex case, requiring the maximum amount of time for the patient's visit *(>45 minutes)* to address the care, evaluation, and follow-up. This may include very complex and time-consuming care including multiple complex dressings, multiple compression wraps, HBOT consultation, comprehensive H&P and assessment. The patient may require full assistance for mobility requiring 2 or more staff members to transfer from one area to another. A severe learning deficit is identified requiring additional time to address the education needs of the patient, and a significant amount of time may be needed for planning and addressing the continuum of care.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
POLICY MANUAL

ISSUE DATE: 06/07 **SUBJECT: Chart Order**

REVISION DATE(S):

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administrative Approval:	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE**

1. A systematic approach to patient record keeping is necessary:
   a. To provide consistency and orderliness
   b. For ease of use for all staff members

B. **POLICY**

1. A medical record will be maintained on all patients treated at the Center.
2. Documents will be maintained in reverse chronological order in the appropriate section of the chart as designated below.

C. **PROCEDURE**

The order and the contents of the patient record will include, but will not be limited to:

1. Front of Chart
   - Admission face sheet
   - Managed Care/ Workers Comp auth
   - Managed Care/ Workers Comp auth
   - Copy of insurance cards
   - Copy of patient information/Intake sheet
2. Case Management
   - Medications Record
3. MD Orders
   - Physician orders
   - Patient instruction sheet
4. Progress Notes
   - Wound documentation/photograph sheet
   - Progress notes
   - Initial H&P
5. Clinician Notes
6. Labs
7. Vascular/Radiology
8. H&P
   - Admission assessment, Parts I & II
   - H&P from outside source
9. Consults/OP Reports
10. Miscellaneous/Prescriptions
11. Home Health
12. Consents
    - Outpatient clinic consent for treatment/photography
    - Conditions of Admission
    - Insurance and billing consent
13. Financial
    - Superbills
14. Hyperbaric Forms

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
POLICY MANUAL

ISSUE DATE: 06/07

SUBJECT: Collaboration

REVISION DATE(S):

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administrative Approval:	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE**

1. To outline the steps taken at the Clinic to provide for individualized patient care while still allowing patients to maintain their primary care physician/patient relationship.

B. **POLICY**

1. All patients will be given an individualized plan of care that will be coordinated with the patient's primary care physician, whenever possible.
2. The clinic physician will communicate with the primary care physician (as well as any other physicians/medical agents/agencies involved with patient care) after the initial visit, and periodically as indicated.
3. Confidentiality of patient medical information will be maintained according to State and Federal requirements.

C. **PROCEDURE**

1. During the initial assessment process, the patient will be asked to provide names, addresses and telephone umbers of physicians currently involved in their care.
2. This information will be recorded in designated areas in the patient record.
3. The clinic physician will communicate with the primary physician, ideally after the first visit, to outline the plan of care.
4. Documentation of the communication will be addressed in the physician's notes. A copy of all correspondence will be maintained in the medical record.
5. Physician progress notes, clinic H&P, pictures, etc. from the clinic record may be sent/faxed at the request of the primary care physician, after applicable signed consent from the patient, and following HIPAA guidelines/hospital policy.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
POLICY MANUAL

ISSUE DATE: 06/07 **SUBJECT: Data Management**

REVISION DATE(S):

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administrative Approval:	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE**

1. Effective use and management of patient data is crucial to the service appraisal process and enhancement efforts. Properly managed data can provide vital information about:
   a. The population served
   b. Patient progress/outcomes
   c. Resources utilized
   d. Resources needed
   e. Compliance with plan of care
   f. Efficacy of the treatment plan

B. **POLICY**

1. It is the intent of the clinic to collect and properly manage data to benefit the patients being treated at the Center.
2. Patient information will be handled following all applicable confidentiality regulations and hospital policies.

C. **PROCEDURE**

1. The patient information to be included in the data entry, but is not limited to, is:
   a. Demographics
   b. Referral source
   c. Clinic physician
   d. Primary care physician
   e. Diagnoses
   f. Diabetes information
   g. Wound assessment information
   h. Wound classification
   i. Pictures
   j. Procedures performed
   k. Insurance information
   l. Acuity of the patient
   m. Patient goals
2. Reports that may be generated by the database may include:
   a. Wound healing progress
   b. Outcome reports
   c. Utilization reports

d. Revenue reports
e. Marketing reports

3. Data will be reviewed and analyzed by a qualified person(s) and reported to pertinent hospital committees and persons.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
POLICY MANUAL

ISSUE DATE: 06/07 **SUBJECT: Discharge Instructions**

REVISION DATE(S):

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administrative Approval:	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE**

1. To ensure that all patients discharged from the Center's program will have adequate instruction regarding wound prevention and/or follow-up care.

B. **POLICY**

1. Patients receiving treatment at the Center will be adequately and appropriately instructed about follow-up care.
2. For continuity of care, home health agencies, case managers, and caregivers involved in the patient's care will be informed of discharge instructions.
3. At the time of discharge from the Center, Nursing will review with the patient the following as it applies:
   a. General diabetic care
   b. Return to primary physician for follow-up care
   c. Skin care
   d. Offloading/non-weightbearing
   e. Edema control measures
   f. Nutrition/dietary restrictions
   g. Activity level
   h. Continued wound care
   i. Other instruction as appropriate
4. Instruction will be documented on the approved *"Discharge Instruction"* form.
5. The patient will sign the discharge form acknowledging receipt and understanding of instructions.
6. The nurse will sign and date as required.
7. The patient will be given a copy of the discharge sheet.
8. Other healthcare providers will be provided with discharge instructions as appropriate.
9. The discharge form or letter will remain a permanent part of the medical record.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
POLICY MANUAL

ISSUE DATE: 06/07 **SUBJECT: Disseminating Medical Information**

REVISION DATE(S):

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administrative Approval:	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE**

1. Patient privacy and confidentiality regulations prohibit the arbitrary sharing of medical information to protect the patient from indiscriminate use. This policy outlines the procedure the Center follows when disseminating patient information.

B. **POLICY**

1. All applicable state and federal regulations and hospital policies will be adhered to when disseminating or requesting patient confidential medical data.
2. Patient information may be obtained without the patient's consent in accordance with court order, subpoena or statute.
3. The patient will be informed of the need for, or the use of, the information being requested or disseminated.
4. The patient will sign the "Authorization for Use or Disclosure of Medical Information" form prior to requesting information from another facility or releasing information, according to hospital policy.
5. To the extent possible, medical information will be guarded against loss, destruction, tampering, and unauthorized access.

C. **PROCEDURE**

1. The physician or his/her designee will explain to the patient the need for information being requested.
2. Patients will be informed that orders will be faxed to appropriate caregivers, home health agencies, etc. (e.g., labs, radiology, etc.).
3. The patient will sign consent, per hospital policy, prior to releasing information.
4. Faxed information will be accompanied by a fax cover sheet, which states that information received in error should not be shared with anyone except with those for whom the information was intended.
   a. If it is received in error, it is requested that the Center be notified immediately by telephone and return the original message to us at the address on the form.
5. Requests for information may be mailed if fax number is not available.
6. Requests for protected information such as drug/alcohol abuse, sexually transmitted diseases, etc. will be referred to the Medical Records Director.
7. Request for clinic records will be handled, per hospital policy, with signed release.
8. Permission from the patient will be obtained prior to use of any medical information/photography for educational, research, or other purposes.

9. The database-managing agency agrees not to share patient information and states so in the contractual agreement.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
POLICY MANUAL

ISSUE DATE: 06/07 **SUBJECT: Home Care Referrals**

REVISION DATE(S):

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administrative Approval:	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE**

1. For optimal health and healing benefits, collaboration with other healthcare agents/agencies across the continuum of care is a vital component of an effective treatment plan. Home care referral helps to ensure continuity of care and provides an open line of communication regarding the patient's condition and progress. In addition, other home needs affecting the patient's well-being are identified and, to the extent possible, can be resolved through a concerted and collaborative effort.

B. **POLICY**

1. The physician and case manager will evaluate the patient's home care needs during the initial visit and anytime during subsequent follow-up visits.
2. The selection of home care/health agencies will be based on:
   a. Patient preference as the primary starting point
   b. Services provided by the agency
   c. Ability to regularly provide necessary care and monitoring
   d. Willingness to work closely with the Center to provide coordinated patient care
3. All applicable State and Federal privacy and confidentiality rules/regulations will be followed when dealing with home health agencies.
4. The clinical staff will address any patient issues/dissatisfaction related to home care services and make any necessary changes to the plan of care, as it relates to outside services.

C. **PROCEDURE**

1. The clinic physician will order home health referrals based on his/her evaluation of the patient's resources for care at home.
2. Once the order is received, the nurse case manager/PT will coordinate the home health referral for specified care by:
   a. Contacting the designated agency
   b. Providing pertinent patient information and physician's orders following the hospital's confidentiality policies
   c. Informing the patient/family of the arrangements and answer questions as needed
   d. Recording all relevant communication with outside agencies in the medical record
3. Other services/agencies that should be considered for the patient's well-being are agencies that provide:
   a. Housekeeping services
   b. Meal services

c. General home care assistance
d. Transportation

4. Information regarding home care agencies will be compiled and maintained in the clinic's resource binder.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
POLICY MANUAL

ISSUE DATE: 06/07 **SUBJECT: Nurse-PT Visit**

REVISION DATE(S):

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administrative Approval:	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE**

1. In some instances a nurse/PT follow-up visit may be appropriate to maintain the continuity of care. This policy delineates the circumstances under which a nurse/PT visit is appropriate and defines the extent of care allowed.

B. **POLICY**

1. A nurse/PT visit is restricted to professional instruction and limited care under the guidance of the primary Center physician. Circumstances where a nurse/PT visit may be scheduled include:
   a. Dressing or compression wrap changes
   b. Professional instruction regarding condition or treatment plan
   c. Drop-in visit
   d. Treatments/procedures defined and approved by the medical staff and the hospital, e.g., compression therapy
   e. A nurse/PT follow-up visit is not a substitute for a physician visit. In these instances, the physician will be notified, when indicated, and a physician follow-up visit will be scheduled.

C. **PROCEDURE**

1. Whenever possible the primary center physician orders a nurse/PT consult visit.
2. In instances where an order is not obtained, such as a drop-in or emergency, a nurse/PT visit may be conducted per approved standards/protocols and within the Nursing standard of practice.
3. The nurse/PT will assess the condition/wound, identify any problems, take appropriate action within the scope of practice, and notify physician, if indicated.
4. Documentation that is related to the nurse/PT visit is recorded in the Clinician's Notes and the Progress Notes, if applicable. Documentation must include:
   a. Reason for visit
   b. Significant signs and symptoms
   c. Assessment information
   d. Procedures/treatment performed
   e. Patient education
   f. Patient response
   g. Any communication with physician
5. The patient is scheduled for a physician visit as soon as appropriate.
6. The patient will be charged appropriately using the BRIEF visit code.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
POLICY MANUAL

ISSUE DATE: 06/07

SUBJECT: Outcome Designation for Non-Healing Wounds

REVISION DATE(S):

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administrative Approval:	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE**

1. Healing wounds utilizing aggressive wound treatment methods may not be appropriate for specified wounds/patients. In addition, because of the extent of certain wounds and/or co-morbidities, some wounds will not fully respond to aggressive wound treatment. This document defines the outcome designation of wounds/patients that have been deemed inappropriate for treatment in the Center.

B. **POLICY**

1. During the initial assessment/treatment period, patients will be evaluated to determine if aggressive treatment or wound healing is a reasonable expectation.
2. Once the treating physician has determined that the patient's wounds will not respond to aggressive wound treatment, or the patient is inappropriate for treatment, the patient will be referred to their primary care physician for follow-up care.
3. A letter will be sent to the primary care physician explaining the reason the patient may not be considered for aggressive wound treatment.

C. **PROCEDURE**

1. The goal of the wound care program is that all patients admitted will heal within a 3- to 4-month timeframe or less.
2. During the initial treatment phase, the treating physician may determine that aggressive wound treatment is not appropriate.
3. If a patient is expected to heal but the treatment period is approaching or exceeds the 3- or 4-month window, the patient should be referred to another Center physician for a second opinion/evaluation, and the subsequent treatment should not exceed a total of 6 months from admission to the program.
4. Wounds that are healing slowly but show significant reduction in volume (∃50%) after the 4-month period may continue to be treated in the Center but will be given an outlier designation (14 weeks).
   a. Per the Quality Program, the medical director and clinical manager will review outliers monthly, and recommendations will be made for continued treatment or discharge.
5. A letter from the treating physician will be sent to the primary care physician explaining the reason for discharge prior to healing, indicating one of the following:
   a. The patient has a living will that specifies "no extraordinary measures", and aggressive wound treatment is not consistent with the patient's expressed wishes

b. The patient has an underlying co-morbid condition that precludes aggressive treatment because it is likely that the wound will not heal
c. The patient has a terminal illness, and wound healing is secondary to the patient's quality of life goal or is contraindicated with patient's primary treatment plan, e.g., cancer chemotherapy
d. It is unreasonable to expect a level of compliance with prescribed treatment necessary to achieve desired healing outcomes due to patient's limited personal or cognitive resources, lack of ongoing care, or appropriate care providers
e. The patient, patient's family, or care provider(s) requests conservative treatment rather than aggressive care
f. Other, as explained by the treatment physician

6. This policy applies only to the current course of treatment. Subsequent admissions will be evaluated anew.

Tri-City Health Care
Oceanside, Californ

Delete. Duplicate policy of Acuity Class System. No longer required.

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
POLICY MANUAL

ISSUE DATE: 06/07

SUBJECT: Acuity Classification System

REVISION DATE(S):

Department Approval:	02/20
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administrative Approval:	04/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. ~~PURPOSE~~

~~1. The acuity classification system has been designed as a component of the productivity standard that was established to safely and effectively manage and staff the multi-service outpatient center. In addition, it also plays an important role in the plan of care for each patient for the following reasons:~~

~~a. It defines the extent of care the patient requires with each visit.~~

~~b. It clarifies and~~

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
POLICY MANUAL

ISSUE DATE: 06/07 **SUBJECT: Admission Procedure**

REVISION DATE(S):

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administrative Approval:	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE**

1. To delineate the admission procedure for all patients who will be undergoing HBOT.

B. **POLICY**

1. All patients under consideration for HBOT will be thoroughly assessed according to the procedure below.
2. Patients will be admitted to the Center following proper assessment and approval by the HBOT physician.

C. **PROCEDURE**

1. The medical record of the patient will be reviewed by the HBOT physician prior to or at the time of consultation, if applicable.
2. The HBOT physician will complete a comprehensive H&P. A history of previous thoracic surgery, pneumothoraces, seizures, and/or ear or sinus problems will be noted, as they are especially important if patient will be undergoing hyperbaric therapy.
3. The assessment will include the need for tests such as EKG or CBC. All patients over 40 years of age or those with a history of cardiac problems must have a recent EKG. A CBC may be ordered at the discretion of the physician.
4. A chest x-ray (CXR) will be ordered if the patient has not had one taken within the previous month. All patients must have a recent CXR, with results kept in the patient's chart.
5. The patient will be instructed on Valsalva techniques and will properly demonstrate the technique before treatment.
6. The patient will be oriented to the chamber and its surroundings. The patient and/or family members will be encouraged to ask questions and to voice any concerns.
7. The patient will sign the consent for HBOT and for photographing of wounds.
8. Photograph of wound and baseline measurement of wound will be taken, if indicated.
9. A copy of the HBOT brochure will be given to the patient and family, including the unit's phone number.
10. An instruction sheet will be given to the patient that details what is required.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
POLICY MANUAL

ISSUE DATE: 06/07 **SUBJECT: Bomb Threat**

REVISION DATE(S):

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	
Administrative Approval	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE**
1. To establish procedure guidelines in the event of a bomb threat emergency.

B. **POLICY**
1. In the event the Center has been placed on alert for a threat of a bomb, the personnel will follow hospital emergency shutdown procedures.

C. **PROCEDURE**
1. Guidelines for patient evacuation to the determined safe location will be followed.
2. If a hyperbaric treatment is underway, prompt and safe termination of the dive will be conducted. The chamber personnel will:
   a. Decompress the patient at a normal travel rate. If danger is imminent, the decompression rate may be increased to the maximum travel rate of 60 fpm (1 foot per second).
   b. Calm and reassure all patients
   c. Remove the patient from the chamber and prepare for transport
   d. Shut down system as applicable and assist with patient transport and support as required
   e. Turn off and unplug all electrical equipment. Shut down system as necessary for safe departure
   f. Evacuate the patients following the emergency evacuation route specified for the department
   g. When appropriate, make contact with the hospital command post to give all names of patients and personnel assigned for a "head count"

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
POLICY MANUAL

ISSUE DATE: 06/07 **SUBJECT: Earthquake**

REVISION DATE(S):

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	
Medical Executive Committee Approval:	
Administrative Approval	**04/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE**

1. To establish procedure guidelines in the event of an earthquake.

B. **PROCEDURE**

1. Decompress the patients at a normal travel rate. If danger is imminent, the decompression rate may be increased to the maximum travel rate of 60 fpm (1 foot per second).
2. Calm and reassure all patients.
3. Remove the patient from the chamber and prepare for transport.
4. Shut down system as applicable and assist with patient transport and support as required.
5. Turn off and unplug all electrical equipment.
6. Shut down system as necessary for safe departure.
7. Evacuate the patients following the emergency evacuation route specified for the department.
8. When appropriate, contact the hospital command post to give all names of patients and personnel assigned for a "head count".

Community Healthcare & Alliance Committee (No meeting held in April, 2020)

Finance, Operations & Planning Committee (No meeting held in April, 2020)

Audit, Compliance & Ethics Committee
(No meeting held in April, 2020)

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

March 25, 2020 – 4:00 o'clock p.m.
Meeting Held via Teleconference

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held via teleconference at 4:00 p.m. on March 25, 2020.

The following Directors constituting a quorum of the Board of Directors were present via teleconference:

Director George W. Coulter
Director Rocky J. Chavez
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
Jeff Scott, Board 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. via teleconference with attendance as listed above. 2. Public Comments – Announcement

2. Approval of agenda.

   It was moved by Director Younger to approve the agenda as presented. Director Reno seconded the motion. The motion passed unanimously (7-0) by a roll call vote.

   Oral Announcement of Items to be discussed during Closed Session

   Chairperson Grass made an oral announcement of the items listed on the March 25, 2020 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one Report Involving Trade Secrets with a disclosure date of August, 2020 and Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees.

5. Motion to go into Closed Session

   It was moved by Director Reno and seconded by Director Chavez to go into Closed Session at 4:05 p.m. The motion passed unanimously (7-0) by a roll call vote.

6. At 5:20 p.m. the Board returned to Open Session with teleconference attendance as previously noted.

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

Chairperson Grass reported the Board in Closed Session discussed a "Trade Secret" matter and took no action.

The Board also heard a report on Quality Assurance matters and took no action.

8. There being no further business, Chairperson Grass adjourned the meeting at 5:21 p.m.

_____
Leigh Anne Grass
Chairperson

ATTEST:

_____
Julie Nygaard
Secretary

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

March 26, 2020 – 4:00 o'clock p.m.
Meeting Held Via Teleconference

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held via teleconference at 4:00 p.m. on March 26, 2020.

The following Directors constituting a quorum of the Board of Directors were present via teleconference:

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
Scott Livingstone, Chief Operations Officer
Barbara Vogelsang, Chief Nurse Executive
Dr. Gene Ma, Chief Medical Officer
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 4:00 p.m. via teleconference with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Younger to approve the agenda as amended. Director Nygaard seconded the motion. The motion passed unanimously (7-0) with a roll call vote.

3. Public Comments – Announcement

   Chairperson Grass read the Public Comments section listed on the March 26, 2020 Special Board of Directors Meeting Agenda.

4. Chairperson Grass led the Pledge of Allegiance.

5. Chairperson Grass read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 10.

6. Auxiliary Report –

Chairperson Grass reported the Auxiliary has made the decision to suspend their operations until further notice in light of COVID-19 and the Governor's Order to stay at home.

7. New Business –

a) Consideration to approve Resolution No. 798, a Resolution of the Board of Directors of the Tri-City Healthcare District Granting Emergency Authority to the CEO During the Pendency of the Declaration of a State of Emergency.

Each Board member was given the opportunity to ask questions.

It was moved by Director Schallock to approve Resolution No. 798, A Resolution of the Board of Directors of the Tri-City Healthcare District Granting Emergency Authority to the CEO During the Pendency of the Declaration of a State of Emergency. Director Coulter 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**

7. Old Business – none

8. Consideration of Consent Calendar

It was moved by Director Nygaard to approve the Consent Agenda. 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**

9. Discussion of items pulled from Consent Calendar

There were no items pulled from the agenda.

10. Comments by Members of the Public

There were no comments by Members of the Public.

11. Comments by Chief Executive Officer

Mr. Steve Dietlin, CEO gave a brief report on COVID 19 and measures the hospital is taking to properly adhere to the Governor's order.

Mr. Dietlin also expressed his appreciation to the front line health care workers and the Medical staff for their collective commitment to patient care,

12. Board Communications

Director Chavez had no comments.

Director Coulter encouraged everyone to stay safe.

Director Nygaard expressed her appreciation to the entire staff and everyone who is working at the hospital diligently to keep our community healthy.

Director Reno echoed Director Nygaard's comments.

Director Schallock expressed his appreciation not only as a board member but on behalf of the community as a whole for the time and efforts of nursing staff, the Medical staff and Administration during this state of emergency.

Director Younger expressed her appreciation to the Tri-City team for their dedication and commitment during this unprecedented time.

13. Report from Chairperson

Chairperson Grass expressed her appreciation to all employees, physicians, contracted positions, vendors and all those who help make Tri-City the place to receive excellent first class care.

14. There being no further business Chairperson Grass adjourned the meeting at 4:20 p.m.

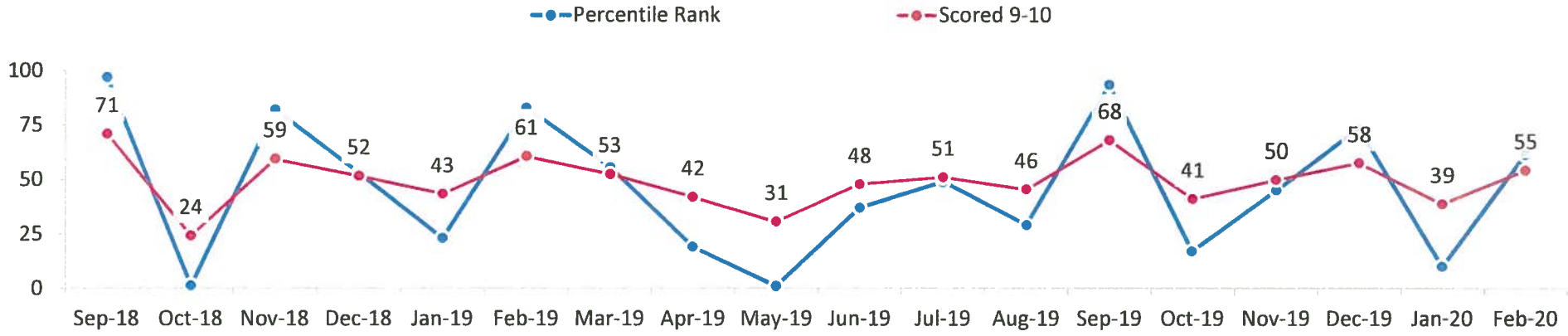
_____
Leigh Anne Grass, Chairperson

ATTEST:

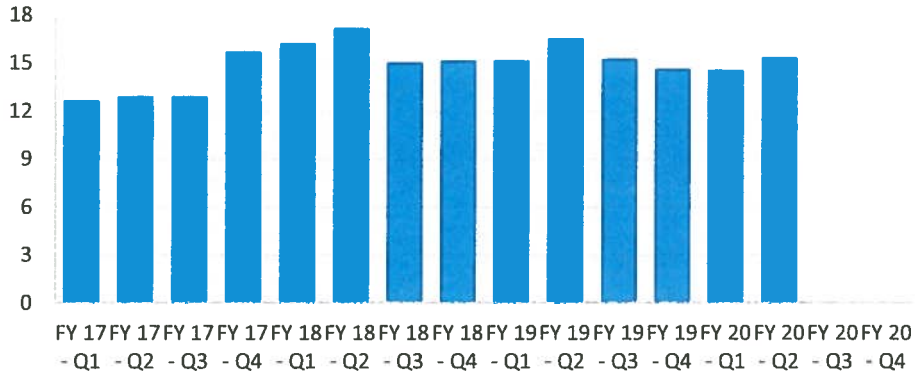
_____
Julie Nygaard, Secretary

Stakeholder Experiences

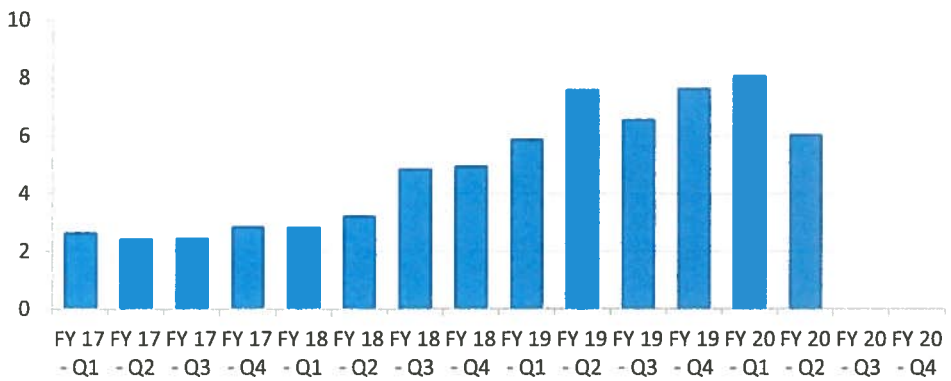
Overall Rating of Hospital (0-10)



Voluntary Employee Turnover Rate



Involuntary Employee Turnover Rate



Volume

Performance compared to prior year: Better | Same | Worse

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	16	19	18	31	30	15	20	19	24				192
FY19	18	29	19	27	18	24	22	16	23	30	25	24	196

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	9	8	9	12	7	5	11	9	11				81
FY19	10	12	3	7	7	9	10	4	16	15	11	12	78

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	9	16	11	11	12	13	10	8	6				96
FY19	19	16	12	16	12	16	17	13	18	16	10	15	139

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	19	23	27	33	31	24	27	29	21				234
FY19	20	23	18	22	17	21	19	16	18	12	20	24	174

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	23	31	35	31	26	29	20				261
FY19	31	31	27	35	38	31	23	40	36	24	29	36	292

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	-	-	-	-	-	-	-	-	-	3.6

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	4.5	7.7	7.0	5.0	3.0	7.1	7.7	9.0				6.3
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	6.8

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	10.3	13.4	9.7	9.5	9.4	7.8	10.7	10.0				10.0
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	10.2

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	143.4	143.6	150.6	143.2	144.0	160.2	153.9	149.3	137.6				147.3
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	155.3

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	168	171	156	159	146	159	153	136	124				1,372
FY19	186	202	170	187	185	166	170	150	177	131	146	156	1,593

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	7	8	7	17	14	10	13	10	7				93
FY19	8	10	6	8	3	15	6	9	11	10	20	13	76

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	5	12	6	11	9	14	8	13				85
FY19	3	4	3	13	13	6	11	17	6	10	7	9	76

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	9	5	2	8	5	5	4	8	5				51
FY19	8	8	6	8	4	14	8	10	16	6	7	5	82

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	1.89	1.91	1.86	1.86	1.79	1.80	1.80	1.81				1.84
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	1.77

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY20	52.8	56.4	59.2	61.2	61.9	62.6	61.5	58.7	53.1				58.6	48-52
FY19	51.0	48.5	50.3	49.5	52.3	56.5	58.9	56.7	57.0	50.5	48.9	53.2	53.4	

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY20	93.0	89.9	90.8	98.4	92.8	85.5	88.5	94.3	88.9				91.3	75-100
FY19	84.9	86.5	90.2	91.4	92.5	87.8	93.1	92.2	83.6	84.1	91.4	87.6	89.1	

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY20	($476)	($494)	($759)	($311)	($1,036)	($1,040)	($860)	($735)	($4,467)				($10,177)	($736)
FY19	($478)	($121)	$119	$254	$342	$236	($527)	$99	$206	$885	$904	($6,138)	$130	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY20	-1.65%	-1.66%	-2.71%	-1.08%	-3.91%	-3.75%	-2.85%	-2.69%	-17.32%				-4.02%	-0.28%
FY19	-1.64%	-0.39%	0.41%	0.86%	1.19%	0.79%	-1.76%	0.34%	0.67%	2.89%	2.88%	-21.60%	0.05%	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCHD EBITDA $ in Thousands (Earnings before Interest, Taxes, Depreciation and Amortization)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY20	$686	$681	$412	$683	$62	$128	$367	$551	($3,164)				$407	$ 9,821
FY19	$796	$1,168	$1,417	$1,561	$1,618	$1,544	$826	$1,468	$1,548	$2,219	$2,221	($4,712)	$11,946	

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY20	2.38%	2.30%	1.47%	2.36%	0.24%	0.46%	1.22%	2.02%	-12.27%				0.16%	3.72%
FY19	2.73%	3.81%	4.90%	5.28%	5.65%	5.20%	2.76%	5.07%	5.00%	7.25%	7.07%	-16.58%	4.48%	

TCMC Paid FTE (Full-Time Equivalent) per Adjusted Occupied Bed

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY20	7.04	6.80	6.21	6.90	6.58	6.44	6.71	6.82	N/A				N/A	6.87
FY19	6.73	6.70	6.75	6.98	7.82	6.50	6.68	6.52	6.71	7.27	7.29	6.79	6.82	

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
FY20	$52.4	$44.8	$43.7	$45.6	$38.2	$31.9	$35.2	$35.8	$34.8				
FY19	$50.0	$49.5	$49.3	$48.1	$37.5	$29.5	$36.3	$32.9	$20.6	$40.7	$57.1	$54.5	

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Building Operating Leases
Month Ending March 31, 2020

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)	47,418.30	07/01/17	06/30/27	**OSNC - Carlsbad** 6121 Paseo Del Norte, Suite 200 Carlsbad, CA 92011	7095
TCMC, A Joint Venture 3231 Waring Court, Suit D Oceanside, CA 92056 V#75482	Approx 1,444	$2.59	(a)	7,508.00	02/01/20	05/31/20	**Dr. Yamanaka MD/ Pulmonary** 3231 Waring Court Suit D Oceanside, CA 92056	7088
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	03/31/20	**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
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)	27,850.00	10/01/12	10/01/22	**Chemotherapy/Infusion Oncology Center** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056	7086
SCRIPPSVIEW MEDICAL ASSOCIATES P O Box 234296 Encinitas, CA 234296 V#83589	3,864	$3.45	(a)	13,316.37	08/08/19	05/31/21	**Encinitas Medical Center** 351 Santa Fe Drive, Suite 351 Encinitas, CA 92023	7095
Total				**$ 171,214.47**				

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

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Education & Travel Expense
Month Ending March 2020

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
8480	CERNER TRAINING	12720 EDU	307.86	79787	PHUONG TRINH
8510	CERNER DA2 TRAINING	31320 EDU	884.58	82086	RICK SANCHEZ
8532	CERNER TRAINING	22120 EDU	314.96	80656	VERA BAKER
8710	CAHQ HEALTHCARE QUALITY CERTIFICATION	21320 EDU	675.00	83691	CALIFORNIA ASSOCIATION FOR
8740	ONS/ONCC CHEMOTHERAPY RENEWAL	22820 EDU	103.00	82110	NORA PAPA
8740	PEDATRIC LIFE SUPPORT COURSE	22820 EDU	150.00	83688	GODOFREDO REYES
8740	COMPTIA NETWOTK PLUS CERTIFICATION	22120 EDU	200.00	82339	WILL VAILENCOUR
8740	CCRN AND ADVANCED CRITICAL CARE COURSE	22120 EDU	200.00	83679	RODINA PINUELA
8740	MRI FOR TECHNOLOGISTS	22120 EDU	200.00	83680	LINDSEY SNYDER
8740	RN TO BSN CHAMBERLAIN UNIVERSITY	22820 EDU	2,500.00	83689	KATHLEEN HOLLAND

**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.