TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
May 28, 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:
Meeting ID: 995 389 5217 Passcode: 169540

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	April, 2020 Financial Statement Results	10 min.	CFO
6	New Business – a) Discussion and possible action relating to submitting a General Obligation Bond Measure for improvements to Tri-City Medical Center for the November 3, 2020 General Election b) Consideration for the Board of Directors of Tri-City Healthcare District to suspend their stipend payments for all meetings during this healthcare crisis.	15 min. 10 min.	Chair Vice Chair
7	Old Business - None	--	--

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

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

	Agenda Item	Time Allotted	Requestor
8	Chief of Staff a) Consideration of May 2020 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on May 26, 2020. b) Consideration of Critical Care Privilege Card	5 min.	COS
9	Consideration of Consent Calendar ***Requested items to be pulled require a second.*** a) Approval of an agreement with the various carriers as reflected on the accompanying Executive Summary through McGriff Insurance Services, Inc. for a term of 12 months beginning July 1, 2020 through June 30, 2021 for a total annual/term cost of $1,822,985. b) Approval of an agreement with Dr. Henry Showah, Coverage Physician for Inpatient Wound Care for a term of 12 months from May 1, 2020 through April 30, 2021, not to exceed an average of 20 hours a month, at an hourly rate of $180 for a total annual and term cost of $43,200. c) Approval of an agreement with Dr. Henry Showah, Coverage Physician for Outpatient Wound Care for a term of 12 months from May 1, 2020 through April 30, 2021, not to exceed an average of 20 hours a month, at an hourly rate of $180, for a total annual and term cost of $43,200. d) Approval of an agreement with Dr. Sharon Slowik, Coverage Physician for Inpatient Wound Care for a term of 12 months from May 1, 2020 through April 30, 2021, not to exceed an average of 20 hours a month, at an hourly rate of $180, for a total cost for the term of $43,200. e) Approval of an agreement with Dr. Sharon Slowik, Coverage Physician for Outpatient Wound Care for a term of 12 months from May 1, 2020 through April 30, 2021, not to exceed an average of 20 hours a month, at an hourly rate of $180, for a total cost for the term of $43,200. f) Approval of an agreement with Yuan Hwang Lin, Cardiothoracic Medical Director of the Cardiovascular Health Institute for a term of 12 months, beginning July 1, 2020 through June 30, 2021, not to exceed 12 hours per month for a total of 144 hours annually, at an hourly rate of $210, for an annual and term cost of $30,240. g) Approval of an agreement with Dr. Yuan Hwang Lin, Cardiovascular Health Institute Operations Committee Member for a term of 12 months beginning July 1, 2020 through June 30, 2021, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5,040. h) Approval of an agreement with Dr. Anitha Rajamanickam, Cardiovascular Health Institute Operations Committee member for a term of 12 months, beginning July 1, 2020 through June 30, 2021, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5,040. i) Approval of an agreement with Dr. Frank Corona, Pulmonary Rehab Medical Director, for a term of 24 months, beginning July 1, 2020 through June 30, 2022, not to exceed 20 hours per month at an hourly rate of $175,	10 min.	Standard

	Agenda Item	Time Allotted	Requestor
	for an annual cost of $42,000 and a total contract term of $84,000. j) Approval of an agreement with Dr. Mohammad Jamshidi-Nezhad, Vascular Surgery Medical Director for a term of 12 months, beginning July 1, 2020 through June 30, 2021, not to exceed 12 hours per month at an hourly rate of $210 for an annual and term cost of $30,240. k) Approval of an agreement with Dr. Mohammad Jamshidi-Nezhad, Cardiovascular Health Institute Operations Committee member for a term of 12 months, beginning July 1, 2020 through June 30, 2021, not to exceed 2 hour per month at an hourly rate of $210, for an annual and term cost of $5,040. l) Approval of an agreement with Dr. David Spiegel, Medical Director for Invasive Cardiology, for a term of 12 months, beginning July 1, 2020 through June 30, 2021, not to exceed 12 hours per month for a total of 144 hours annually, at an hourly rate of $210 for an annual and term cost of $30,240. m) Approval of an agreement with Dr. David Spiegel, Cardiovascular Health Institute Operations Committee member for a term of 12 months, beginning July 1, 2020 through June 30, 2021, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5,040. n) Approval of an agreement with Dr. Donald Ponec, Medical Director of the Cardiovascular Health Institute, for a term of 12 months, beginning July 1, 2020 through June 30, 2021, not to exceed an average of 8 hours per month at an hourly rate of $210, for an annual and term cost of $20,160. o) Approval of an agreement with Dr. Donald Ponec, Cardiovascular Health Institute Quality Committee member, for a term of 12 months, beginning July 1, 2020 through June 30, 2021, not to exceed 2 hours per month at an hourly rate of $210, for an annual and term cost of $5,040. p) Approval of an agreement with Dr. Ashish Kabra, Non-Invasive Cardiology Medical Director, for a term of 12 months, beginning July 1, 2020, through June 30, 2021, not to exceed 12 hours per month per physician for a total of 144 hours annually, at an hourly rate of $210, for an annual and term cost of $30,240. q) Approval of an agreement with Dr. Ashish Kabra, Cardiovascular Health Institute Quality Committee member, for a term of 12 months, beginning July 1, 2020 through June 30, 2021, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5,040. r) Approval of an agreement with Dr. Ashish Wadhwa to join the existing ENT-Otolaryngology ED On-Call Coverage Physician panel for a term of 13 months, beginning June 1, 2020 through June 30, 2021, at a daily rate of $650 for a term cost of $256,750. s) Approval of an agreement with the Neurology Center of Southern California for increased physician coverage for ARU for a flexible term, not to exceed sixteen (16) months, beginning June 1, 2020 through September 30, 2021 (Dependent on Program Flex) for a monthly cost, not to exceed $6,250 and a total cost for the term not to exceed $100,000. t) Approval of an agreement with Drs. Christopher Devereaux, Thomas Krol, Javaid Shad, Michael Shim and Matthew Viernes as the Gastroenterology		

	Agenda Item	Time Allotted	Requestor
	General & ERCP ED-Call Coverage Physicians for a term of 24 months, beginning July 1, 2020 through June 30, 2022, at a daily rate of $775 for GI for an annual cost of $282, 875 and ERCP at a daily rate of $500 for an annual cost of $182,500 and a total cost for the term of $930,750. u) Approval of an agreement to add Dr. Hussna Wakily to the currently existing Panel Agreement for ED On Call Coverage – General Surgery for a term of 12 months, beginning July 1, 2020 through June 30, 2021. v) Approval of an agreement with Dr. Brian Mudd for Oral/Max Surgery ED Call Coverage for a term of 24 months, beginning July 1, 2020 through June 30, 2022, at a daily rate of $350 for a term cost of $255,500. w) Approval of an agreement with Drs. Anish Kabra, Mohammad Pashmforoush, Pargol Samani, Kenneth Carr, Karim El-Sherief, David Spiegel and Anitha Rajamanickam for Cardiology-General ED Call Coverage for a term of 24 months, beginning July 1, 2020 through June 30, 2022, at a daily rate of $300, for an annual cost of $109,500 and term cost of $219,000. x) Approval of an agreement with Drs. David Spiegel, Kenneth Carr, Karim El Sherief, Anita Rajamanickam for Cardiology-STEMI for a term of 24 months, beginning July 1, 2020 through June 30, 2022, at a daily rate of $1,000 for a total cost of the term of $730,000. y) Approval of an agreement with Drs. Maulik Zaveri, Peter Krall, Srinivas Iyengar, Logan Haak, James Davies, Atul Jain, Neeta Varshney, Jean Paul Abboud, as the Ophthalmology ED-Call Coverage Physicians for a term of 24 months, beginning July 1, 2020 through June 30, 2022, at a daily rate of $300, for an annual cost for FY2021 of $109,500, FY2022 of $109,500 and a total term cost $219,000. z) Approval of an agreement with Drs. Neville Alleyne, David Amory, Payam Moazzaz, Tyrone Hardy, Mark Stern, Kevin Yoo, Sunil Jeswani and Howard Tung as the Spine ED Call Coverage Physicians for a term of 24 months, beginning July 1, 2020 through June 30, 2022, at a daily rate of $450, for a total term cost of $328,500. aa) Approval of an agreement with Drs. Michael Burke, Brian Goelitz, Justin Gooding, Charles McGraw, Michael Noud, Donald Ponec, Cyrus Shabrang and Richard Saxson as the interventional Radiology (IR) ED-Call Coverage Physicians for a term of 24 months, beginning July 1, 2020 through June 30, 2022, at a daily rate of $750, for an annual cost of $273,750 and total term cost of $547,500. bb) Approval of an agreement with Dr. James Johnson, Physician Chairperson of MDQA/Peer Review/QAPI for a term of 12 months, beginning July 1, 2020 through June 30, 2021, not to exceed an average of 33 hours in total per month or 400 hours annually, at an hourly rate of $155 and an Educational Allowance not to exceed $10,000, for an annual cost not to exceed $72,000. (5) Administrative & Board Committees **A. Administrative Policies** **1) Patient Care Services Policies & Procedures** a) Admission Criteria Policy (NEW)		

	Agenda Item	Time Allotted	Requestor
	b) Antimicrobial Stewardship Policy (DELETE) c) Cardiac Rehab Center (On Campus) Emergency Treatment Standardized Procedure d) Catheter Clearance with Alteplase (Cathflo Activase) Procedure (DELETE) e) Chemotherapy Exposure, Spills, and Handling of Linens Contaminated with Chemotherapeutic Agents Procedure f) Chemotherapy Extravasation Procedure g) Code Blue Response Plan Policy h) Enteral Feeding Preparation, Storage, Distribution and Administration Policy i) Food Brought in from Outside the Hospital Policy (DELETE) j) Food Storage on Nursing Units k) Lumbar Drains, Care of Procedure l) Neutropenic Precautions Policy m) Patient Classification (Acuity) Procedure n) Safe Surrender o) Transporting Ventilator Patients Procedure p) Ultrasound Guided Peripheral Intravenous Access q) Utilization of Staff, Staffing Patterns Policy r) Visiting Guidelines **2) Administrative Policies & Procedures District Operations 200** a) Control for Locks and Keys 243 b) Equipment Medical Device Reporting – Sequester 201 c) Helicopters on District Policy 207 d) Signage - 215 **3) Unit Specific – Information Technology 600** a) Access to Restricted Financial, Employee b) Remote or Portable Computing 623 c) Telephone Authorization Code 600 (DELETE) **4) Unit Specific – Cardiac Rehab** a) Glucose Monitoring and Exercise Therapy for Diabetic (DELETE) **5) Unit Specific Emergency Department** a) Wandering Band System Procedure **6) Unit Specific – Home Care** a) Unna Boot Application **7) Unit Specific – Infection Control** a) Risk Assessment and Surveillance Plan **8) Unit Specific – Medical Staff** a) Influenza Vaccination of Physicians and Allied Health Professionals (AHP) 8710-547 b) Standards for Endovascular Repair of Aortic Aneurysms 8710-503 **9) Unit Specific – Neonatal Intensive Care (NICU)** a) Formula, Preparation and Storage of b) Intubation Procedure, NICU c) NICU Disaster Procedure d) Primary Nurse Assignment (DELETE)		

	Agenda Item	Time Allotted	Requestor
	10) Unit Specific – Outpatient Behavioral Health a) Admission to Inpatient Behavioral Health Unit b) Involuntary Patient Detention (DELETE) c) Physician Progress Note d) Psychiatric Emergencies e) Solicitation of Patients & Referral to Self		
	11) Unit Specific – Surgical Services a) Block Time Policy b) Cell Saver Set-up, Use and Monitoring Procedure c) CPR in Surgery Policy d) Hysteroscopy Policy e) Intraoperative Deaths Policy f) Organ Tissue Procurement Policy g) Perioperative Documentation h) Positioning the Surgical Patient Policy i) Scheduling Surgical Procedures Policy j) Surgical Patients with Acid Implant Policy k) Surgical Supply Stocking, Rotation and Outdate l) TCMC Employees and Independent Contractor Work Policy (DELETE) m) Visitors in the OR Policy		
	12) Unit Specific – Women & Newborn Services a) Instrument Cleaning Process and Transport to Sterile Processing Department (SPD)		
	13) Unit Specific – Wound Care a) Medical Equipment Maintenance b) Patient Advocacy c) Patient Charges d) Patient Chart e) Patient Photography f) Patient Reception g) Patient Survey Process i) Program Description j) Registration k) Scheduling l) Staff Development m) Staffing Plan n) Telephone Management o) Wound Measurement p) Wound Staging		
	14) Unit Specific – Wound Hyperbaric Oxygen Therapy a) Patient Changing Area		
	15) Formulary Requests a) Eravcycline (Xerava)		
(6)	Board Committees		
	A. Community Healthcare Alliance Committee Director Chavez, Committee Chair *(No meeting held in May, 2020)*		CHAC Comm.

	Agenda Item	Time Allotted	Requestor
	B. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 0 *(No meeting held in May, 2020)*		FO&P Comm.
	C. Audit, Compliance & Ethics Committee Director Younger, Committee Chair Open Community Seats – 0 *(No meeting held in May, 2020)*		Audit, Comp. & Ethics Comm.
	(7) Minutes – Approval of: a) April 28, 2020, Regular Meeting (8) Meetings and Conferences – None (9) Dues and Memberships - None (10) Reports (a) Dashboard – Included (b) Construction Report – None (c) Lease Report – (April, 2020) (d) Reimbursement Disclosure Report – (April, 2020) (e) Seminar/Conference Reports – None		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
14	Total Time Budgeted for Open Session	1 hour	
15	Adjournment		

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
May 13, 2020

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 5/29/2020 – 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 5/29/2020 through 4/30/2022:

- **BAIRAMIAN, Jack MD/Anesthesiology (ASMG)**
- **FELDMAN, Tatyana MD/Anesthesiology (ASMG)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
May 13, 2020

ADDITIONAL PRIVILEGE REQUEST (Effective 5/29/2020)

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

- **SEIF, Joseph MD** — **Anesthesiology**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
May 13, 2020

PROCTORING RECOMMENDATIONS

- DALLA BETTA, Michael DO — Emergency Medicine
- FARHOOMAND, Kaveh DO — Internal Medicine
- FRANZ, Cortney FNP — Allied Health Professional
- LAWLER, Abigail MD — Internal Medicine
- YAKHNENKO, Ilya MD — Internal Medicine

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
May 13, 2020

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 6/01/2020 – 5/31/2022)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 6/01/2020 through 5/31/2022, 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:

- **BEN-HAIM, Sharona, MD/Neurological Surgery/Active**
- **CHOUDRY, Bilal, MD/Neurology/Active**
- **CONTARDO, Marcus, MD/Pathology/Active**
- **FERNANDEZ, Janice, MD/Anesthesiology/Active**
- **FISCHER, Andrew, MD/Emergency Medicine/Active**
- **GOKALDAS, Reshma, MD/Neurology/Active**
- **GONZALES, Michelle, MD/Family Medicine/Refer and Follow**
- **JAFFER, Jihad, MD/Physical Medicine & Rehab/Provisional**
- **KOBAYASHI, Gary, MD/Internal Medicine/Refer and Follow**
- **KROL, Thomas, MD/Gastroenterology/Active**
- **LE, Yung, MD/Internal Medicine/Active**
- **LEE, Anna, MD/Pediatrics/Active**
- **LEE, Dandy, MD/Anesthesiology/Active**
- **LIAGHAT, Arash, MD/Anesthesiology/Provisional**
- **LINSON, Patrick, MD/Radiation Oncology/Active**
- **MAHIL, Amreesh, MD/Anesthesiology/Active**
- **MCCLAY, Edward, MD/Oncology/Active**

Attachment B

- MITCHELL, Charles, MD/Radiology/Active
- NELSON, Jesse, DO/Anesthesiology/Provisional
- PHILLIPS, Jason, MD/Urology/Active
- RASH, Dominique, MD/Radiation Oncology/Active
- RAYAN, Sunil, MD/Vascular Surgery/Active Affiliate
- TUNG, Howard, MD/Neurological Surgery/Active
- WANG, Chunyang, MD/Neurology/Active

UPDATE TO PREVIOUS REAPPOINTMENT:

- KELLY, Jon, MD/Orthopedic Surgery/Active
- RAJAMANICKAM, Anitha, MD/Interventional Cardiology/Active

RESIGNATIONS: (Effective date 5/31/2020 unless otherwise noted)

Automatic Resignation:

Voluntary:

- CURLEY, Edward, MD/Pediatrics
- SEIGLER, David, MD/Psychiatry
- TRICARICO, Jacqueline, PA/Allied Health Professional
- VERMA, Vishal, MD/Teleradiology

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Privileges in Critical Care Medicine

Provider Name:

Request	Privilege

Criteria:

Initial:
1.Subspecialty Board Certification or actively in the process of obtaining certification by the American Board of Medical Specialties, or the American Osteopathic Association, or have completed a critical care fellowship in the past four (4) years or foreign equivalent training/board..
2. If training was completed more than 24 months prior to application, documentation of provisions of care to at least 50 patients in a critical care unit during the past 12 months as an attending physician reflective of the scope of privileges requested is required.

Proctoring:
Admit patients and Consultation - Six (6) ICU inpatient cases . Perform history & physical examination - Eligible for release from proctoring once six (6) admits or consult cases have been released from proctoring.

Reappointment:
Minimum of 100 cases representative blend of cases within the previous twenty-four (24) months and Maintenance of Certification.

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.

___ Admit patients

___ Consultation, including via telemedicine (F) and sleep tests/polysomnography

___ Perform history & physical examination, including via telemedicine (F)

___ **GENERAL CRITICAL CARE PRIVILEGES:** By selecting this privilege, you are requesting the General Critical Care privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

___ Airway maintenance, including intubation
___ Ventilator management
___ Insertion and management of arterial and pulmonary artery catheters
___ Calibration and operation of hemodynamic recording systems
___ Diagnostic paracentesis
___ Tube thoracostomy
___ Percutaneous
___ Open
___ Gastroesophageal balloon tamponade
___ Emergency pericardiocentesis
___ Emergency tracheostomy/cricothroidotomy
Central Venous Insertion
Fiberoptic Bronchoscopy
____ Diagnostic
____ Therapeutic

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Privileges in Critical Care Medicine

Provider Name:

Request	Privilege

SPECIAL PRIVILEGES:

Description: Must also meet Required Qualifications for Core Privileges

___ Percutaneous tracheostomy/cricothyrotomy tube placement*

Percutaneous Tracheostomy /cricothyrotomy tube placement Criteria:

Initial:

1. Concomitant bronchoscopy privileges
2. Documentation of hands-on training course required if residency or fellowship training did not include training for percutaneous tracheostomy. If training was completed more than 24 months prior to application, documentation of five (5) cases is required.

Proctoring: Three (3) cases

Reappointment: Five (5) cases within the previous twenty-four (24) months

___ Administration of Moderate sedation (Refer to Medical Staff policy #8710-517 for Initial, Proctoring, and Reappointment Criteria)

___ Use of fluoroscopy equipment (Valid Radiology Supervisor and Operator Certificate or Fluoroscopy Supervisor and Operator Permit required.

_____

Print Applicant Name

_____

Applicant Signature

_____

Date

_____

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

_____

Date

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
NSURANCE RENEWAL PROPOSAL – MC GRIFF INSURANCE SERVICES, INC.

Type of Agreement		Medical Directors		Panel	X	Other: Property & Casualty Insurance Renewal
Status of Agreement		New Agreement	X	Renewal – New Rates		Renewal – Same Rates

Vendor's Name: Various Insurance Carriers – See Attached Executive Premium Summary

Area of Service: Finance Department

Term of Agreement: 12 months, Beginning, July 1, 2020 – Ending, June 30, 2021

Maximum Totals:

Annual Cost	Total Term Cost
$1,822,985	$1,822,985

Description of Services/Supplies:

- Umbrella Professional and General Liability Insurance (Zurich)
- Property Insurance & Cyber Insurance (AIG)
- Management Liability Insurance (AIG & RSUI)
- Automobile Insurance (Philadelphia)
- Pollution Insurance (Tokio Marine)
- Others: Volunteers, Employed Lawyers, Heli-Pad Liability, GL/PL TPA Contract

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

***To be included in proposed FY Budget*

Person responsible for oversight of agreement: Susan Bond, General Counsel / Ray Rivas, Chief Financial Officer

Motion:
I move that the TCHD Board of Directors authorize the agreement with the various carriers as reflected on the accompanying Executive Summary through McGriff Insurance Services, Inc. for a term of 12 months, beginning July 1, 2020 and ending June 30, 2021 for a total annual/term cost of $1,822,985.

EXECUTIVE SUMMARY – 2020-2021

Thank you for the opportunity to present our renewal proposal for Tri-City District Healthcare. A quick snapshot of your renewal pricing to your expiring premium is as follows:

Coverage	2019 Company	AM Best Rating	2019 Premiums	2020 Premiums	$ Change
Umbrella					
(GL/PL $20M w/ $2M SIR)	Zurich	A (Excellent) XV	$318,000	$360,000	$42,000
Claims TPA	Western Litigation		$65,000	$65,000	0
			$383,000	**$425,000**	$42,000
Automobile	Philadelphia	A++ (Superior) XV	$66,454	$62,219	($4,235)
Property	AIG	A (Excellent) XV	$335,285	$362,389	$27,104
Cyber	AIG	A (Excellent) XV	$64,754	$65,313	$559
Directors & Officers / Employment Practices / Fiduciary Liability					
Primary $5M	AIG	A (Excellent) XV	$393,750	$450,000	$56,250
$5M XS $5M	RSUI	A (Excellent) XV	$185,625	$212,140	$26,515
Excess Side A - $5mm x $10mm	AIG	A (Excellent) XV	$164,700	$164,300	($400)
Cardiovascular Institute	AIG	A (Excellent) XV	$12,000	$25,000	$13,000
Orthopedic Institute	AIG	A (Excellent) XV	$18,064	$0	($18,064)
Neuro Institute	AIG	A (Excellent) XV	$18,064	$0	($18,064
Crime – 3 Year Term 2018/2021; Billed in Full 2018	Fidelity & Deposit Companies (Zurich)	A+ (Superior) XV	$0	$0	3-Yr. Term
Pollution	Tokio Marine	A+ + (Superior) XV	$46,911	$37,145	($9,766)
Student Accident	Axis	A+ (Superior) XV	$1,761	$1,593	($168)
Employed Lawyers	Philadelphia	A++ (Superior) XV	$10,781	$10,781	$0
Heli-Pad Liability	American Alternative	A+ (Superior) XV	$5,465	$7,105	$1,640
			$1,706,614	**$1,822,985**	**$116,371**

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
PHYSICIAN AGREEMENT FOR COVERING PHYSICIAN – INPATIENT WOUND CARE

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

Physician's Name: Henry Showah, M.D.

Area of Service: Inpatient Wound Care

Term of Agreement: 12 months, Beginning, May 1, 2020 - Ending, April 30, 2021

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

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	12 month (Term) Cost
$180	20	240	$3,600	$43,200

Position Responsibilities:

- Provide supervision for the clinical operation of the Inpatient Wound Care Team
- Provide staff education to improve outcome of care
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Ensure that services provided are in compliance with regulatory standards
- Participate in Quality Assurance and Performance Improvement activities
- Timely communication with primary care physicians and/or other community health resources
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions
- Utilization Review, Quality Improvement: Actively participate in hospital and Medical Staff utilization review, quality, performance improvement and risk programs

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

***To be included in the proposed FY Budget*

Person responsible for oversight of agreement: Kim Poston, Manager-Clinical, Wound Care Carlsbad / Barbara Vogelsang, Chief Nurse Executive

Motion: I move that the TCHD Board of Directors authorize Dr. Henry Showah, Coverage Physician for Inpatient Wound Care for a term of 12 months beginning May 1, 2020, and ending April 30, 2021, not to exceed an average of 20 hours a month, at an hourly rate of $180 for a total annual and term cost of $43,200.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
PHYSICIAN AGREEMENT FOR COVERING PHYSICIAN – OUTPATIENT WOUND CARE

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

Physician's Name: Henry Showah, M.D.

Area of Service: Outpatient Wound Care

Term of Agreement: 12 months, Beginning, May 1, 2020 - Ending, April 30, 2021

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

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	12 month (Term) Cost
$180	20	240	$3,600	$43,200

Position Responsibilities:

- Provide supervision for the clinical operation of the Outpatient Wound Care Team
- Provide staff education to improve outcome of care
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Ensure that services provided are in compliance with regulatory standards
- Participate in Quality Assurance and Performance Improvement activities
- Timely communication with primary care physicians and/or other community health resources
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions
- Utilization Review, Quality Improvement: Actively participate in hospital and Medical Staff utilization review, quality, performance improvement and risk programs

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

***To be included in the proposed FY Budget*

Person responsible for oversight of agreement: Kim Poston, Manager-Clinical, Wound Care Carlsbad / Barbara Vogelsang, Chief Nurse Executive

Motion: I move that the TCHD Board of Directors authorize Dr. Henry Showah as the Coverage Physician for Outpatient Wound Care for a term of 12 months from May 1, 2020, and ending April 30, 2021, not to exceed an average of 20 hours a month, at an hourly rate of $180 for a total annual and term cost of $43,200.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
PHYSICIAN AGREEMENT FOR COVERING PHYSICIAN – INPATIENT WOUND CARE

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

Physician's Name: Sharon Slowik, M.D.

Area of Service: Inpatient Wound Care

Term of Agreement: 12 months, Beginning, May 1, 2020 - Ending, April 30, 2021

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

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	12 month (Term) Cost
$180	20	240	$3,600	$43,200

Position Responsibilities:

- Provide supervision for the clinical operation of the Inpatient Wound Care Team
- Provide staff education to improve outcome of care
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Ensure that services provided are in compliance with regulatory standards
- Participate in Quality Assurance and Performance Improvement activities
- Timely communication with primary care physicians and/or other community health resources
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions
- Utilization Review, Quality Improvement: Actively participate in hospital and Medical Staff utilization review, quality, performance improvement and risk programs

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

***To be included in the proposed FY Budget*

Person responsible for oversight of agreement: Kim Poston, Manager-Clinical, Wound Care Carlsbad / Barbara Vogelsang, Chief Nurse Executive

Motion: I move that the TCHD Board of Directors authorize Dr. Sharon Slowik as the Coverage Physician for Inpatient Wound Care for a term of 12 months from May 1, 2020, and ending April 30, 2021, not to exceed an average of 20 hours a month, at an hourly rate of $180 for a total cost for the term of $43,200.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
PHYSICIAN AGREEMENT FOR COVERING PHYSICIAN – OUTPATIENT WOUND CARE

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

Physician's Name: Sharon Slowik, M.D.

Area of Service: Outpatient Wound Care

Term of Agreement: 12 months, Beginning, May 1, 2020 - Ending, April 30, 2021

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

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	12 month (Term) Cost
$180	20	240	$3,600	$43,200

Position Responsibilities:

- Provide supervision for the clinical operation of the Outpatient Wound Care Team
- Provide staff education to improve outcome of care
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Ensure that services provided are in compliance with regulatory standards
- Participate in Quality Assurance and Performance Improvement activities
- Timely communication with primary care physicians and/or other community health resources
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions
- Utilization Review, Quality Improvement: Actively participate in hospital and Medical Staff utilization review, quality, performance improvement and risk programs

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

***To be included in the proposed FY Budget*

Person responsible for oversight of agreement: Kim Poston, Manager-Clinical, Wound Care Carlsbad / Barbara Vogelsang, Chief Nurse Executive

Motion: I move that the TCHD Board of Directors authorize Dr. Sharon Slowik as the Coverage Physician for Outpatient Wound Care for a term of 12 months beginning May 1, 2020 and ending April 30, 2021, not to exceed an average of 20 hours a month for a total cost for the term of $43,200.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
CARDIOVASCULAR HEALTH INSTITUTE – SPECIALTY MEDICAL DIRECTORSHIP

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

Vendor's Name: Yuan Hwang Lin, M.D. - Cardiothoracic Medical Director

Area of Service: Cardiovascular Health Institute

Term of Agreement: 12 months, Beginning, July 1, 2020 – Ending, June 30, 2021

Maximum Totals:

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$210	12	144	$2,520	$30,240	$30,240

Description of Services/Supplies:

Physicians shall service as Medical Director and shall be responsible for the medical direction of the listed specialty area and the performance of the other medical administrative service as outlined in the previously approved Co-Management Agreement for the Institute.

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

**To be included in the proposed FY Budget*

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

Motion:

I move that the TCHD Board of Directors authorize the agreement with Dr. Yuan Hwang Lin as the Cardiovascular Medical Director for a term of 12 months, beginning July 1, 2020 through June 30 2021, not to exceed 12 hours per month for a total of 144 hours annually, at an hourly rate of $210 for an annual and term cost of $30,240.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
PHYSICIAN AGREEMENT FOR CARDIOVASCULAR HEALTH INSTITUTE – OPERATIONS COMMITTEE

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

Vendor's Name: Dr. Yuan Hwang Lin

Area of Service: Cardiovascular Health Institute – Operations Committee

Term of Agreement: 12 months, Beginning, July 1, 2020 – Ending, June 30, 2021

Maximum Totals:

Rate/Hour	Hours Per Month	Hours per Year	Monthly Cost	Annual Cost	Total Term Cost
$210	2	24	$420	$5040	$5040

Description of Services/Supplies:

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

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

**To be included in the proposed FY Budget*

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

Motion:
I move that that the TCHD Board of Directors authorize the agreement with Dr. Yuan Hwang Lin as Cardiovascular Health Institute – Operations Committee member for a term of 12 months, beginning July 1, 2020 through June 30, 2021, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5,040.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
PHYSICIAN FOR CARDIOVASCULAR HEALTH INSTITUTE – OPERATIONS COMMITTEE

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

Vendor's Name: Dr. Anitha Rajamanickam

Area of Service: Cardiovascular Health Institute – Operations Committee

Term of Agreement: 12 months, Beginning, July 1, 2020 – Ending, June 30, 2021

Maximum Totals:

Rate/Hour	Hours Per Month	Hours per Year	Monthly Cost	Annual Cost	Total Term Cost
$210	2	24	$420	$5040	$5040

Description of Services/Supplies:

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

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

**To be included in the proposed FY Budget*

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

Motion:
I move that the TCHD Board of Directors authorize the agreement with Dr. Anitha Rajamanickam, Cardiovascular Health Institute – Operations Committee member for a term of 12 months, beginning July 1, 2020 through June 30, 2021, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5,040.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
PHYSICIAN AGREEMENT FOR PULMONARY REHABILITATION SERVICE LINE

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

Vendor's Name: Dr. Frank Corona
Dba Tri-City Pulmonary Medical Group, A professional Corporation

Area of Service: Pulmonary Services Department

Term of Agreement: 24 months, Beginning, July 1, 2020 – Ending, June 30, 2022

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

Rate/Hour	Hours Per Month	Hours per Year	Monthly Cost	Annual Cost	Total Term Cost
$175	20	240	$3,500	$42,000	$84,000

Description of Services/Supplies:

- Medical Director Leadership support of the Pulmonary Rehabilitation service line.
- Medical Leadership oversight of the respiratory care department (Pulmonary Services) and the respiratory care practitioners.
- Review and make recommendation regarding clinical applications of respiratory care. Assistance in developing policies, procedures, clinical protocols, forms, reports and records by TCMC in connection with the department.
- Assist with the provision and design of educational services to the respiratory care staff members.

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

**To be included in the proposed FY Budget*

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

Motion:
I move that the TCHD Board of Directors authorize the agreement with Dr. Frank Corona as the Pulmonary Rehab Medical Director for a term of 24 months, beginning July 1, 2020 through June 30, 2022, not to exceed 20 hours per month at an hourly rate of $175 for an annual cost of $42,000 and a total contract term of $84,000.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
PHYSICIAN AGREEMENT FOR CARDIOVASCULAR HEALTH INSTITUTE– OPERATIONS COMMITTEE

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

Vendor's Name: Dr. Jamshidi-Nezhad, Mohammad

Area of Service: Cardiovascular Health Institute – Operations Committee

Term of Agreement: 12 months, Beginning, July 1, 2020 – Ending, June 30, 2021

Maximum Totals:

Rate/Hour	Hours Per Month	Hours per Year	Monthly Cost	Annual Cost	Total Term Cost
$210	2	24	$420	$5040	$5040

Description of Services/Supplies:

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

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

**To be included in the proposed FY Budget*

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

Motion:
I move that the TCHD Board of Directors authorize the agreement with Drs. Dr. Jamshidi-Nezhad, Mohammad as Cardiovascular Health Institute – Operations Committee member for a term of 12 months, beginning July 1, 2020 through June 30, 2021, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5,040.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
CARDIOVASCULAR HEALTH INSTITUTE–SPECIALTY MEDICAL DIRECTOR

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

Vendor's Name: David Spiegel, M.D. - Invasive Cardiology, Medical Director

Area of Service: Cardiovascular Health Institute

Term of Agreement: 12 months, Beginning, July 1, 2020 – Ending, June 30, 2021

Maximum Totals:

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$210	12	144	$2,520	$30,240	$30,240

Description of Services/Supplies:

Physicians shall service as Medical Director and shall be responsible for the medical direction of the listed specialty area and the performance of the other medical administrative service as outlined in the previously approved Co-Management Agreement for the Institute.

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

**To be included in the proposed FY Budget*

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

Motion:

I move that the TCHD Board of Directors authorize the agreement with Dr. David Spiegel as the Invasive Cardiology Medical Director for a term of 12 months, beginning July 1, 2020 – Ending June 30 2021, not to exceed 12 hours per month for a total of 144 hours annually, at an hourly rate of $210 for an annual and term cost of $30,240.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
PHYSICIAN AGREEMENT FOR CARDIOVASCULAR HEALTH INSTITUTE – OPERATIONS COMMITTEE

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

Vendor's Name: Dr. David Spiegel

Area of Service: Cardiovascular Health Institute – Operations Committee

Term of Agreement: 12 months, Beginning, July 1, 2020 – Ending, June 30, 2021

Maximum Totals:

Rate/Hour	Hours Per Month	Hours per Year	Monthly Cost	Annual Cost	Total Term Cost
$210	2	24	$420	$5040	$5040

Description of Services/Supplies:

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

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

**To be included in the proposed FY Budget*

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

Motion:
I move that the TCHD Board of Directors authorize the agreement with Dr. Spiegel David as Cardiovascular Health Institute – Operations Committee member for a term of 12 months, beginning July 1, 2019 through June 30, 2021, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5040.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
CARDIOVASCULAR HEALTH INSTITUTE MEDICAL DIRECTOR

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

Vendor's Name: Dr. Donald Ponec, Cardiovascular Health Institute Medical Director

Area of Service: Cardiovascular Health Institute

Term of Agreement: 12 months, Beginning, July 1, 2020 – Ending, June 30, 2021

Maximum Totals:

Rate/Hour	Hours Per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$210	8	96	$1,680	$20,160	$20,160

Description of Services/Supplies:

Physicians shall service as the Institute Medical Director and shall be responsible for the medical direction of the Institute and the performance of the other medical administrative service as outlined in the previously approved Co-Management Agreement for the Institute.

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

**To be included in the proposed FY Budget*

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

Motion:

I move that the TCHD Board of Directors authorize the agreement with Dr. Donald Ponec as the Cardiovascular Health Institute Medical Director for a term of 12 months, beginning July 1, 2020 through June 30 2021, not to exceed an average 8 hours per month or 96 hours annually, at an hourly rate of $210 for an annual and term cost of $20,160.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
PHYSICIAN AGREEMENT FOR CARDIOVASCULAR HEALTH INSTITUTE– QUALITY COMMITTEE

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

Vendor's Name: Dr. Donald Ponec

Area of Service: Cardiovascular Health Institute – Quality Committee

Term of Agreement: 12 months, Beginning, July 1, 2020 – Ending, June 30, 2021

Maximum Totals:

Rate/Hour	Hours Per Month	Hours per Year	Monthly Cost	Annual Cost	Total Term Cost
$210	2	24	$420	$5040	$5040

Description of Services/Supplies:

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

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

**To be included in the proposed FY Budget*

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

Motion:
I move that the TCHD Board of Directors authorize the agreement with Dr. Donald Ponec as Cardiovascular Health Institute – Quality Committee member for a term of 12 months, beginning July 1, 2020 through June 30, 2021, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5040.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
CARDIOVASCULAR HEALTH INSTITUTE– SPECIALITY MEDICAL DIRECTORSHIP

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

Vendor's Name: Ashish Kabra, M.D. – Non-Invasive Cardiology, Medical Director

Area of Service: Cardiovascular Health Institute

Term of Agreement: 12 months, Beginning, July 1, 2020 – Ending, June 30, 2021

Maximum Totals:

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$210	12	144	$2,520	$30,240	$30,240

Description of Services/Supplies:

Physicians shall service as Medical Director and shall be responsible for the medical direction of the listed specialty area and the performance of the other medical administrative service as outlined in the previously approved Co-Management Agreement for the Institute.

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

**To be included in the proposed FY Budget*

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

Motion:

I move that the TCHD Board of Directors authorize the agreement with Dr. Ashish Kabra as the Non-Invasive Cardiology Medical Director for a term of 12 months, beginning July 1, 2020 through June 30 2021, not to exceed 12 hours per month per physician for a total of 144 hours annually, at an hourly rate of $210 for an annual and term cost of $30,240.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
PHYSICIAN AGREEMENT FOR CARDIOVASCULAR HEALTH INSTITUTE – QUALITY COMMITTEE

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

Vendor's Name: Dr. Ashish Kabra

Area of Service: Cardiovascular Health Institute – Quality Committee

Term of Agreement: 12 months, Beginning, July 1, 2020 – Ending, June 30, 2021

Maximum Totals:

Rate/Hour	Hours Per Month	Hours per Year	Monthly Cost	Annual Cost	Total Term Cost
$210	2	24	$420	$5040	$5040

Description of Services/Supplies:

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

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

**To be included in the proposed FY Budget*

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

Motion:
I move that the TCHD Board of Directors authorize the agreement with Dr. Ashish Kabra as Cardiovascular Health Institute – Quality Committee member for a term of 12 months, beginning July 1, 2019 through June 30, 2021, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5,040.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: May 27, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – ENT - Otolaryngology

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

Physician's Name(s): Ashish Wadhwa, M.D.
Area of Service: Emergency Department On-Call: ENT - Otolaryngology

Term of Agreement: 13 months, Beginning, June 1, 2020 – Ending, June 30, 2021

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: ENT – Otolaryngology

Rate/Day	Panel Days per Year	Panel Annual Cost
$650	FY20(6/1-6/30/20): 30 days FY21: 365 days	FY20: $19,500 FY22: $237,250
	Total Term Cost:	**$256,750**

Position Responsibilities:

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

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

**To be included in the proposed FY Budget*

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff Services / Gene Ma, MD, Chief Medical Officer

Motion: I move that the TCHD Board of Directors authorize physician Ashish Wadhwa, M.D. to join the existing ENT - Otolaryngology ED On-Call Coverage Physician contract for a term of 13 months, beginning June 1, 2020 and ending June 30, 2021 at a daily rate of $650 for a total term cost of $256,750.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
INCREASED ACUTE REHABILITATION UNIT (ARU) COVERAGE PROPOSAL

Type of Agreement		Medical Directors	X	Panel	X	Other: Increased ARU Physician Coverage
Status of Agreement	X	AMENDMENT		Renewal – New Rates		Renewal – Same Rates

Vendor's Name: The Neurology Center of Southern California

Area of Service: Increased Physician Coverage for Acute Rehabilitation Unit (ARU)

Term of Agreement: Flexible - not to exceed Sixteen (16) months, Beginning, June 01, 2020 – Ending, September 31, 2021 (Dependent on Program Flex)

Bid Process Requirement:

Yes		**No**	X

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$6,250	**NTE** $75,000	**NTE** $100,000

Description of Services:

- The Neurology Center of Southern California will provide additional physician coverage for up to twenty (20) ARU patients at Tri-City Medical Center as part of development and implementation of the State of Emergency Temporary Program Flex.
- The term of the amendment could be effective June 01, 2020 and duration of service will be dependent on the length of time the SD CDPH Program Flex remains in force.

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

**To be included in Proposed Budget*

Person responsible for oversight of agreement: (Scott Livingstone)

Motion:
I move that the TCHD Board of Directors authorize the agreement with The Neurology Center of Southern California for increased physician coverage for ARU for a flexible term not to exceed sixteen (16) months, beginning June 01, 2020 and ending September 31, 2021 (Dependent on Program Flex) for a monthly cost not to exceed $6,250, and a total cost for the term not to exceed $100,000.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE - Gastroenterology – General & ERCP

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

Physician's Name: Christopher Devereaux, M.D., Thomas Krol, M.D., Javaid Shad, M.D., Michael Shim, M.D., Matthew Viernes, M.D.

Area of Service: Emergency Department On-Call: Gastroenterology – General & ERCP

Term of Agreement: 24 months, Beginning, July 1, 2020 – Ending, June 30, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: Gastroenterology

Rate/Day	Panel Days per Year	Annual Panel Cost
GI -$775 ERCP-$500	FY21:365 FY21:365 FY22:365 FY22:365	$282,875 $182,500 $282,875 $182,500
	Total Term Cost:	**$930,750**

Position Responsibilities:

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

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

**To be included in the proposed FY Budget*

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff Services / Gene, Ma, M.D., Chief Medical Officer

Motion:
I move that the TCHD Board of Directors authorize physicians Christopher Devereaux, M.D.; Thomas Krol, M.D.; Javaid Shad, M.D.; Michael Shim, M.D.; Matthew Viernes, M.D. as the Gastroenterology General & ERCP ED-Call Coverage Physicians for a term of 24 months, beginning July 1, 2020 and ending June 30, 2022 at a daily rate of $775 for GI, for an annual cost of $282,875 and ERCP at a daily rate of $500 for an annual cost of $182,500, and a total cost for the term of $930,750.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – General Surgery

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

Physician's Name: Hussna Wakily, M.D.

Area of Service: Emergency Department On-Call: General Surgery

Term of Agreement: 12 months, Beginning, July 1, 2020 – Ending June 30, 2021

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Adding physician to existing panel; no increase in expense

Rate/Day	Panel Days per Year	Panel Annual Cost
$1,400	FY21: 365 days	$511,000
	Total Term Cost:	**$511,000**

Unfunded Cholecystectomy Cost	Estimated Cases per Year	Estimated Annual Cost
$725, per case	FY21: 36	$26,100
Unfunded Laparoscopic Cholecystectomy with Common Bile Duct Exploration	**Estimated Cases per Year**	**Estimated Annual Cost**
Procedure Code 47564: $1,144.51, per case	FY21: 5	$5,722.55
Procedure Code 47550: $168.05, per case	FY21: 5	$840.25
	Total Term Cost:	**$32,662.80**

Position Responsibilities:

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

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

*To be included in the proposed FY Budget

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff Services / Gene Ma, MD, Chief Medical Officer

Motion: I move that the TCHD Board of Directors approve the agreement to add Dr. Hussna Wakily to the currently existing Panel Agreement for ED On-Call Coverage-General Surgery for a term of 12 months, beginning July 1, 2020 through June 30, 2021.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Oral/Max Surgery

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

Physician's Name: Brian Mudd, D.D.S.

Area of Service: Emergency Department On-Call: Oral/Max Surgery

Term of Agreement: 24 months, Beginning, July 1, 2020 – Ending, June 30, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: Oral/Max Surgery

Rate/Day	Panel Days per Year	Panel Annual Cost
$350	FY21: 365 days FY22: 365 days	$127,750 $127,750
	Total Term Cost:	**$255,500**

Position Responsibilities:

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

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

**To be included in the proposed FY Budget*

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff Services / Gene Ma, M.D., Chief Medical Officer

Motion: I move that theTCHD Board of Directors authorize physician Brian Mudd, D.D.S. as the Oral /Max Surgery ED -Call coverage physician for a term of 24 months, beginning July 1, 2020 and ending June 30, 2022 at a daily rate of $350, for a term cost of $255,500.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – CARDIOLOGY, GENERAL

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

Physician's Name: Anish Kabra, M.D.; Mohammad Pashmforoush, M.D.; Pargol Samani, M.D.; David Spiegel, M.D.; Kenneth Carr, M.D.; Karim El-Sherief, M.D.; Anitha Rajamanickam, M.D.

Area of Service: Emergency Department On-Call: Cardiology, General

Term of Agreement: 24 months, Beginning, July 1, 2020 – Ending, June 30, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: General Cardiology

Rate/Day	Panel Days per Year	Panel Annual Cost
$300	FY21: 365 FY22: 365	$109,500 $109,500
	Total Term Cost:	**$219,000**

Position Responsibilities:

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

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

**To be included in the proposed FY Budget*

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff Services / Gene Ma, MD, Chief Medical Officer

Motion: I move that the TCHD Board of Directors authorize Drs. Anish Kabra, Mohammad Pashmforoush, Pargol Samani, Kenneth Carr; Karim El-Sherief, David Spiegel; and Anitha Rajamanickam, M.D. as the Cardiology-General ED -Call coverage physicians for a term of 24 months, beginning July 1, 2020 ending June 30, 2022, at a daily rate of $300, for an annual cost of $109,500 and total term cost of $219,000.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: May 28, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Cardiology-STEMI

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

Physician's Name: David Spiegel, M.D.; Kenneth Carr, M.D.; Karim El Sherief, M.D.; Anitha Rajamanickam, M.D.

Area of Service: Emergency Department On-Call: Cardiology-STEMI

Term of Agreement: 24 months, Beginning, July 1, 2020 – Ending, June 30, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: Cardiology-STEMI

Rate/Day	Panel Days per Year	Panel Annual Cost
$1,000 - STEMI	FY21: 365 FY22: 365	$365,000 $365,000
	Total Term Cost:	**$730,000**

Position Responsibilities:

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

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

**To be included in the proposed FY Budget*

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff / Gene Ma, MD, Chief Medical Officer

Motion: I move that the TCHD Board of Directors authorize David Spiegel, M.D.; Kenneth Carr, M.D.; Karim El Sherief, M.D.; Anitha Rajamanickam, M.D. as the coverage physicians for Cardiology-STEMI for a term of 24 months, beginning July 1, 2020 and ending June 30, 2022, at a daily rate of $1,000, for an annual cost of $365,000 and a total term cost of $730,000.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Ophthalmology

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

Physician's Name: Maulik Zaveri, MD; Peter Krall, MD; Srinivas Iyengar, MD; Logan Haak, MD; James Davies, MD; Atul Jain, MD; Neeta Varshney, MD; Jean Paul Abboud, MD

Area of Service: Emergency Department On-Call: Ophthalmology
Term of Agreement: 24 months, Beginning, July 1, 2020 – Ending, June 30, 2022
Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Maximum Totals: For entire Current ED On-Call Area of Service Coverage: Ophthalmology
No increase in Expense

Rate/Day	Panel Days per Year	Panel Annual Cost
$300/Day	FY21: 365 FY22:365	$109,500 $109,500
	Total Term Cost:	**$219,000**

Position Responsibilities:

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

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

*To be included in proposed FY Budget.

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff / Gene Ma, M.D., Chief Medical Officer

Motion: I move that the TCHD Board of Directors authorize Maulik Zaveri, MD; Peter Krall, MD; Srinivas Iyengar, MD; Logan Haak, MD; James Davies, MD; Atul Jain, MD; Neeta Varshney, MD: Jean Paul Abboud, MD as the Ophthalmology ED-Call Coverage Physicians for a term of 24 months, beginning July 1, 2020 and ending June 30, 2022 at a daily rate of $300 , for an annual cost of $109,500 and a total term cost of $219,000.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Ophthalmology

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

Physician's Name: Maulik Zaveri, MD; Peter Krall, MD; Srinivas Iyengar, MD; Logan Haak, MD; James Davies, MD; Atul Jain, MD; Neeta Varshney, MD; Jean Paul Abboud, MD

Area of Service: Emergency Department On-Call: Ophthalmology
Term of Agreement: 24 months, Beginning, July 1, 2020 – Ending, June 30, 2022
Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Maximum Totals: For entire Current ED On-Call Area of Service Coverage: Ophthalmology
No increase in Expense

Rate/Day	Panel Days per Year	Panel Annual Cost
$300/Day	FY21: 365 FY22:365	$109,500 $109,500
	Total Term Cost:	**$219,000**

Position Responsibilities:

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

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

*To be included in proposed FY Budget.

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff / Gene Ma, M.D., Chief Medical Officer

Motion: I move that the TCHD Board of Directors authorize Maulik Zaveri, MD; Peter Krall, MD; Srinivas Iyengar, MD; Logan Haak, MD; James Davies, MD; Atul Jain, MD; Neeta Varshney, MD: Jean Paul Abboud, MD as the Ophthalmology ED-Call Coverage Physicians for a term of 24 months, beginning July 1, 2020 and ending June 30, 2022 at a daily rate of $300 , for an annual cost of $109,500 and a total term cost of $219,000.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – SPINE

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

Physician's Name: Neville Alleyne, MD; David Amory MD; Payam Moazzaz MD; Tyrone Hardy MD; Mark Stern MD; Kevin Yoo MD; Sunil Jeswani MD; and Howard Tung MD;

Area of Service: Emergency Department On-Call: Spine

Term of Agreement: 24 months, Beginning, July 1, 2020 – Ending, June 30, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: SPINE

Rate/Day	Panel Days per Year	Panel Annual Cost
$450	FY21:365 FY22:365	$164,250 $164,250
	Total Term Cost:	**$328,500**

Position Responsibilities:

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

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

*To be included in the proposed FY Budget

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff/ Gene, Ma, MD, Chief Medical Officer

Motion:

I move that the TCHD Board of Directors authorize Alleyne Neville MD, David Amory MD, Payam Moazzaz MD, Tyrone Hardy MD, Mark Stern MD, Kevin Yoo MD, Sunil Jeswani MD and Howard Tung MD as the Spine ED-Call Coverage Physicians for a term of 24 months, beginning July 1, 2020 and ending June 30, 2022, at a daily rate of $450, for a total term cost of $328,500.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MAY 28, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE–Interventional Radiology (IR)

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

Physician's Name: Michael Burke, M.D.; Brian Goelitz, M.D.; Justin Gooding, M.D.; Charles McGraw, M.D.; Michael Noud, M.D.; Donald Ponec, M.D.; Richard Saxon, M.D.

Area of Service: Emergency Department On-Call: Interventional Radiology (IR)

Term of Agreement: 24 months, Beginning, July 1, 2020 – Ending, June 30, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: IR

Rate/Day	Panel Days per Year	Panel Annual Cost
$750	FY21:365 FY22:365	$273,750 $273,750
	Total Term Cost:	**$547,500**

Position Responsibilities:

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

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

**To be included in the proposed FY Budget*

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff Services / Gene, Ma, M.D., Chief Medical Officer

Motion: I move that the TCHD Board of Directors authorize Drs. Michael Burke, Brian Goelitz, Justin Gooding, Charles McGraw, Michael Noud, Donald Ponec, and Richard Saxon as the Interventional Radiology (IR) ED-Call Coverage Physicians for a term of 24 months, beginning July 1, 2020 and ending June 30, 2022 at a daily rate of $750 for an annual cost of $273,750 and a total term cost of $547,500.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: May 28, 2020
Medical Staff Leadership Agreement-MDQA Peer Review and QAPI Committees

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

Physician's Name: James Johnson, MD (Manta Med)

Area of Service: Medical Staff: MDQA Peer Review and QAPI Committees

Term of Agreement: 12 months, Beginning, July 1, 2020 – Ending, June 30, 2021

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

Rate/Hour	Maximum Hours per Month	Hours per Year Not to Exceed	Monthly Cost NTE	Annual/ Term Cost Not to Exceed
$155	33	400	$5166.67	$62,000
Education Allowance – Annual Maximum NTE				$10,000
			Total Cost:	**$72,000**

Position Responsibilities:

Chairperson MDQA Peer Review and QAPI Committees:

Promote initiatives for improving quality of patient care and services within TCHD

- Lead MDQA Peer Review and QAPI as Physician Chairperson;
- Provides Medical oversight for Quality/Performance Improvement regarding patient care;
- Evaluates with the MDQA-Peer Review and QAPI members effectiveness of Teams leading QA/PI initiatives;
  - Makes recommendations, with the QAPI members, for initiative interventions and outcomes
- Identify opportunities for improvement;
- Makes recommendations to develop processes to fill in gaps in systems;
- Attends National Association Healthcare Quality annually, when able, to bring best practice recommendations to the QAPI membership;

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 / Gene Ma, MD, Chief Medical Officer

Motion: I move that the TCHD Board of Directors authorize James Johnson, MD as the Physician Chairperson of MDQA/Peer Review/QAPI for a term of 12 months, beginning July 1, 2020 and ending June 30, 2021, not to exceed an average of 33 hours in total per month or 400 hours annually, at an hourly rate of $155 for an annual cost of $62,000, an Educational Allowance not to exceed $10,000 and a total for the term not to exceed $72,000.

ADMINISTRATION CONSENT AGENDA
May 21st, 2020

CONTACT: Barbara Vogelsang, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Admission Criteria Policy	Practice Change	Forward To BOD For Approval
2. Antimicrobial Stewardship Policy	3 Year Review, Practice Change	Forward To BOD For Approval
3. Cardiac Rehab Center (On Campus) Emergency Treatment Standardized Procedure	2 Year Review, Practice Change	Forward To BOD For Approval
4. Catheter Clearance with Alteplase (Cathflo Activase) Procedure	DELETE	Forward To BOD For Approval
5. Chemotherapy Exposure, Spills, and Handling of Linens Contaminated with Chemotherapeutic Agents Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
6. Chemotherapy Extravasation Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
7. Code Blue Response Plan Policy	3 Year Review, Practice Change	Forward To BOD For Approval
8. Enteral Feeding Preparation, Storage, Distribution, and Administration Policy	3 Year Review, Practice Change	Forward To BOD For Approval
9. Food Brought in from Outside the Hospital Policy	DELETE	Forward To BOD For Approval
10. Food Storage on Nursing Units	3 Year Review, Practice Change	Forward To BOD For Approval
11. Lumbar Drains, Care of Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
12. Neutropenic Precautions Policy	3 Year Review, Practice Change	Forward To BOD For Approval
13. Patient Classification (Acuity) Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
14. Safe Surrender	3 Year Review, Practice Change	Forward To BOD For Approval
15. Transporting Ventilator Patients Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
16. Ultrasound Guided Peripheral Intravenous Access	3 Year Review	Forward To BOD For Approval
17. Utilization of Staff, Staffing Patterns Policy	3 Year Review	Forward To BOD For Approval
18. Visiting Guidelines	3 Year Review	Forward To BOD For Approval
Administrative Policies & Procedures		
District Operations 200		
1. Control for Locks and Keys 243	3 Year Review	Forward To BOD For Approval
2. Equipment Medical Device Reporting-Sequester 201	3 Year Review	Forward To BOD For Approval
3. Helicopters on District Policy 207	3 Year Review	Forward To BOD For Approval
4. Signage 215		Forward To BOD For Approval
Information Technology 600		
1. Access to Restricted Financial, Employee 608	3 Year Review, Practice Change	Forward To BOD For Approval

ADMINISTRATION CONSENT AGENDA
May 21st, 2020

CONTACT: Barbara Vogelsang, CNE

Policies and Procedures	Reason	Recommendations
2. Remote or Portable Computing 623	3 Year Review, Practice Change	Forward To BOD For Approval
3. Telephone Authorization Code 600	DELETE	Forward To BOD For Approval
Unit Specific		
Cardiac Rehab		
1. Glucose Monitoring and Exercise Therapy for Diabetic	DELETE	Forward To BOD For Approval
Emergency Department		
1. Wandering Band System Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
Home Care		
1. Unna Boot Application	3 Year Review, Practice Change	Forward To BOD For Approval
Infection Control		
1. Risk Assessment and Surveillance Plan	Practice Change	Forward To BOD For Approval
Medical Staff		
1. Influenza Vaccination of Physicians and Allied Health Professionals (AHP) 8710-547	3 Year Review	Forward To BOD For Approval
2. Standards For Endovascular Repair of Aortic Aneurysms 8710-503	3 Year Review	Forward To BOD For Approval
Neonatal Intensive Care (NICU)		
1. Formula, Preparation and Storage of	2 Year Review, Practice Change	Forward To BOD For Approval
2. Intubation Procedure, NICU	DELETE	Forward To BOD For Approval
3. NICU Disaster Procedure	2 Year Review, Practice Change	Forward To BOD For Approval
4. Primary Nurse Assignment	DELETE	Forward To BOD For Approval
Outpatient Behavioral Health		
1. Admission to Inpatient Behavioral Health Unit	3 Year Review, Practice Change	Forward To BOD For Approval
2. Involuntary Patient Detention	DELETE	Forward To BOD For Approval
3. Physician Progress Note	3 Year Review, Practice Change	Forward To BOD For Approval
4. Psychiatric Emergencies	3 Year Review, Practice Change	Forward To BOD For Approval
5. Solicitation of Patients & Referral to Self	NEW	Forward To BOD For Approval
Surgical Services		

ADMINISTRATION CONSENT AGENDA
May 21st, 2020

CONTACT: Barbara Vogelsang, CNE

Policies and Procedures	Reason	Recommendations
1. Block Time Policy	3 Year Review, Practice Change	Forward To BOD For Approval
2. Cell Saver Set-Up, Use and Monitoring Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
3. CPR in Surgery Policy	3 Year Review, Practice Change	Forward To BOD For Approval
4. Hysteroscopy Policy	3 Year Review, Practice Change	Forward To BOD For Approval
5. Intraoperative Deaths Policy	3 Year Review, Practice Change	Forward To BOD For Approval
6. Organ Tissue Procurement Policy	DELETE	Forward To BOD For Approval
7. Perioperative Documentation	3 Year Review, Practice Change	Forward To BOD For Approval
8. Positioning the Surgical Patient Policy	3 Year Review, Practice Change	Forward To BOD For Approval
9. Scheduling Surgical Procedures Policy	Practice Change	Forward To BOD For Approval
10. Surgical Patients with Acid Implant Policy	3 Year Review, Practice Change	Forward To BOD For Approval
11. Surgical Supply Stocking, Rotation and Outdate	Practice Change	Forward To BOD For Approval
12. TCMC Employees and Independent Contractor Work Policy	DELETE	Forward To BOD For Approval
13. Visitors in the OR Policy	3 Year Review, Practice Change	Forward To BOD For Approval
Women & Newborn Services		
1. Instrument Cleaning Process and Transport to Sterile Processing Department (SPD)	3 Year Review, Practice Change	Forward To BOD For Approval
Wound Care		
1. Medical Equipment Maintenance	3 Year Review	Forward To BOD For Approval
2. Patient Advocacy	3 Year Review	Forward To BOD For Approval
3. Patient Charges	3 Year Review	Forward To BOD For Approval
4. Patient Chart	3 Year Review	Forward To BOD For Approval
5. Patient Photography	3 Year Review	Forward To BOD For Approval
6. Patient Reception	3 Year Review	Forward To BOD For Approval
7. Patient Survey Process	3 Year Review	Forward To BOD For Approval
8. Patient Visual-Auditory Privacy	3 Year Review	Forward To BOD For Approval
9. Program Description	3 Year Review	Forward To BOD For Approval
10. Registration	3 Year Review	Forward To BOD For Approval
11. Scheduling	3 Year Review	Forward To BOD For Approval
12. Staff Development	3 Year Review	Forward To BOD For Approval
13. Staffing Plan	3 Year Review	Forward To BOD For Approval
14. Telephone Management	3 Year Review	Forward To BOD For Approval
15. Transportation	3 Year Review	Forward To BOD For Approval

ADMINISTRATION CONSENT AGENDA
May 21st, 2020

CONTACT: Barbara Vogelsang, CNE

Policies and Procedures	Reason	Recommendations
16. Wound Measurement	3 Year Review	Forward To BOD For Approval
17. Wound Staging	3 Year Review	Forward To BOD For Approval
Wound Hyperbaric Oxygen Therapy		
1. Patient Changing Area	3 Year Review	Forward To BOD For Approval
Formulary Requests		
Eravacycline (Xerava)	NEW	Forward To BOD For Approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 03/02 **SUBJECT: Admission Criteria**

REVISION DATE(S): 10/02; 06/03, 05/05, 12/05, 05/09, 02/12, 08/12, 01/15, 04/17, 08/18

~~Department~~ Patient Care Services Content Expert Approval:	~~07/18~~12/19
Clinical Policies & Procedures Committee Approval:	~~07/18~~01/20
Nurse Executive Council Approval:	~~07/18~~04/20
Medical Staff Department/Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~07/1~~/804/20
Administration Approval:	~~08/18~~05/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/18

A. **PURPOSE:**

1. To provide guidelines for the medical staff, nursing personnel, ancillary disciplines, and admitting personnel to ensure:
   a. A consistent process for admission of patients
   b. An appropriate level of care is based on patient's needs/situation

B. **POLICY:**

1. Admission Requirements:
   a. Hospital admission requires a physician's order.
   b. Patients may be admitted to inpatient or observation status per current InterQual guidelines.
      i. Patients must be 18~~14~~ years of age or older to be admitted **to all units except Labor and Delivery or Neonatal Intensive Care Units**.
         ~~1) Patient must be 18 years and above to be admitted to the Progressive Care Unit (PCU) or Behavioral Health Services (BHS) and Inpatient Behavioral Health Unit (IBHU).~~
         ~~2~~**1)** Refer to Women and Newborn Services Neonatal Intensive Care Unit (NICU) Policy: Admission and Discharge Criteria for the NICU regarding infants up to adjusted 44 week post conceptual age
   c. The attending physician shall be designated by the admitting physician at the time of patient admission.
   d. The Administrative Supervisor (AS) /~~Assistant Nurse~~ **Nursing Leadership**~~Manager (ANM)~~ or designee assigns a bed based upon patient diagnosis, acuity, age, bed availability and physician/ request.
   e. Additional considerations:
      i. The decision to admit a patient continues to be the responsibility of the treating physician.
         1) If cases arise where the circumstances would pose a hazard to the patient's health and/or safety and the appropriate setting is in question, then the case shall be referred for secondary review per chain of command.

ii. Each unit may have limitations of ability to care for certain types of patients in terms of physical layout, environment, equipment, staff expertise, availability, or patient acuity.

iii. Temporary staffing adjustments shall be made for those patients whose acuity level exceeds established guidelines.

1) If patient admission requirements exceed hospital bed and/or staffing capacity, AS collaborates with **the Nursing Leadership or designee**~~ANM, Charge Nurses and/or Managers~~, then forwards the request to hold admissions to the Clinical Operations On Call if deemed necessary.

iv. Bed placement for those with specific gender identity or sexual orientation needs will be assigned on a case by case basis~~. This is~~ to ensure ~~that~~ the patient's comfort and ~~quality of~~ care needs are met during their admission.

f. Admission of patients to the nursing units may occur by any of the following methods:

i. Direct Admissions:

1) Patients may come directly from a physician's office, their home, a long-term care facility or outpatient department as ordered by a physician.

2) The physician **or designee** calls the AS for a bed assignment per Patient Care Services (PCS) Policy Transferring and Receiving Patients from Outside Tri-City Medical Center (TCMC).

3) The AS shall conduct a telephone triage on the patient to assess status. Admission orders are required for each patient. The Registered Nurse will call the admitting physician for orders once the patient arrives to the nursing unit. Orders may also be faxed to Registration Department at 760-940-4016, entered electronically or sent with the patient.

4) The AS assigns the patient to the appropriate unit and informs the ~~ANM~~**Nursing Leader or designee**~~/relief charge~~.

5) Ambulatory patients report to the Registration Department between the hours of 0500-1800 and to the Emergency Department between the hours of 1800-0500.

6) The Registrar notifies the unit that the patient has arrived. Patients admitted via Registration may be escorted to the nursing unit by the office staff or volunteer personnel.

7) Patients unable to complete the registration process in one of the registration areas due to severity of illness or discomfort shall be escorted directly to the nursing unit. These patients shall be registered at the bedside by a registrar or by a family member/conservator/designee in the registration office.

8) Patients experiencing acute symptoms shall be triaged in the Emergency Department (ED) prior to being escorted by clinical staff to the respective nursing units.

9) If an inpatient bed is unavailable, the patient may be:

a) Admitted to the ED for evaluation and treatment.

b) Requested to remain in physician's office until bed available.

c) Requested to remain home until bed available.

ii. Admissions to Acute Rehabilitation:

1) When a physician orders an inpatient be evaluated for admission to Acute Rehab, the Rehab Coordinator will determine if the patient meets the admission criteria.

2) Once approval is obtained, the patient must be discharged from the inpatient unit and admitted as a direct admit to Rehab with a new financial account number (FIN#) when a bed is available.

a) The inpatient unit secretary will request a Rehab bed in Aionex

b) The RN will complete the Depart process including all required documentation.
c) A Cerner communication notice will be sent to Registration upon transfer.
i) Registration will create the new financial identification number (FIN#).

iii. Emergency Admission:
1) ED admission to an inpatient unit:
a) After a physician determines that an Emergency Department patient will be admitted, the ED unit secretary will enter the bed request into Aionex, AS/~~ANM~~**Nursing Leader** or designee will assign the bed in Aionex, and inputs the bed number into FirstNet.
~~2) ED patients being admitted to the BHS are converted to an Inpatient status with the same FIN # when a bed is available.~~

iv. Transfer Admission:
1) The AS shall arrange patient transfers from another in-house patient care unit or outside facility.

v. Surgical Admission:
1) Surgery patients are pre-scheduled through Surgery Scheduling.
2) Surgery Scheduling schedules the appointment for Pre-Operative Education.
3) Surgery Scheduling generates a computerized list of pre-scheduled surgical admissions and forwards the list to the AS.
4) The AS assigns the bed and notifies the nursing unit.

vi. Outpatient Admissions:
1) Registration processes all outpatient admissions.

vii. Boarders:
1) WNS - Boarders are newborn infants admitted after delivery and not discharged with their mother. Boarders may be admitted to the newborn nursery or NICU based on infant status.
2) ED – Boarders are patients with admission orders greater than four (4) hours after a bed has been requested for inpatient admission or observation.

viii. The following departments coordinate admissions to their unit(s), see department specific admission criteria:
~~1) BHS - Inpatient – Outpatient Observation.~~
~~2)~~**1)** Neonatal Intensive Care Unit (NICU),
~~3)~~**2)** Acute Rehabilitation Unit (ARU or Rehab)
~~4)~~**3)** Women and Newborn Services
~~5)~~**4)** Progressive Care Unit (PCU)

2. Unit Specific Criteria:
a. Intensive Care Unit (ICU) (1 East, 1 West):
i. This level is appropriate to use when the patient has an acute cardiac, medical, surgical, or trauma event, along with any of the following:
1) Invasive hemodynamic monitoring
2) Urgent temporary pacemaker insertion
3) Urgent cardioversion
4) Intra-aortic Balloon pump (IABP)
5) Continuous cardiac monitoring
6) Acute intubation and mechanical ventilation management
7) Sepsis
8) Therapeutic Hypothermia
9) Cardiovascular Surgery
10) Advanced Hemodynamic monitoring

~~10)~~**11) Organ Donor**

ii. The following patients shall not be managed on this unit due to the lack of available resources:
1) Undergoing organ transplants
2) Requiring specialized burn treatments
3) Under the age of ~~14~~**18** ~~or less than 35kg~~ **except for post-partum patients**

b. Telemetry (2 East, 2 West, 4 East, 4 West, 3 **East**~~Pavilion~~):
i. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available cardiac monitored beds.
1) Continuous cardiac monitoring
2) Continued mechanical ventilation with stable ABG's and extended ventilator weaning
3) Stable temporary pacemaker insertion or transcutaneous pacing
4) See Telemetry Policy: Admission and Discharge Criteria

c. Progressive Care Unit (3 North, 3 South)
i. This is a 41 bed secured unit that provides various services to patients age 18 and above demonstrating aberrant behavior requiring 24 hour supervision concurrently with their medical condition. Justice involved individuals may be placed on this unit. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available bed.
1) Continuous Cardiac Monitoring
2) Chemotherapy Administration
3) Acute rehabilitation
~~4) Ante-partum care~~
~~5)~~**4)** ~~Post-partum care~~
~~6)~~**5)** Medical-Surgical

d. Acute Care Services (1 North, 2 Pavilion, 4 Pavilion and Acute Rehabilitation):
i. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available beds.
1) Post critical care or Telemetry monitoring
2) Procedures requiring inpatient hospitalization
3) IV medications requiring hospitalization for initial therapy
4) Designated inpatient post surgical care.
ii. 1 North/Ortho (Ortho and Medical/Surgical Patients)
1) This unit specializes in nursing care for patient's ages ~~14~~**18** years of age and older suffering from diseases, injuries or conditions of the human musculoskeletal system.
2) Orthopedic diagnoses are emphasized including orthopedic surgeries such as total joint replacement and spinal surgeries.
iii. 2 Pavilion (Oncology and Medical/Surgical Patients)
1) This unit provides nursing care for adolescent patients (ages ~~14~~**18** years to 21 years) or adult patients (age 22 years and older).
a) Patients receiving chemotherapy must be age 18 or older.
2) Oncological diagnoses are emphasized along with women's surgeries and general medical surgical diagnosis.
iv. 4 Pavilion (Dialysis, Rate Monitoring for Medical/Surgical patients, Designated Stroke Unit, and Epilepsy Monitoring Unit [EMU])
1) This unit specializes in nursing care for patients ages ~~14~~**18** years of age and older:
a) Medical/Surgical patients requiring rate monitoring
b) Hemodynamically stable patients status post CVA
c) Visual monitoring of stable epilepsy patients (EMU)

v. Acute Rehabilitation Unit (ARU)
1) The ARU provides restorative and maintenance programs for the adult patient (ages ~~14~~ **18**years and older) suffering from cerebral vascular disease and other diseases or conditions requiring neurological or functional rehabilitation services.

e. Emergency Services:
i. This unit provides nursing care for patients of all ages that:
1) Require medical care and are in stable, mild, moderate, or acute status.
2) ~~Are afflicted w~~**W**ith conditions involving major trauma, major burns, or requiring hyperbaric therapy, and pediatric intensive care services that can be stabilized to the degree medically feasible and subsequently transferred to facilities providing these specialty services in compliance with Emergency Medical Treatment and Active Labor Act (EMTALA) regulations.

f. Women and Newborn Services:
i. This unit specializes in nursing care for:
1) Perinatal patients who have conditions associated with antepartum, intrapartum and/or postpartum management needs to include surgical requirements related to perinatal care.
2) Neonates that may need resuscitation, stabilization and/**or** ongoing evaluation.

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

~~1. Behavioral Health Unit Inpatient Policy: Inpatient Unit Admission Criteria~~
~~2.~~1. Patient Care Services Policy: Transferring of Patients and Recovering Patients from Outside TCMC
~~3.~~2. Patient Care Services Policy: Transfer of Patients, Intra Facility
~~4.~~3. Surgery Policy: Scheduling Surgical Procedures
~~5.~~4. Telemetry Policy: Admission and Discharge Criteria
~~6.~~5. Women Newborn and Services NICU Policy: Admission and Discharge Criteria for NICU

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 10/10 **SUBJECT:** Antimicrobial Stewardship

REVISION DATE: 07/13, 05/17 ~~**POLICY NUMBER: IV.WW**~~

Patient Care Service Content Expert~~Department Approval~~:	~~12/16~~03/20
Clinical Policies & Procedures Committee Approval:	~~01/17~~03/20
Nurse Executive Council Approval:	~~02/17~~04/20
Medical Staff Department/Division Approval:	n/a
Pharmacy & Therapeutics Committee:	~~03/17~~03/20
Medical Executive Committee Approval:	~~04/17~~04/20
Administration Approval:	05/20
Professional Affairs Committee Approval:	~~05/17~~ n/a
Board of Directors Approval:	05/17

A. **PURPOSE:**
1. To provide a process in order to promote judicious use of antimicrobials
2. The goals of the Antimicrobial Stewardship Program (ASP) include, but are not limited to:
   a. Minimize adverse effects and events secondary to the use of antimicrobial agents.
   b. Reduce, minimize, and/or prevent the emergence of resistant microorganisms.

B. **POLICY:**
1. A physician supervised multidisciplinary antimicrobial stewardship workgroup shall evaluate the judicious use of antimicrobials in accordance with guidelines established by the federal government and professional organizations.
2. **Antimicrobial stewardship activities, outcomes, and all quality indicators shall be reported quarterly by the Infectious Disease physician or pharmacist to the Pharmacy Therapeutics Committee, Infection Control and bi-annually to the Quality Assurance / Performance Improvement (QAPI) Committee.**~~Antimicrobial stewardship activities, outcomes, and all quality indicators shall be reported quarterly by the Infectious Disease physician or pharmacist to the Pharmacy Therapeutics Committee and Infection Control~~.

C. **PROCEDURE:**
1. Antimicrobial Stewardship Workgroup:
   a. Clinicians:
      i. A single physician leader, knowledgeable in the area of infectious diseases, responsible for program outcomes.
      ii. A pharmacist leader, knowledgeable in the area of infectious diseases, will co-lead the program.
   b. Infection Control:
      i. Infection control activities
      ii. Quality indicators (*C. difficile*, MDRO, device related infections, procedure related infections, etc)
   c. Information Systems:
      i. Computerized alerts and warnings
      ii. Data generation and reporting
   d. Microbiology:
      i. Culture and sensitivity reporting/alerting
      ii. Annual antibiogram
   e. Administration:
      i. Financial support of program

2. Antimicrobial Stewardship Activities:
   a. Prospective audit and feedback conducted by pharmacist leader in conjunction with physician leader.
      i. This process involves prospectively reviewing the use of antimicrobial agents and contacting the prescriber with recommendations for optimizing current antimicrobial therapy on an individual patient.
   b. Development and implementation of a restricted antibiotic policy (Refer to Pharmacy policy "Restricted Antimicrobials").
   c. Surveillance and trending of antimicrobial use patterns and quality indicators.
   d. Education to clinicians and staff:
      i. Development of evidence based, institution-specific guidelines for the treatment of common infections.
   e. Other activities:
      i. IV to Oral route conversion program.
      ii. Renal dose adjustment of antimicrobials.
      iii. Preparation of retrospective reviews (i.e. Medication Use Evaluation).

D. **REFERENCES:**

1. Barlam TF, Cosgrove SE, Abbo LM, et al. Implementing an Antibiotic Stewardship Program: Guidelines by the Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America. Clin Infect Dis 2016; 62:e51.
2. Centers for Disease Control and Prevention. Core Elements of Hospital Antibiotic Stewardship Programs. http://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html (Accessed on December 12, 2016).

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: CARDIAC REHAB CENTER (ON CAMPUS) EMERGENCY TREATMENT

I. **POLICY:**

A. Function: Safe and standardized management of unexpected cardiovascular events or exercise related changes in cardiovascular status including, but not limited to, acute angina or change in anginal pattern, stable angina, chest wall/incisional/musculoskeletal pain, cardiac dysrhythmias, hypotensive/syncopal episodes, and acute dyspnea.

B. Circumstances:
1. Setting: Cardiac Rehabilitation service area (on campus), Tri-City Medical Center
2. Supervision: RN; upon arrival of a physician, nursing staff shall follow physician orders instead of standardized procedure.
3. Patient contraindications – Patients with written orders to the contrary of the Standardized Procedure. Patients with Special Considerations:
   i. No Code – A no-code is synonymous with "no resuscitation" or "do not resuscitate".

C. Definitions:
1. Acute angina: Pain, pressure, heaviness, burning sensation, indigestion. May be felt in center of chest, arms, neck, jaw, and shoulders. Other symptoms may include weakness, shortness of breath, diaphoresis, nausea vomiting (1 or more symptoms may be present.)
2. Change in Anginal pattern: Change in frequency, duration, and pattern of angina.
3. Stable Angina: Angina symptoms are relieved with rest or nitroglycerin.
4. Chest wall/incisional/musculoskeletal pain: Atypical pain associated with movement, stretching, straining, coughing, and palpable tenderness.
5. Cardiac ~~Dysrythmias~~**Dysrhythmias**: Any rhythm other than sinus rhythm that requires immediate intervention due to life threatening potential or that result in the patient becoming symptomatic (compromised).
6. Hypotensive/syncopal episodes: Any decrease in blood pressure of 30 - 40 mmHg or more from pre-exercise levels or less than 80 mmHg systolic associated with symptoms.

D. Data Base:
1. Subjective: Patient complaints including, but not limited to, pain, pressure heaviness, burning sensation, indigestion felt in center of chest, arms, neck, jaw, shoulders. Other symptoms may include weakness, shortness of breath, nausea, dizziness, light-headedness, and confusion.
2. Objective: Cardiac rate and rhythm disturbances, decreased level of responsiveness, hypotension, labored respiration, oxygen saturation less than 92%, diaphoresis, vomiting.
3. Assessment: Unexpected cardiovascular events/exercise related changes in cardiovascular status.
4. Plan:
   i. Initiate standardized procedure as appropriate and notify cardiologist or primary physician (if no cardiologist) as soon as possible.

Patient Care Services Content Expert ~~Department~~ Review	Clinical Policies & Procedures	Nurse Executive Council Committee	Division of Cardiology	Pharmacy & Therapeutics Committee	Inter-disciplinary Practice Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
09/02, 03/10, 12/12, 06/16, 11/18	03/10, 02/13, 08/16, 06/19	12/10, 02/13, 09/16, 06/19	10/16, 08/19	01/11, 05/13, 11/16, 11/19	01/11, 09/13, 01/17, 01/20	02/11, 10/13, 02/17, 04/20	05/20	03/17, n/a	08/03, 01/05, 06/06, 08/08, 02/11, 10/13, 03/17

ii. Call CODE BLUE by dialing 66 to respond to Cardiac Rehab Center as appropriate.
iii. Assist with transportation of patient to Emergency Department (ED) via wheelchair or gurney as appropriate. Provide protection of umbrella to protect patient from rain or inclement weather during transportation.

II. **PROCEDURE:**

A. Acute Angina or Change In Anginal Pattern:
1. Stop exercise
2. Assess patient's blood pressure, SpO_2, heart rate and rhythm, lung sounds, respirations, color and mentation. Assess chest pain (location, severity, character).
3. Administer oxygen to maintain SpO_2 greater than 95%.
4. Administer nitroglycerin (NTG) **0.4mg/actuation** spray or tablets 0.4 mg sublingual at 5-minute intervals, not to exceed three sprays for symptoms of angina unrelieved by rest.
   i. If chest pain is unrelieved after 3 NTG sprays, transport to ED for further evaluation.

B. Stable Angina:
1. **Administer nitroglycerin (NTG) spray or tablets 0.4 mg sublingual at 5-minute intervals, not to exceed three sprays or tablets for symptoms of angina unrelieved by rest.**
   i. If chest pain is unrelieved after 3 NTG sprays or tablets, transport to ED for further evaluation.
~~1. Administer prophylactic nitroglycerin as indicated and per physician order.~~
2. Assess and document patient's response to nitroglycerin and exercise.
3. Assess patient's blood pressure, heart rate and rhythm, respirations, color and mentation.
4. Stop activity if angina is unrelieved and proceed as for acute angina.

C. Chest Wall/Incisional/Musculoskeletal Pain:
1. Evaluate cause of pain.
2. Assess blood pressure, heart rate and rhythm, respirations, color, and mentation.
3. Discontinue modalities that aggravate symptoms, or decrease workloads.
4. Notify physician if symptoms persist.
5. Document assessment and treatment on patient's chart.
6. Re-evaluate at next exercise session.

D. Treatment for Dysrhythmias That May Result in Cardiopulmonary Arrest:
1. Assessment
   i. Establish baseline if time allows and patient is stable (Historical Data)
      a) Review baseline ECG
      b) Review medications
      c) Inquire regarding the use of stimulants (i.e. caffeine, smoking, cold remedies)
   ii. Evaluation of new arrhythmias
      a) Evaluate hemodynamic status, i.e., blood pressure, heart rate, skin color and temperature, lightheadedness, dizziness, shortness of breath.
2. Treatment
   i. Ventricular fibrillation and pulseless ventricular tachycardia, asystole, PEA
      a) **Initiate CPR per American Heart Association guidelines (AHA)** ~~**at a rate of 100-120/minute ratio 30:2**~~ **and** Call Code Blue
      ~~b) Begin BLS~~
      b) Place on a cardiac monitor
      c) For Ventricular fibrillation or pulseless ventricular tachycardia, Defibrilate ~~**with 200 joules**~~**per AHA guidelines.**
      d) Resume CPR immediately after shock for 5 cycles or 2 minutes
      ~~c)~~**e) Establish IV access with NS**

ii. Symptomatic Cardiac Rhythm: Complete heart block, symptomatic bradyarrhythmia or tachyarrhythmia
   a) Administer oxygen to maintain SPO_2 greater than 95%
   b) Place on a cardiac monitor
   c) Alert Lift Team/Rapid Response Team (RRT) to assist with immediate transport to ED

iii. New changes in cardiac rhythm: stable bradyarrhythmia or tachyarrhythmia, new onset atrial fibrillation, increase in premature ventricular contractions (PVC), or runs of stable ventricular tachycardia
   a) Stop exercise
   b) Assess patient's blood pressure, respiratory rate, SPO_2 percentage, skin color, temperature, mentation, and other symptoms
   c) Administer oxygen to maintain SPO_2 greater than 95%
   d) Contact physician for further orders
   e) Transport to ED with assistance of Lift Team if necessary

E. Hypotensive Episodes:
1. Assist patient to supine position.
2. Assess blood pressure, heart rate, rhythm, respiration, oxygen saturation, skin color, temperature, mentation, and presence of other symptoms.
3. Administer oxygen to maintain SPO_2 saturation greater than 95%
4. Notify physician
5. If no improvement, transport to the ED

F. Acute Dyspnea:
1. Stop exercise.
2. Assess oxygen saturation by pulse oximetry
   i. If oxygen saturation is less than 92%, place patient on oxygen and titrate to oxygen saturations greater than 95%.
3. Assess breath sounds
4. Assess patient for use of rescue drug inhalers and encourage patient to use inhaler if available.
5. Notify physician if symptoms do not improve and transport to the Emergency Department (ED) via wheelchair or gurney.

G. Left Ventricular Assist Device (LVAD):
1. Check to see if pump is still working:
   i. Look to see if all lights are green
   ii. Listen for quiet whirling sound with stethoscope or feel by placing hand over abdomen
2. Check that all connections to power source and fix if loose or disconnected.
3. Replace current batteries with a new, fully charged pair.
4. Contact LVAD coordinator
5. If patient unstable, call RRT to assist with immediate transport to ED
   i. No compressions
   ii. Keep all connections together if defibrillation is necessary,
      a) DO NOT stop pump prior to delivering shock.

H. Documentation:
1. Document event, intervention, and response in the medical record and notify the physician.
2. Record subjective data
3. Record rhythm strip, blood pressure, heart rate, oxygen saturation
4. Send information to primary physician/cardiologist

III. REQUIREMENTS FOR CLINICIANS PROVIDING INTERVENTIONS:

A. Current **unencumbered** California RN license.

B. Education: Successful completion of ACLS course (with current course completion card)~~, performance of annual mock code~~.
C. Experience: Initial job requirements.
D. Initial Evaluation: During Orientation period.
E. Ongoing Evaluation: Annually **with skills validation.**

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 ACLS-certified Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform Cardiac Rehab Center (On Campus) Emergency Treatment Standardized Procedure.

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**CATHETER CLEARANCE WITH ALTEPLASE (CATHFLO® ACTIVASE®)**
~~Purpose:~~	~~Provide assistance to Registered Nurses with id occlusions and instructions for restoring patency with alteplase (Cathflo® Activase®) in the adult p~~
~~Supportive Data:~~	~~Skill Level: Registered Nurse (RN) - requires ph~~
~~Equipment:~~	~~2 mg vial of alteplase (Cathflo® Activase®) from pharmacy~~ ~~alteplase (Cathflo® Activase®) Catheter specific flush~~ ~~6 alcohol pads x 2~~ ~~Non-vented port protector or sterile needleless cap~~ ~~Sterile gloves~~ ~~(2) 10 mL sterile water~~ ~~10 mL syringe filled with normal saline~~ ~~(2) 10 mL syringes~~ ~~Anti-reflux valves (Microclave) for each clotted lumen~~ ~~Port Protectors for each clotted lumen~~ ~~(2) packages of 4x4 gauze~~

DELETE – follow manufacturer's instruction for use, link created on Intranet under Clinical Products

~~A. DEFINTIONS:~~

~~1. Patency – a catheter that flushes easily, without resistance, aspirates easily with brisk, free-flowing blood return.~~

~~2. Partial Occlusion – flushing or instilling into a catheter can be done but flow is sluggish or difficult to infuse.~~

~~3. Persistent Withdrawal Occlusion – flushing or instilling is done without resistance; however there is no blood return.~~

~~a. Often caused by a fibrin tail hanging off of the end of the catheter.~~

~~b. When flushing the catheter, the tail moves away from the distal tip of the catheter; but when withdrawing blood from the catheter, the fibrin tail acts as a flap which occludes the distal tip.~~

~~4. Complete Occlusion – inability to flush or withdraw blood from the catheter.~~

~~B. PROCEDURE:~~

~~1. Obtain physician/Allied Health Professional (AHP) order for alteplase (Cathflo® Activase®) to restore patency to each occluded central venous lumen.~~

~~2. Obtain reconstituted alteplase (Cathflo® Activase®) from pharmacy.~~

~~a. If not reconstituted by pharmacy, perform hand hygiene and perform steps outlined below:~~

~~i. Reconstitute alteplase (Cathflo® Activase®) to final concentration of 1 mg/mL.~~

~~ii. Aseptically withdraw 2.2 mL of sterile water using 10 mL syringe. (Do not use Bacteriostatic Water.)~~

~~iii. Inject the 2.2 mL of sterile water into the alteplase (Cathflo® Activase®) vial. Slight foaming is not unusual. Let the vial stand undisturbed to allow large bubbles to dissipate.~~

~~iv. Mix by swirling until the contents are completely dissolved. Complete dissolution should occur within 3 minutes. DO NOT SHAKE. The reconstituted alteplase (Cathflo® Activase®) is a colorless to pale yellow solution.~~

~~3. Perform hand hygiene and withdraw 2 mg (2 mL) of alteplase (Cathflo® Activase®) using a 10 mL syringe.~~

~~4. Clamp clotted lumen.~~

~~5. Disconnect intravenous (IV) tubing (if applicable); place sterile luer cap on end of tubing.~~

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Medical Staff Department or Division	Pharmaceutical & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
05/03, 5/08, 2/11, 7/14, 08/16, **11/19**	03/11, 7/14, 08/16, **12/19**	03/11, 7/14, 09/16, **02/20**	n/a	9/14, 09/16, **03/20**	04/11, 10/14, 09/16, **04/20**	**05/20**	05/11, 11/14, 10/16, **n/a**	7/03, 3/04, 3/06, 8/08, 05/11, 12/14, 11/16

6. Open one package of 4x4 gauze, keep gauze on top of opened package, and place both the opened package and gauze under the clotted lumen.
7. Open three (3) alcohol preps using aseptic technique and place on opened 4x4 package.
   a. Remove anti-reflux valve and use alcohol pad to vigorously cleanse the threads of the clotted lumen.
   b. Repeat two times using a new alcohol pad each time.
8. Attach 10 mL syringe containing alteplase (Cathflo® Activase®) to clotted port.
9. Unclamp catheter and instill alteplase (Cathflo® Activase®) slowly.
   a. Do not force.
   b. If resistance met, gently pump syringe to facilitate instillation of alteplase (Cathflo® Activase®).
10. Clamp lumen, remove syringe, and apply anti-reflux (Microclave) valve and port protector.
11. Document the date and time alteplase (Cathflo® Activase®) was instilled on a alteplase (Cathflo® Activase®) "Do Not Flush" label. Place the label directly over the microclave.
12. Allow catheter lumen to dwell undisturbed for 30 minutes.
13. Instruct patient to alert nurse performing alteplase (Cathflo® Activase®) procedure if any requests to draw from line by other staff during dwell time occur.
14. After 30 minutes, perform hand hygiene, don clean gloves, remove the alteplase (Cathflo® Activase®) label and microclave using aseptic technique, attach a 10 mL syringe, unclamp lumen, and aspirate for blood return.
   a. If resistance is met, gently pump syringe to facilitate movement of lysed clot, being careful not to flush lumen contents into the patient.
   b. Maintain negative pressure with the syringe for at least 30 seconds, then attempt to aspirate for blood return.
   c. If blood easily aspirates, complete the following steps:
      i. Aspirate 5 mL blood to remove alteplase (Cathflo® Activase®) and residual clot, clamp lumen, and discard blood.
      ii. Unclamp lumen and flush with 5-10 mL of normal saline, then reclamp lumen.
      iii. Remove syringe and clean lumen treads with alcohol pads.
      iv. Attach a new microclave and port protector or return to IV infusion.
      v. Document administration of alteplase (Cathflo® Activase®) and flush volume on electronic medication administration record (eMAR).
      vi. Document alteplase (Cathflo® Activase®) catheter clearance in medical record.
      vii. Discard any unused solution.
15. If unable to aspirate blood return after 30 minutes, allow the alteplase (Cathflo® Activase®) to dwell undisturbed an additional 90 minutes (total dwell time is 120 minutes).
   a. Clamp lumen, remove syringe, and apply anti-reflux (Microclave) valve and port protector.
   b. Reapply alteplase (Cathflo® Activase®) sticker directly over microclave, document the time (the time represents the last attempt to access the port).
16. After 120 minutes, perform hand hygiene, don clean gloves, remove alteplase (Cathflo® Activase®) sticker and microclave using aseptic technique, attach a 10 mL syringe, unclamp lumen, and aspirate for blood.
   a. If blood easily aspirates, complete the following steps:
      i. Aspirate 5 mL of blood to remove alteplase (Cathflo® Activase®) and residual clot, clamp lumen, and discard blood.
      ii. Unclamp lumen and flush with 5-10 mL of normal saline, then reclamp lumen.
      iii. Remove syringe and clean lumen treads with alcohol pads.
      iv. Attach a new microclave and port protector or return to IV infusion.
      v. Document administration of alteplase (Cathflo® Activase®) and flush volume on eMAR.
      vi. Document (alteplase) catheter clearance in medical record.
      vii. Discard any unused solution.
17. If unable to aspirate for blood return after 120 minutes:

a. Discard unused alteplase (Cathflo® Activase®).
b. Obtain equipment as outlined in the equipment section of procedure.
c. Notify pharmacy and request a second dose of 2 mg of alteplase (Cathflo® Activase®).
d. Repeat procedure beginning with step 1.

18. If blood easily aspirates after using a total of 4 mg of alteplase (Cathflo® Activase®):
a. Aspirate 5 mL blood, clamp lumen and discard blood.
b. Unclamp lumen and flush with alteplase (Cathflo® Activase®) catheter specific flush, then reclamp lumen.
c. Remove syringe and clean lumen treads with alcohol pads.
d. Attach a new microclave and port protector or return to IV infusion.
e. Document administration of alteplase (Cathflo® Activase®) and flush volume on eMAR.
f. Document catheter clearance in medical record.
g. Discard any unused solution.

19. If unable to aspirate for blood return after using a total of 4 mg of alteplase (Cathflo® Activase®):
a. Clamp clotted lumen, remove syringe, and discard unused alteplase (Cathflo® Activase®).
b. Clean lumen treads with a total of three alcohol wipes using aseptic technique.
c. Place microclave and port protector on clamped clotted lumen.
d. Apply label to microclave marked "Do Not Touch" with the date, time, and your initials.
e. Document administration of alteplase (Cathflo® Activase®) on eMAR.
f. Notify physician and document unable to obtain patency of lumen in the medical record.
g. Communicate events during hand-off.

C. **RELATED DOCUMENTS:**
1. Patient Care Services Procedure: Central Venous Access Devices

D. **REFEERNCES:**
1. Genentech USA, Inc. (2016). Cathflo activase (alteplase) reconstitution, dosing, and administration. Retrieved from http://www.cathflo.com/dosing/index.jsp

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**CHEMOTHERAPY EXPOSURE, SPILLS, AND HANDLING OF LINENS CONTAMINATED WITH CHEMOTHERAPEUTIC AGENTS AND BODY FLUIDS, ACCIDENTAL EXPOSURE TO RADIOACTIVE BODY FLUIDS**
Purpose:	To outline staff responsibility and management of chemotherapy spills, radioactive body fluid exposures, and handling of contaminated linens.
Supportive Data:	To prevent staff exposure to chemotherapy and radiopharmaceuticals
Equipment:	Chemotherapy Spill Kit

A. **POLICY:**

1. Many drugs used in the treatment of cancer are considered to be hazardous to health care workers.
   a. The term hazardous refers to drugs/chemicals requiring special handling because of potential health risks.
2. Staff working with chemotherapy drugs and the body fluids of patients that have received chemotherapy shall adhere to this procedure and reference Patient Care Services Disposal of Chemotherapy Waste procedure.
   a. Body fluid include**ings but not limited to** sweat, saliva, emesis, urine, feces, semen, vaginal fluid, or blood.
3. Do not use chemical inactivators due to the potential for dangerous by-products.
   a. Exception: Sodium thiosulfate is used to inactivate nitrogen mustard.

B. **PROCEDURE FOR SPILL MANAGEMENT:**

1. For chemotherapy spills greater than 400 mL in any department:
   a. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in kit).
   b. Remove personnel and patients from the immediate area.
      i. Immediate area is approximately 20-foot perimeter.
   c. If spill occurs in a patient's room, evacuate patient(s) from the room and close door.
   d. Nursing to contact Environmental Services (EVS) supervisor at 760-644-6973.
      i. EVS to contact EOC Safety Officer regarding the chemotherapy spill at 760-590-0352.
2. For chemotherapy spills less than 400 mL:
   a. Non-Oncology Nursing Units Responsibilities for spills on hard surfaces estimated at less than 400 mL
      i. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in chemo spill kit).
      ii. Contact EVS Supervisor of the chemotherapy spill 760-644-6973.
   b. EVS Responsibilities for spills on hard surfaces estimated at 400 mL or less:
      i. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in chemo spill kit).
      ii. Don personal protective equipment in the following order:
         1) N-95 mask (For additional mask(s) please use the N-95 masks located on the unit.)
         2) First pair of chemotherapy gloves
         3) Chemotherapy gown with the cuffs over the first pair of gloves
         4) Second pair of chemotherapy gloves over the cuffs of the gown
         5) Splash goggles or face shield
         6) Protective Shoecovers
      iii. Place spill pillows from spill kit in a "V" position on outer perimeter of spill to prevent spreading of fluid.
      iv. Place one towel from the spill kit over spill to absorb fluid.

Department Review	Clinical Policies & Procedures	Nursing Executive Council Committee	Division of Oncology	Pharmacy & Therapeutics	Medical Executive Committee	Admin stration	Professional Affairs Committee	Board of Directors
3/00, 10/06, 5/09, 2/12, 9/15, 09/19	4/12, 8/15, 6/16, 10/19	4/12, 09/15, 7/16, 10/19	4/12, 09/15, 07/16, 03/20	09/15, 6/16, 11/19	5/12. 10/15, 08/16, 04/20	05/20	6/12, 11/15, 09/16, n/a	6/12, 12/15, 09/16

v. Pick up saturated towel and spill pillows and place in small chemotherapy waste bag.
vi. Use brush to sweep any glass or fragments into scoop and place in small chemotherapy waste bag with discarded towels and spill pillows.
vii. Use the DIMENSION 3 procedure of the EVS guidelines to complete the cleaning.
viii. After DIMENSION 3 cleaning, use remaining towels to wipe up the rinse and fully dry area. Place towels in small chemotherapy waste bag and seal.
ix. Place sealed bag in Spill Kit box and seal the box with bright orange chemotherapy waste label.
x. Remove personal protective equipment in the following order.
1) Outer pair of gloves
2) Chemotherapy gown
3) N95 mask
4) Splash goggles or face shield
5) Protective Shoecovers
6) Final pair of gloves
xi. Place personal protective equipment in large chemotherapy waste bag along with spill kit box and seal the bag.
xii. Place sealed bag in the designated chemotherapy waste area on the unit.
xiii. Complete the Hazardous Drug Exposure Report and give to the supervisor of the EVS department.
xiv. The EVS supervisor shall submit copies of the Hazardous Drug Exposure Report to Employee Health Services and to the EOC Officer.

c. Oncology Unit/Outpatient Infusion Center/Pharmacy responsibilities for spills on hard surfaces <u>estimated between 200 mL and 400 mL:</u>
i. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in chemo spill kit).
ii. Delegate to a co-worker to contact EVS Supervisor of the chemotherapy spill and/or EOC Safety Officer regarding the chemotherapy spill. EVS is responsible for spills on the oncology and pharmacy units that are between 200 mL and 400 mL.
1) 760-644-6972 (Day Shift) or pager 760-926-0841
2) 760-644-6973 (Evening Shift) or pager 760-926-0832
3) 760-644-6974 (Night Shift) or pager 760-926-0834
4) 760-590-0352 (EOC Officer)

d. Oncology Unit/Outpatient Infusion Center/Pharmacy responsibilities for spills on hard surfaces <u>estimated at less than 200 mL:</u>
i. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in chemo spill kit).
ii. Contact or delegate a co-worker to contact Environmental Services (EVS) Supervisor of the chemotherapy spill.
1) 760-644-6972 (Day Shift) or pager 760-926-0841
2) 760-644-6973 (Evening Shift) or pager 760-926-0832
3) 760-644-6974 (Night Shift) or pager 760-926-0834
iii. Don personal protective equipment in the following order:
1) N-95 mask (For additional mask(s) please use the N-95 masks located on the unit.)
2) First pair of chemotherapy gloves
3) Chemotherapy gown with the cuffs over the first pair of gloves
4) Second pair of chemotherapy gloves over the cuffs of the gown
5) Splash goggles or face shield

6) Protective Shoecovers

iv. To clean up a spill from a hard surface estimated as less than 200 mL:

1) Place spill pillows in a "V" position on outer perimeter of spill to prevent spreading of fluid.
2) Place one towel from the spill kit over spill to absorb fluid.
3) Pick up saturated towel and spill pillows and place in small chemotherapy waste bag.
4) Use brush to sweep any glass or fragments into scoop and place in small chemotherapy waste bag with discarded towels and spill pillows.
5) EVS must use the DIMENSION 3 procedure of their EVS guidelines to complete the cleaning.
6) After EVS has completed the DIMENSION 3 cleaning, use remaining towels to wipe up the rinse and fully dry area. Place towels in small chemotherapy waste bag and seal.
7) Place sealed bag in Spill Kit box and seal the box with bright orange chemotherapy waste label.
8) Remove personal protective equipment in the following order:
   a) Outer pair of gloves
   b) Chemotherapy gown
   c) N95 mask
   d) Splash goggles or face shield
   e) Protective Shoecovers
   f) Final pair of gloves
9) Place personal protective equipment in large chemotherapy waste bag along with spill kit box and seal the bag.
10) Place sealed bag in the designated chemotherapy waste area on the unit.
11) Complete the Hazardous Drug Exposure Report and give to the clinical manager on the nursing unit.
12) The clinical manager shall submit copies of the Hazardous Drug Exposure Report to Employee Health Services and to the Environment of Care (EOC) Safety Officer.

C. **PROCEDURE -- EXPOSURE AND PREVENTION RELATED TO CHEMOTHERAPY AGENTS AND BODY FLUIDS:**

1. In the event of skin exposure to chemotherapeutic agent; remove any contaminated garment and immediately wash contaminated skin with soap and water.
2. In case of eye exposure, immediately flush the eye with saline solution or water for at least five minutes.
3. All linen exposed to a chemotherapy agent or body fluid of a patient that is currently receiving or has received chemotherapy in the past 48 hours, must be placed (using chemotherapy gloves and gown) in a Yellow chemotherapy waste bag and tagged by the EVS with a "Special Handling Ticket" before adding it to the general hospital linen.
4. Contact EVS when chemo waste linen bag is 2/3 full. EVS will place the chemo waste linen bag in a regular hospital blue linen bag and will place a special handling ticket on the outside of the blue linen bag before it can be placed in the general hospital linen.
5. Place any disposable cytoxic contaminated materials into a sealed, leak proof chemo waste plastic bag. Use puncture proof chemotherapy waste containers for sharps, breakable items and/or items that are saturated with body fluids. See Patient Care Services: Disposal of Chemotherapy Waste Procedure.
6. All containers will be clearly labeled citing the hazardous nature of the contents-Chemotherapy.
7. Report any cytotoxic exposures or spills to your supervisor.
8. Report any employee exposure to employee health services and/or emergency department.

a. Fill out Illness/Injury Investigation Report

9. Report any patient exposure to the patient's healthcare provider and per institution policy.

D. **PROCEDURE - PRECAUTIONS WHEN HANDLING BODY FLUIDS OF A PATIENT RECEIVING CHEMOTHERAPY(Precautions need to be taken during and 48 hours after last Chemotherapy Dose):**

1. Wear appropriate personal protective equipment (PPE) which may include the following:
   a. N-95 mask
   b. Double chemotherapy gloves
   c. Chemotherapy gown
   d. Splash goggles or face shield
   e. Protective shoecovers
2. Disposing of body fluid
   a. Dispose of body fluids in the toilet.
   b. DO NOT USE THE TOILET SPRAYER. Rinse containers with a cup of water to prevent splashing
   c. Before flushing toilet, cover open toilet with chux. (New chux to be used with each flush).
   d. Flush toilet twice
   e. Place personal protective equipment and chux in chemotherapy waste bag.
   f. Non-Oncology contact EVS to dispose of chemo waste bag when they become ¾ of the way full.
   g. Oncology unit will place sealed chemo waste bag in the designated chemotherapy waste area on the unit.
3. All linen exposed to a chemotherapy agent or body fluid of a patient that is currently receiving or has received chemotherapy in the past 48 hours, must be placed (using chemotherapy gloves and gown) in a Yellow chemotherapy waste bag and tagged by the EVS with a "Special Handling Ticket" before adding it to the general hospital linen.
4. Skin care of incontinent adult receiving chemotherapy
   a. Clean patients skin well after voiding or having a bowel movement
   b. Apply protective barrier ointment or cream before diapering
5. All disposable equipment (i.e. foley catheter, bedpan, graduated cylinder, and diapers) used in caring for chemotherapy patients must be disposed of in a chemotherapy waste container and placed in the designated chemotherapy waste area on the unit.

E. **PROCEDURE - RADIOACTIVE BODY FLUIDS, EXPOSURE RELATED TO:**

1. In the event of exposure from the body fluid, immediately remove any contaminated garment or shoes being careful to avoid contact with substance.
2. Place contaminated articles in red radioactive marked containers in room.
3. Place as much distance from contaminated articles and self as possible.
4. Immediately wash contaminated skin with soap and water.
5. Alert Radiation Safety Officer and manager via in room phone or call light, of radiation exposure.
6. Do not leave room unless cleared by Radiation Safety Officer.
7. Report any employee exposure to employee health department or emergency department.
   a. Fill out appropriate injury form
8. Report any patient exposure to the patient's healthcare provider and per institution policy.

F. **RELATED DOCUMENTS:**

1. PCS Disposal of Chemotherapy Waste Procedure

G. **REFERENCES**

1. ONS Chemotherapy and Biotherapy Guidelines and Recommendations for Practice, 2014, Fourth Edition

2. Center for Disease Control and Prevention. Occupational Exposure to Antineoplastic Agents and Other Hazardous Drugs. http://www.cdc.gov/niosh/topics/antineoplastic/December 12, 2014
3. Medical Waste Management Act January 2015 California Health and Safety Code Sections 117600 – 118360
4. "Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings." National Institute for Occupational Safety and Health (NIOSH), 2014. http://www//cdc/gov/niosh/docs/2004-165/#c. "Kendall Chemobloc Procedure." Tyco Healthcare. 2006 www.tycohealthcare.com
5. Oncology Nursing Society. Manual for Radiation Oncology Nursing Practice and Education, 4th Edition, 2012. Print

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**CHEMOTHERAPY EXTRAVASATION**
Purpose:	To outline the responsibility of the registered nurses in the event of chemotherapy extravasation
Supportive Data:	The Oncology Nursing Society Chemotherapy Biotherapy and Guidelines sets the standard for best practice in the care of oncology patients.
Equipment:	Extravasation Kit

A. **DEFINITIONS:**

1. Extravasation: Passage or escape into tissue of antineoplastic drugs. Tissue slough and necrosis may occur.
   a. Extravasation is a medical emergency. Immediate intervention must occur if extravasation is suspected.
2. Flare Reaction: A local allergic reaction to an agent, manifested by streaking or red blotches along the vein, but without pain.

B. **POSSIBLE SIGNS AND SYMPTOMS OF EXTRAVASATION:**

1. Swelling (most common)
2. Stinging, burning, or pain at the injection site (not always present)
3. Intravenous (IV) flow rates that slow or stop
4. Lack of blood return (extravasation can occur with the presence of a blood return)
5. Erythema, inflammation, or blanching at the injection site (not always immediately evident)
6. Induration
7. Vesicle formation
8. Ulceration
9. Necrosis -- Tissue damage may progress for six months after the incident
10. Sloughing
11. Damage to tendons, nerves and joints

C. **CHEMOTHERAPEUTIC VESICANTS AND IRRITANTS THAT CAN CAUSE TISSUE DAMAGE**

1. **Vesicants**
   a. Alkylating Agents
      ~~i. CISplatin (only at concentrations ≥0.5 mg/ml)~~
      ~~ii.~~**i.** Mechlorethamine Hydrochloride
   b. Antitumor Antibiotic
      i. DOXOrubicin
      ii. DAUNOrubicin
      iii. Mitomycin
      iv. Dactinomycin
      v. Epirubicin
      vi. Idarubicin
   c. Vinca Alkaloid or Micro-tubular Inhibiting Agent
      i. vinCRIStine
      ii. vinBLAStine
      iii. Vindesine (non-formulary)
      iv. Vinorelbine
   d. Topoisomerage II Inhibitor
      i. Mitoxantrone
   e. Miscellaneous
      i. Amsacrine
   f. Taxane
      i. PACLItaxel (irritant with vesicant-like properties)

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Division of Oncology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
2/07; 2/10; 1/13, 5/16, 10/19	3/07; 2/10;2/13, 6/16, 10/19	4/07, 2/10;2/13, 7/16, 10/19	07/16, 03/20	06/16, 11/19	4/07;3/10;5/13, 08/16, 04/20	05/20	4/07, 4/10, 6/13, 09/16, n/a	4/07, 4/10, 06/13, 09/16

2. **Irritants**
   a. Alkylating Agents
      i. CARBOplatin
      ~~i.~~**ii. CISplatin (vesicant at concentrations ≥0.5 mg/ml)**
      ~~ii.~~**iii.** Dacarbazine
      ~~iii.~~**iv.** Ifosfamide
      ~~iv.~~**v.** Melphalan
      ~~v.~~**vi.** OXALIplatin
   b. Nitrosourea
      i. Carmustine
      ~~i.~~**ii. Streptozocin**
   c. Antitumor Antibiotic
      i. DAUNOrubicin liposomal
      ii. Bleomycin
   d. Epipodophyllotoxin
      i. Etoposide
      ii. Teniposide (non-formulary)
   e. Taxane
      i. Docetaxel
   f. Proteasome Inhibitor
      i. Bortezomib
   g. Antimetabolite
      ~~ii.~~**i. Gemcitabine**

D. **PROCEDURE:**

1. Initial management
   a. Stop administration and IV fluids immediately.
   b. Don two (2) pairs of chemotherapy gloves.
   c. Disconnect the IV tubing from the IV device (central or peripheral IV site). DO NOT REMOVE the peripheral IV or noncoring port needle.
   d. Attempt to aspirate the residual drug from the IV device or port needle by using a 1-3 ml syringe.
   e. Remove the peripheral IV device or port needle
   f. Assess the site of the suspected extravasation and photograph site.
   g. Assess symptoms experienced by patient.
   h. Notify the physician and report the patient's symptoms, amount of extravasation and the extent of the extravasation. Review Vesicant Extravasation Management Guidelines with physician and obtain orders for treatment.
      i. For central lines, collaborate with physician regarding the need to discontinue the central line, need for a radiographic flow study to determine the cause of the extravasation and future plans for IV access.
   i. Administer antidote if ordered by physician per the manufacturers recommendations.
   j. Apply a hot or cold compress per Vesicant Extravasation Management Guidelines.
   k. Document the following information in the medical record:
      i. Description of the events that occurred
      ii. Drug
      iii. Dilution
      iv. Amount of Drug Infiltrated
      v. Method of Drug Administration
      vi. Type of IV device
      vii. Description of Site
         1) Size
         2) Color
         3) Texture

l. Document Physician Notification

2. Post–Extravasation Care
   a. Photograph the initial extravasation site including:
      i. Measuring guide for size or length / width / depth
      ii. Date of photograph
      iii. Patients initials
      iv. Medical record number
      v. Location
   b. Photograph every Monday, Wednesday and Friday.
   c. Instruct the patient to rest and elevate the site for 48 hours and then may resume normal activity.
   d. Give patient written instructions regarding what symptoms they should report immediately, local care of the site, pain management and the plan for follow up. Document all patient education in the Cerner Education All Topics Powerform.
   e. Educate patient to ensure that no medications are given distally to an extravasation injury.

E. **RELATED DOCUMENTS:**
1. PCS Procedure: Chemotherapy Administration
2. Vesicant Extravasation Management Guidelines

F. **REFERENCES:**
1. Chu E, DeVita VT, Jr., Copur MS et al. Physicians' Cancer Chemotherapy Drug Manual 2008. Sudbury: Jones and Barlett, 2008
2. Clamon GH. The Chemotherapy Source Book. 4th ed. Philadelphia. Lippincott Williams & Wilkins, 2008: 148-51
~~3. Dorr RT and Von Hoff DD. Cancer Chemotherapy Handbook. 2 ed. Norwalk: Appleton and Lange; 1994:109-18~~
~~4.~~3. Goolsby TV and Lombardo FA. Extravasation of Chemotherapeutic Agents: Prevention and Treatment. Seminars in Oncology. 2006; 33(1): 139-43
~~5.~~4. Infusion Nursing Society (January/February 2011). Infusion Nursing Standards of Practice. Journal of Infusion Nursing, Vol. 34, Number 1S.
5. **Jackson-Rose, J. et al. (2017). Chemotherapy extravasation: Establishing a national benchmark for incidence among cancer centers. *Clinical Journal of Oncology Nursing, 21(4)*. doi: 10.1188/17.CJON.438-445.**
6. The Oncology Nursing Society (20194). ONS Chemotherapy and **Immunotherapy**~~Biotherapy (4th ed.)~~, p. **255-257**~~158–160~~.

Vesicant Extravasation Management Guidelines

Oncology Nursing Society (20194) Chemotherapy and Immunotherapy~~Biotherapy~~ Guidelines and Recommendations for Practice (~~4th Edition~~) pp ~~255158-257160~~

Table 13-3. Vesicant Extravasation Management Guidelines

Classification/Drug	Immediate Topical Therapy	Antidote or Treatment	Administration, Monitoring, and Follow-Up
Alkylating agents • Mechlorethamine hydrochloride (nitrogen mustard, Mustargen®)	Apply cold pack for 6–12 hours following sodium thiosulfate antidote injection (Lundbeck LLC, 2012).	Antidote: Sodium thiosulfate Mechanism of action: Neutralizes mechlorethamine to form nontoxic thioesters that are excreted in the urine Preparation: Prepare 1/6 molar solution (4.14 g of sodium thiosulfate per 100 ml of sterile water for injection or 2.64 g of anhydrous sodium thiosulfate per 100 ml, or dilute 4 ml of sodium thiosulfate injection [10%] with 6 ml of sterile water for injection) (Lundbeck LLC, 2012). Storage: Store at room temperature between 15°C–30°C (59°F–86°F).	Inject 2 ml of the sodium thiosulfate solution for each milligram of mechlorethamine suspected to have extravasated. Inject the solution subcutaneously into the extravasation site using a 25-gauge or smaller needle (change needle with each injection). Dose may be divided into 3–4 syringes to inject around the site of extravasation. The needle should be changed with each new injection. Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. Instruct patients to monitor the extravasation site and to report fever, chills, blistering, skin sloughing, and worsening pain. Instruct patients with peripheral extravasations to report arm or hand swelling and stiffness.
• Trabectedin (Yondelis®)	Apply cold pack for 15–20 minutes at least 4 times a day for the first 24 hours.	No known antidotes or treatments exist.	Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy (Janssen Pharmaceutical Companies, 2015). In collaboration with the provider, refer patients for specialized care when indicated or needed (e.g., plastic or hand surgery consult, physical therapy, pain management, rehabilitation services).

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Table 13-3. Vesicant Extravasation Management Guidelines *(Continued)*

Classification/Drug	Immediate Topical Therapy	Antidote or Treatment	Administration, Monitoring, and Follow-Up
Anthracenedione • Mitoxantrone (Novantrone®)	Apply cold pack for 15–20 minutes at least 4 times a day for the first 24 hours.	No known antidotes or treatments exist.	Extravasation typically causes blue discoloration of the infusion site area and may require debridement and skin grafting (Fresenius Kabi USA, 2013). Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. In collaboration with the provider, refer patients for specialized care when indicated or needed (e.g., plastic or hand surgery consult, physical therapy, pain management, rehabilitation services).
Antitumor antibiotics (anthracyclines) • Daunorubicin (Cerubidine®) • Doxorubicin (Adriamycin®) • Epirubicin (Ellence®) • Idarubicin (Idamycin®)	Apply cold pack but remove at least 15 minutes prior to dexrazoxane treatment.	Treatment: Dexrazoxane for injection (Langer, 2007; Schulmeister, 2007) Mechanism of action: Unknown Dose: The recommended dose of dexrazoxane is based on the patient's body surface area: • Day 1: 1,000 mg/m² • Day 2: 1,000 mg/m² • Day 3: 500 mg/m² The maximum recommended dose is 2,000 mg on days 1 and 2 and 1,000 mg on day 3. The dose should be reduced 50% in patients with creatinine clearance values < 40 ml/min. Preparation: Each 500 mg vial of dexrazoxane must be mixed with 50 ml diluent. The patient's dose is then added to a 1,000 ml normal saline infusion bag for administration. Storage: Store at room temperature between 15°C–30°C (59°F–86°F).	Initiate the first dexrazoxane infusion as soon as possible and within 6 hours of the anthracycline extravasation. Infuse dexrazoxane over 1–2 hours in a large vein in an area other than the extravasation area (e.g., opposite arm). The same arm should be used only when the patient's clinical status (e.g., lymphedema, loss of limb) precludes use of the unaffected arm, and a large vein above the extravasation site should be used for dexrazoxane administration. Dimethyl sulfoxide should not be applied to the extravasation area. Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. Instruct patients to monitor the extravasation site and to report fever, chills, blistering, skin sloughing, and worsening pain. Instruct patients with peripheral extravasations to report arm or hand swelling and stiffness. Instruct patients about treatment side effects (e.g., nausea, vomiting, diarrhea, stomatitis, bone marrow suppression, elevated liver enzyme levels, infusion site burning). Monitor patients' complete blood count and liver enzyme levels.
Antitumor antibiotics (miscellaneous) • Dactinomycin (actinomycin D, Cosmegen®) • Daunorubicin and cytarabine (Vyxeos™) • Doxorubicin hydrochloride liposome (Doxil®) • Mitomycin (Mutamycin®)	Apply cold pack for 15–20 minutes at least 4 times a day for the first 24 hours.	No known antidotes or treatments exist.	Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. In collaboration with the provider, refer patients for specialized care when indicated or needed (e.g., plastic or hand surgery consult, physical therapy, pain management, rehabilitation services).

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Table 13-3. Vesicant Extravasation Management Guidelines *(Continued)*

Classification/Drug	Immediate Topical Therapy	Antidote or Treatment	Administration, Monitoring, and Follow-Up
Plant alkaloids and microtubule inhibitors • Vinblastine (Velban®) • Vincristine (Oncovin®)	Apply warm pack for 15–20 minutes at least 4 times a day for the first 24–48 hours. Elevate extremity (peripheral extravasations).	Antidote: Hyaluronidase (Kreidieh et al., 2016) Mechanism of action: Degrades hyaluronic acid and promotes drug dispersion and absorption Preparation: Prepare per package insert. Do not dilute. Use solution as provided. Store in refrigerator at 2°C–8°C (36°F–46°F).	Administer 150 units of the hyaluronidase solution as 5 separate injections, each containing 0.2 ml of hyaluronidase, subcutaneously into the extravasation site using a 25-gauge or smaller needle (change needle with each injection). Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. Instruct patients to monitor the extravasation site and to report fever, chills, blistering, skin sloughing, and worsening pain. Instruct patients with peripheral extravasations to report arm or hand swelling and stiffness.
Taxanes • Cabazitaxel (Jevtana®) • Docetaxel (Taxotere®) • Paclitaxel (Taxol®) • Paclitaxel protein-bound particles for injectable suspension (Abraxane®)	Apply cold pack for 15–20 minutes at least 4 times a day for the first 24 hours.	No known antidotes or treatments exist.	Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. Instruct patients to monitor the extravasation site and to report fever, chills, blistering, skin sloughing, and worsening pain. Instruct patients with peripheral extravasations to report arm or hand swelling and stiffness.

Table 14. Vesicant Extravasation Management Guidelines

Classification/Drug	Immediate Topical Therapy	Antidote or Treatment	Antidote or Treatment Administration, Patient Monitoring, and Follow-Up
Alkylating agent • Mechlorethamine hydrochloride (nitrogen mustard, Mustargen®)	Apply ice for 6–12 hours following sodium thiosulfate antidote injection (Lundbeck, 2012).	Antidote: Sodium thiosulfate Mechanism of action: Neutralizes mechlorethamine to form nontoxic thioesters that	Inject 2 ml of the sodium thiosulfate solution for each milligram of mechlorethamine suspected to have extravasated. Inject the solution SC into the extravasation site using a 25-gauge or smaller needle (change needle with each injection). Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. Instruct the patient to monitor the extravasation site and report fever, chills, blistering, skin sloughing, and worsening pain. Instruct the patient with peripheral extravasations to report arm or hand swelling and stiffness.
Anthracenedione • Mitoxantrone (Novantrone®)	Apply ice pack for 15–20 minutes at least four times a day for the first 24 hours.		Extravasation typically causes blue discoloration of the infusion site area and may require debridement and skin grafting (EMD Serono, Inc., 2008). Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. In collaboration with the physician or advanced practice nurse, refer the patient for specialized care when indicated or needed (e.g., plastic or hand surgery consult, physical therapy, pain management, rehabilitation services).

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Table 14. Vesicant Extravasation Management Guidelines *(Continued)*

Classification/Drug	Immediate Topical Therapy	Antidote or Treatment	Antidote or Treatment Administration, Patient Monitoring, and Follow-Up
Anthracyclines • Daunorubicin (Cerubidine®) • Doxorubicin (Adriamycin®) • Epirubicin (Ellence®) • Idarubicin (Idamycin®)	Apply ice pack (but remove at least 15 minutes prior to dexrazoxane treatment).	Treatment: Dexrazoxane for injection (Totect® Kit, Blocodex, Inc., 2011) Note: Totect is the U.S. Food and Drug Administration (FDA)-approved treatment for anthracycline extravasation, and its manufacturer maintains a patent for use on the product. Although Zinecard® and generic dexrazoxane are neither indicated nor FDA-approved for anthracycline extravasation treatment, their clinical efficacy in treating anthracycline extravasations has been documented in the literature (Arroyo et al., 2010; Conde-Estévez et al., 2010; Langer, 2007, 2008;	The first dexrazoxane infusion should be initiated as soon as possible and within 6 hours of the anthracycline extravasation. Dexrazoxane should be infused over 1–2 hours in a large vein in an area other than the extravasation area (e.g., opposite arm). The same arm should be used only when the patient's clinical status (e.g., lymphedema, loss of limb) precludes use of the unaffected arm, and a large vein distal to the extravasation site should be used for dexrazoxane administration. Dimethyl sulfoxide should not be applied to [illegible]asation area. [illegible]extravasation area for pain, [illegible]iation, and skin sloughing peri- [illegible] needed or in accordance with [illegible]l policy. [illegible]patient to monitor the extrava- [illegible] and report fever, chills, blister- [illegible]oughing, and worsening pain. [illegible]ents with peripheral extravasa- [illegible]ort arm or hand swelling and [illegible]patient about treatment side [illegible]g., nausea/vomiting, diarrhea, [illegible] bone marrow suppression, el- [illegible]r enzyme levels, infusion-site [illegible]patient's complete blood count [illegible]nzyme levels.
Antitumor antibiotics • Mitomycin (Mutamycin®) • Dactinomycin (actinomycin D, Cosmegen®)	Apply ice p[illegible] for 15–20 [illegible]utes at le[illegible] four times [illegible] day for th[illegible] 24 hours.		[illegible]extravasation area for pain, [illegible]ation, and skin sloughing peri- [illegible] needed or in accordance with [illegible]l policy. [illegible]ion with the physician or ad- [illegible]ctice nurse, refer the patient [illegible] specialized care when indicated or needed (e.g., plastic or hand surgery consult, physical therapy, pain management, rehabilitation services)
Plant alkaloids and microtubule inhibitors • Vinblastine (Velban®) • Vincristine (Oncovin®) • Vinorelbine (Navelbine®)	Apply warm pack for 15–20 minutes at least 4 times per day for the first 24–48 hours. Elevate extremity (peripheral extravasations).	Antidote: Hyaluronidase Mechanism of action: Degrades hyaluronic acid and promotes drug dispersion and absorption Preparation: Available hyaluronidase preparations are • Amphadase™ (bovine, hyaluronidase injection) (Amphastar Pharmaceuticals, 2005): Vial contains 150 units per 1 ml; use 1 ml of solution. Do not dilute. Use solution as provided. Store in refrigerator at 2°C–8°C (36°F–46°F)	Administer 150 units of the hyaluronidase solution as five separate injections, each containing 0.2 ml of hyaluronidase, SC into the extravasation site using a 25-gauge or smaller needle (change needle with each injection). Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. Instruct the patient to monitor the extravasation site and report fever, chills, blistering, skin sloughing, and worsening pain.

(Continued on next page)

DELETE

Table 14. Vesicant Extravasation Management Guidelines *(Continued)*

Classification/Drug	Immediate Topical Therapy	Antidote or Treatment	Antidote or Treatment Administration, Patient Monitoring, and Follow-Up
Plant alkaloids and microtubule inhibitors *(cont.)*		• Hylenex® (recombinant, hyaluronidase	Instruct patients with peripheral extravasa- s to report arm or hand swelling and ness.
Taxanes • Docetaxel (Taxotere®) • Paclitaxel (Taxol®) • Paclitaxel protein-bound particles for injectable suspension (Abraxane®)	Apply ice pack for 15–20 minutes at least 4 times a day for the first 24 hours.	**DELETE**	taxel extravasation may cause hyper- mentation, redness, and tenderness nofi-aventis U.S. LLC, 2007). axel is a mild vesicant; extravasa- may cause induration, blistering, rarely tissue necrosis (Bristol-Myers ibb Co., 2011; Stanford & Hardwicke, 3). in-bound paclitaxel extravasation been identified during post-approv- se and reported to the manufactur- It is advisable to monitor the infu- site closely for possible infiltration ing administration (Celgene Corp., 2). ss the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. Instruct the patient to monitor the extravasation site and to report fever, chills, blistering, skin sloughing, and worsening pain. Instruct patients with peripheral extravasations to report arm or hand swelling and stiffness.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 12/02	**SUBJECT: Code Blue Response Plan**
REVISION DATE(S): 11/02, 03/03, 05/05, 05/06, 11/07, 01/08, 01/09, 02/10, 05/11, 03/16	**~~POLICY NUMBER: IV.T~~**

Patient Care Services Content Expert Approval:	**~~08/17~~11/17~~05~~/18**
Clinical Policies & Procedures Committee Approval:	**~~12/14~~11/17~~08~~/18**
~~Nursing~~ Nurse Executive ~~Council~~ Committee Approval:	**~~12/14~~12/17~~09~~/18**
Department of Emergency Medicine Approval:	**~~01/16~~02/18~~10/18~~12/18~~02/19~~04/19~~07/19~~11/19**
Division of Pulmonary Approval:	**03/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~02/16~~04/20**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**~~03/16~~ n/a**
Board of Directors Approval:	**03/16**

A. **PURPOSE:**

1. To provide a systematic method for responding to a cardiopulmonary emergency on adults or children age **fourteen** (14) or older within the hospital and outside of the facility on hospital property.

B. **DEFINITION(S):**

~~1. Code Blue Response Areas:~~

~~a. Patient Care Areas – areas in the main building with crash carts and AED/defibrillators readily available (for example Cardiac Rehabilitation building and Magnetic Resonance Imaging (MRI) building).~~

~~b. Non-patient Care Areas: areas on the main campus where crash cart and AED/defibrillators not readily available (for example the Business Administration Management (BAM) building, registration and parking area).~~

~~2.~~1. **Justice Involved Individual: Any individual who is under lawful physical arrest/ in the custody of a Law Enforcement Officer and brought to Tri-City Healthcare District (TCHD) to receive medical care, evaluation, treatment, or admission.**

C. **POLICY:**

1. A Code Blue shall be called on any apneic and/or pulseless adult or child age **fourteen** (14) or older.
2. Any person may initiate a Code Blue by dialing '66' on the telephone. The Operator shall announce "Code Blue" and the location over the **public address** (PA) system three **(3)** times, twice.

~~2.~~a. **For a Code Blue in a non-patient care area where crash carts are not readily available (for example, the Business Administration Building, Human Resources, Security Buildings and parking areas), staff shall also dial 911 on the telephone to initiate local Emergency Medical Response (EMR) team.**

~~Response to the Code shall occur according to the following response plan.~~

D. **RESPONSE PLAN ON MAIN CAMPUS ~~WITHIN PATIENT CARE AREAS~~:**

1. **Remove the patient from any wet areas or metallic objects to prevent burns and inappropriate transmission of current.**

a. **Justice Involved Individual: ensure the patient's metal shackles are removed prior to defibrillation or emergent cardioversion.**

~~1.~~**2.** Initial response in non-cardiac monitored areas:
a. Staff shall initiate Basic Life Support (BLS) measures until Code Blue Response Team arrives.

~~2.~~**3.** Initial response in cardiac monitored areas:
a. Staff shall initiate BLS and Advanced Cardiac Life Support (ACLS) measures and initiates the Code Blue and Emergency Care Standardized Procedure until **the** Code Blue Response Team arrives.

~~3.~~**4.** Code Blue response team:
a. The following staff shall respond to the Code Blue **(see ~~Attachment A "~~Shared Mental Model~~"~~ for suggested positions around the patient):**
i. Two **(2)** Intensive Care Unit (ICU) Code Blue **Registered** Nurses **(RN)**:
1) Brings Code Blue Cart (contains defibrillator/pacemaker~~,~~ **and** ~~ambu~~ **resuscitation** bag**/mask),** ~~and~~ emergency intubation medications**, and intraosseous insertion kit** ~~)~~ to the scene.
a) If the code blue occurs in the Cardiac Wellness Center, the responding Code Blue Team members are responsible for bringing the emergency intubation drugs **and intraosseous insertion kit** only.
2) Initiates and implements the Standardized Procedure for Code Blue and Emergency Care until the physician arrives.
3) Remain with patient until released by physician or patient is transferred to receiving unit.
a) Inpatients shall be transferred to the **ICU** ~~Intensive Care Unit~~ or appropriate level of care based on physician order.
~~a)~~**b) Non-inpatients shall be transferred to the Emergency Department (ED)**
4) ~~Ensures~~ **Complete** the Emergency Event form in the patient's electronic health ~~(EHR)~~ record **(EHR)** ~~is completed~~.
ii. Emergency Department (ED) Physician:
1) Responds when available and shall be responsible for leading resuscitative efforts.
iii. Hospitalist:
1) Responds when available and shall be responsible for coordinating post-resuscitative care
iv. Intensivist:
1) Responds when available and shall be responsible for post-resuscitative care
~~1)~~**2) If patient is already in ICU, Intensivist shall respond when present and shall be responsible for leading resuscitative efforts and assuming post-resuscitative care**
~~iii.~~**v.** Primary **RN**~~Nurse~~:
1) Remains in room to assure responders have current patient information.
2) Accesses patient's record and assures responders have information requested (i.e., labs, x-rays, reports).
3) Documents in the EHR:
a) Pre-code assessment findings
b) Interventions implemented prior to Code Blue team arrival
4) Delegate notification~~Notifies~~ **of** the family member/significant other **and physician**~~or ensures the physician or receiving Registered Nurse (RN) notifies family member/significant other of~~ **regarding** change in **patient** condition.

~~4.~~**5)** **Provide communication to receiving nurse if family member/significant other and physician have been notified**

~~iv.~~**vi.** **Two (2)** Respiratory Care Practitioners:
1) Ventilates patient
2) Obtains arterial blood gases ~~and "Code Blue lab panel"~~ as ordered
3) Documents interventions performed on the Emergency Event record

~~v.~~**vii.** **Electrocardiogram** (ECG) Technician:
1) Brings ECG machine

~~vi.~~**viii.** Lift Team~~.~~:
1) Brings gurney and backboard to area
2) Assists with **cardiopulmonary resuscitation** (CPR)
3) Transports patient to receiving unit

~~vii.~~**ix.** Assistant Nurse Manager**(ANM)/ Relief Charge Nurse or Designee** ~~Relief Charge Nurse~~:
1) ~~Assigns recorder role, if not already done~~ **Completes Cardiopulmonary Arrest Record and provides completed form to ICU Code Blue RN**
~~2) Ensures paperwork and documentation is completed on the Cardiopulmonary Arrest Record Emergency Event form in the patient's electronic health (EHR) record are completed is completed~~
~~3.~~**2)** Ensures, post code the ~~"~~medication tray~~"~~ inside of the crash cart is re-locked with a secure tie (located in the crash cart) for containment at end of code
3) Ensures, post Code, the ~~"~~opened~~"~~ crash cart is locked with the plastic key lock externally, is placed in a secured area, and the Sterile Processing Department (SPD) is notified to pick up the used cart

x. Administrative Supervisor:
1) Ensures only required personnel are positioned around patient and nonessential personnel are released to their regular duties.
~~4.~~**2) Facilitates communication to patient's family during the code**

~~viii.~~**xi.** Unit Secretary:
1) Assures patient's chart is ~~in room~~ **available as appropriate**~~, phone is available in room,~~ and places call to primary physician as directed
~~1.~~**2) Other duties as directed by Code Blue Team**

~~ix.~~**xii.** Security Personnel:
1) Maintains scene safety and keeps area clear of congestion

~~x.~~**xiii.** Sterile Processing Department:
1) Sends an adult crash Cart and two infusion pumps to the area involved
2) Retrieves used crash cart and intubation tray post code

b. For a Code Blue in non-patient care areas where crash carts are not readily available:

i. In additions to the above responders, the following will respond:
1) ED Emergency Medical Technicians (EMTs)
a) Brings defibrillator, airway bag, resuscitation bag/mask, gurney and backboard to the scene

ii. TCHD staff will update the EMR team upon their arrival
~~**EMR team**~~
~~2) management and transportation of victim to ED~~

~~E. RESPONSE PLAN FOR CODE BLUE IN NON-PATIENT CARE AREAS:~~
~~1. Code Blue response team~~
~~a. Two Intensive Care Unit (ICU) Code Blue Nurses~~
~~i. Brings Code Blue Cart (contains defibrillator/pacemaker, ambu bag and emergency intubation medications) to the scene inside main hospital building~~
~~1) Exception to areas when bringing the cart will delay the response~~

~~ii. Ensures BLS measures have been implemented and facilitates patient transport to the ED~~

~~b. Emergency Medical Technicians (EMTs):~~

~~i. Brings a defibrillator, airway bag, ambu bag, gurney and backboard to the scene~~

~~c. ED Physician:~~

~~i. Responds when available and leads resuscitative efforts~~

~~d. Respiratory Care Practitioner:~~

~~i. Brings oral airway ambu bag and resuscitation bag to the scene~~

~~ii. Ventilates patient and manages airway~~

~~e. Security Personnel:~~

~~i. Maintains scene safety and keeps area clear of congestion~~

~~F.~~E. **RESPONSE PLAN AT AFFILIATED CENTERS:**

1. Examples including but not limited to:
   - ~~a. Outpatient Service Center~~
   - ~~b.~~**a.** Home Care
   - ~~c.~~**b.** Hospice
   - ~~d.~~**c.** Outpatient Behavioral Health Services
   - ~~e.~~**d.** Outpatient Rehabilitation Service Center
   - ~~f.~~**e.** Outpatient Nuclear Medicine
   - ~~g.~~**f.** Outpatient Imaging
   - ~~h.~~**g.** Open MRI
   - ~~i.~~**h.** Vista Palomar Park Clinic
   - ~~j.~~**i.** Wound Care Center
   - **j.** Tri-City Wellness Center: Cardiac Rehab & Outpatient Rehab
   - k. **Outpatient Infusion Center**
2. The staff of the above mentioned areas are to initiate BLS measures and call 911 to facilitate management and transport of the patient to the ED.
3. The staff in Home Care, Partial Hospitalization, and Outpatient Rehabilitation Services must clearly indicate the facilities are located in Vista to ensure the appropriate authorities respond.

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

1. **Patient Care Services Policy: Justice Involved Patients**
2. **Patient Care Services Standardized Procedure: Code Blue and Emergency Care**
3. **Shared Mental Model: Positions Around The Patient**

G. **REFERENCE(S):**

1. American Heart Association (~~2010~~**2015**). BLS for healthcare providers: *Professional Student Manual.*
2. American Heart Association (AHA) (~~2010~~**2015**). Highlights of 2010 AHA guidelines for CPR
3. American Heart Association (AHA) (~~2010~~**2015**). Handbook of emergency cardiovascular care for healthcare providers.
4. Pediatric advanced life support (~~2010~~**2015**). American Heart Association (AHA).

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 2/94

SUBJECT: Enteral Feeding and Nourishment Preparation, Storage, Distribution, and Administration

REVISION DATE: 04/00; 10/02, 06/03, 07/05, 08/07, 05/10, 05/13, 03/17

~~**POLICY NUMBER: IV.AA.3**~~

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

A. **PURPOSE:**

1. To assure proper preparation, storage, distribution, and administration of enteral feedings.

B. **POLICY:**

1. Food & Nutrition Services is responsible for **enteral feedings and nourishment** ~~preparation,~~ storage and **delivery to nursing units.** ~~distribution of enteral feedings~~.
   ~~1.~~**a. For NICU see Women and Newborn Services NICU: Formula, Preparation and Storage of**
2. Nursing shall administer enteral feedings **and deliver nourishments** to patients.
3. ~~Most o~~Enteral formulas utilized shall be prepared and packaged by various medical nutritional companies and shall be available in cans**/cartons** ~~-~~or closed system liter bottles.
4. Homemade, blenderized formulas shall not be processed at Tri-City Medical Center.
5. Canned**/bottled or closed** ~~-or bottled~~ enteral formulas shall be stored in the nursing pantry areas **upon delivery to the unit**.
   a. **Unused, ~~O~~o**pened cans **or liters** of formula shall be **stored in a refrigerator and** labeled with ~~the~~ **a 24 hour expiration** date **and time.** ~~and time of~~ expiration, ~~and refrigerated and discarded if not used within 24 hours~~.
   b. Unopened cans of formula shall be **stored and** discarded on manufacturer's expiration date.
6. ~~Nursing and Food & Nutrition shall process orders for enteral feedings.~~ Food & Nutrition Service workers shall process and gather product for delivery to nursing station via food carts **after receiving a tube feeding or nourishment order via the electronic health~~medical record system~~.** ~~after the tube feedings are verified for accuracy by the Food & Nutrition supervisor~~.
7. Closed feeding system hang times shall be according to the labeled manufacturer's recommendation. **Nursing must ~~D~~d**ocument the date and time the container **is** opened on the container. ~~Attach~~ **N**~~n~~ew tubing **is** ~~with~~ **required with** each **new** container.
   a. Label feeding system tubing with *change day sticker* indicating date tubing is to be changed using numerical day and month.
8. Formula used in an open system should be changed every eight hours for adult patient and

every four hours for neonates, the tubing and the bag shall be flushed thoroughly with tap water; any existing formula shall be discarded and new formula should be added.

a. **Nursing instructions for ~~O~~open** system bags**- open system bags** and tubing should be changed every 24 hours. Label the open system bag with date and time formula is first placed in the bag. Label feeding system tubing with change day sticker indicating date tubing is to be changed using numerical day and month.

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

1. **Women and Newborn Services NICU: Formula, Preparation and Storage of**

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

1. ASPEN Guidelines ~~(2012)~~

Tri-City Medical Center
Oceanside, California

DELETE – incorporated into Patient Care Services Policy: Food Storage on Nursing Units

PATIENT CARE SERVICES

ISSUE DATE: 5/78

SUBJECT: Food Brought in from Outside the Hospital

REVISION DATE: 4/00, 6/03, 7/05, 4/08, 03/11

~~**POLICY NUMBER: IV.AA.1**~~

Department Approval:	~~02/17~~02/20
Clinical Policies & Procedures Committee Approval:	~~02/17~~04/20
Nursing Leadership~~Executive Council~~ Approval:	~~02/17~~05/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	05/20
Professional Affairs Committee Approval:	~~03/17~~ n/a
Board of Directors Approval:	03/17

~~A. Food brought from outside for patient:~~

~~1. Food shall not be contraindicated on the patient's diet.~~

~~2. Food is to be eaten immediately and not stored.~~

~~a. Food prepared outside of the hospital shall not be stored in the patient food refrigerators.~~

~~3. Any such occurrence will be documented in the patient's medical record.~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 8/02	**SUBJECT:** Food Storage on Nursing Units~~Expiration Dates~~
REVISION DATE: 6/03, 7/05, 03/11, 03/17	~~POLICY NUMBER: XI.D~~

Patient Care Services Content Expert Approval:	02/20
Clinical Policies & Procedures Committee Approval:	~~01/1110/1502/17~~04/20
Nursing Leadership~~Executive Council~~ Approval:	~~01/1110/1502/17~~05/20
Medical Staff Department/Division Approval Date(s):	n/a
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval:	~~02/11~~ n/a
Administration Approval:	05/20
Professional Affairs Committee Approval:	~~03/1103/17~~ n/a
Board of Directors Approval:	~~03/11~~03/17

A. **POLICY:**

~~1. Food Storage on the Nursing Units:~~

~~a.~~1. **Only patient food should be stored in patient refrigerators.** ~~Food shall not be stored in a refrigerator used to store medicines, chemicals, or specimens~~.

~~b.~~2. Food items shall not be removed from the patient trays and placed in the patient nutrition refrigerators.

~~c.~~3. Refrigerators designated for food are used for food and food products only.

~~i.~~a. All foods without manufacturer's expiration dates shall be dated with an expiration date 3 days from date placed in refrigerator.

~~ii.~~b. Upon opening any item, it shall be re-dated for 24 hours from opening and discarded on new expiration date.

~~iii.~~c. All foods shall be covered or protected during transit.

4. **Food brought in from the outside for the patient:**
   - a. **Food shall not be contraindicated on the patients diet.**
   - b. **Food is to be eaten immediately and not stored.**
     - i. **Food prepared outside of the hospital shall not be stored in the patient food refrigerators.**
     - ii. **Any such occurrence will be documented in the patient's medical record.**

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**LUMBAR DRAINS, CARE OF**
Purpose:	To assist staff in caring for the patient with a lumbar drain. The lumbar drain is a drain inserted into the subarachnoid space of the spinal column within the levels of T-12 to L-5. The lumbar drain is placed in order to drain cerebrospinal fluid (CSF) from the spinal column.
Supportive Data:	The lumbar drain is a specific procedure, which differs from any other type of neurological drain used within the care system currently and requires specific knowledge.
Equipment:	Personal Protective Equipment (PPE)

A. **POLICY:**

~~1. A lumbar drain and a comprehensive neurological assessment shall be performed every 2 hours, or per MD orders including:~~

~~a. Insertion site, including redness, skin integrity, signs/symptoms of infection, signs of CSF leakage.~~

~~b. Signs/symptoms of meningeal irritation (nuchal rigidity, photosensitivity, headache and irritability)~~

~~c. Drainage for color, clarity, and amount, hourly.~~

~~d. Dressing dry and intact and covers tubing, with no kinks.~~

~~2. Do not use bactericidal agent near insertion site, or tubing.~~

~~3. Do not allow drainage tubing to become kinked.~~

1. **See Online Skill Lumbar Catheter Insertion, Care and Removal with the following exceptions:**

~~4.~~a. Only the physician may access the closed system drainage system **including obtaining specimens**.

~~5. Clamp the drainage tubing if drainage tubing becomes disconnected and notify physician immediately (it is recommended that physician replace drain).~~

~~6. Notify physician for signs/symptoms of infection, meningeal irritation, decrease/absence of CSF fluid drainage, damp dressing, or change in baseline neurological status (i.e., cognition, motor sensory or focal deficit.)~~

~~B. **PROCEDURE:**~~

~~1. **Care of patient:**~~

~~a. Maintain the head of the patient's bed at the level ordered or at least 15 - 20 degrees.~~

~~b. Maintain the patient's head, neck and back in neutral position, avoid hyper flexion, rotation, or extension of neck or back. The patient may be turned as necessary.~~

~~c. Clamp the drain for less than (5) five minutes during care activities that require movement of the patient or change in level of the head of the bed.~~

~~d. Maintain the height of the drainage bag at the level ordered to maintain drainage at the rate physician ordered (usually 10 - 20mL's per hour).~~

~~e. Communicate with all patient care professionals, the presence of the drain.~~

~~f. Instruct the patient to avoid coughing, sneezing, or straining.~~

~~2.~~b. Removal of ~~Drains~~ **drains is** ~~(~~performed by the Physician/Interventional Radiologist~~)~~

~~a.~~i. Cover drain exit site per Physician/Interventional Radiologist order

~~i.~~1) If no orders, place sterile dressing over drain exit site and secure with tape

~~b.~~ii. Verify with Physician/Interventional Radiologist that the drain is intact. If the drain is not intact collect drain, tubing and any other product associated with the drain and contact Risk Management for instruction on where to send the product for further evaluation

~~c.~~iii. Document removal in medical record

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
5/10	07/11, 10/15, 03/20	08/11. 10/15, 04/20	n/a	n/a	10/11, 11/15, 04/20	05/20	11/11, 01/16, n/a	12/11, 01/16

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

1. Elsevier. (2020, 03 26). *Lumbar Catheter Insertion, Care and Removal.* Retrieved 03 26, 2020, from Elsevier Skills: https://point-of-care.elsevierperformancemanager.com/skills/101/extended-text?skillId=CC_091#scrollToTop

~~1.~~2. ~~American Association of Neuroscience Nurses. (2011). Care of the patient undergoing intracranial pressure monitoring/external ventricular drainage or lumbar drainage. Retrieved from www.aan.org.~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 06/13 **SUBJECT:** Neutropenic Precautions

REVISION DATE: 06/13, 01/17

Patient Care Services Content Approval:	**11/19**
Clinical Policies & Procedures Committee Approval:	**~~07/16~~12/19**
Nurse Executive Council Approval:	**~~07/16~~02/20**
Infection Control Committee Approval:	**~~10/16~~03/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~10/16~~04/20**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**~~01/17~~ n/a**
Board of Directors Approval:	**01/17**

A. **POLICY:**
1. To outline steps for preventing infections in patients with neutropenia.
2. Patients who are identified as neutropenic have the greatest risk for infection
3. Neutropenia is defined as an absolute neutrophil count [ANC] of <500 cells/mL
4. The primary nurse must educate the patient and family on neutropenic precautions.

B. **PROCEDURE:**
1. If patient has been identified as having an ANC of <500 cells/mL move patient to a private room.
2. Do not place patient in a negative pressure room unless patient requires respiratory isolation for Airborne Precautions per the Tricity Medical Center's infection control manual.
3. Place sign outside of the patient's room that states "please check in with the nurses' station before entering the room". Never place a sign that states "neutropenia". This is a Health Insurance Portability and Accountability Act (HIPAA) violation.
4. Do not allow staff or visitors who have symptoms of respiratory infection to visit or care for patient
5. All visitors:
   a. Must be screened for respiratory infections
   b. Must perform hand hygiene before entering the patient's room.
6. Children must be accompanied by a responsible adult (other than the patient) at all times when visiting.
   a. Only one child may visit at a time.
   b. All children must wear a mask if visiting patient.
7. Healthcare team, patient, family and visitors must adhere to neutropenic precautions.
8. Neutropenic Precautions:
   a. Hygiene
      i. All healthcare team members must use standard precautions and do hand hygiene frequently when caring for neutropenic patients
      ii. Patient must wash hands frequently and ensure they are dried properly
      iii. Patient should keep their skin clean and dry at all times (bathe daily)
      iv. Patient must protect skin from cuts and burns
      v. Patient must perform **daily** ~~frequent~~ oral care ~~(at least 3 - 4 times a day)~~
      vi. Only use an electric shaver to remove hair (no razors).
      vii. Patient's perineal area should be cleansed after voiding and bowel movement
      viii. Menstruating women should avoid tampons
      ix. Rectal thermometers, enemas, suppositories and rectal examinations are contraindicated

b. Visitors
   i. No visitors with respiratory infections
   ii. Patient should avoid people with colds or contagious illness such a chicken pox, herpes zoster or influenza

c. Environment
   i. No fresh or dried plants and flowers in patient room
   ii. Change the water of any water containers or pitchers and denture cups daily

d. Food/Food Preparation
   i. Patient should not eat any foods that have not either been cooked or washed properly.
   ~~ii. Patient should be placed on a neutropenic diet~~
   ~~iii.~~ii. Food items for the patient from the cafeteria must be covered when transported to the unit for the patient
   ~~iv.~~iii. Fruits and vegetables should be well washed before eating
   ~~v.~~iv. **Avoid** ~~No~~ uncooked meats, seafood, and eggs
   ~~vi.~~v. Patient should not share food utensils

e. Vaccinations
   i. Influenza and pneumonia vaccinations are recommended
   ii. Patient should not receive live vaccines such as oral polio, varicella, small pox, or nasal flu vaccine.
   iii. Patient should avoid contact with people who have been vaccinated with a live virus within the past 30 days

f. Miscellaneous
   i. Refrain from providing direct care for pets or farm animals.
   ii. Avoid contact with animal feces, saliva, litter box contents or barns.
   iii. Do not enter or travel through, construction/renovation or where construction material/debris has been placed or where fields have recently been plowed.

C. **RELATED DOCUMENTS:**
1. Infection Control Policy: Standard and Transmission Based Precautions

D. **REFERENCES:**
1. Oncology Nursing Society (2014).Chemotherapy Biotherapy Guidelines and Recommendations for Practice Third Edition.
2. Oncology Nursing Society (2016) PEP-Preventions of Infection.
3. Infectious Diseases Society of America (IDSA) to guide clinicians in the care of patients with chemotherapy and induced neutropenia and in the management of febrile neutropenia. http://cid.oxfordjournals.org/content/52/4/e56.full.

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**PATIENT CLASSIFICATION (ACUITY)**
Purpose:	To provide an assessment of the care needs intensity of each patient per shift to assist in determining the appropriate staffing based on acuity and ratios
Supportive Data:	In accordance with the rules and regulations of Title 22 and Joint Commission

A. **RESPONSIBILITIES:**

1. **Nursing Leadership**~~The Managers, Assistant Nurse Manager (ANM)~~ or designees ~~is~~are responsible to ensure that licensed staff complete Patient Classifications (Acuity) for their patients each shift.
   a. Each patient's classification should reflect the patient's actual care intensity and Activities of Daily Living (ADL) needs for the current shift.
2. Nursing is responsible for Patient Classification utilizing the Cerner Acuity Powerform; this includes Acute Rehab, 1 North, 2 Pavilion, 4 Pavilion, Behavioral Health Unit (BHU), Intensive Care Unit (ICU), Mother Baby, Neonatal Intensive Care (NICU), Telemetry and Inpatient Progressive Care Unit **(PCU)**.
3. The Emergency Department and Labor & Delivery will utilize a census based tracking form.
~~3.~~**4. NICU see: Women and Newborn Services NICU: Patient Assignment NICU**

B. **PROCEDURE FOR THOSE UTILIZING THE CERNER POWERFORM FOR ACUITY:**

1. A task will be triggered **each shift** ~~at 1200 and midnight each day~~ to the nurse assigned to the patient on their unit.
2. The primary Registered Nurse (RN) is required to complete the acuity on the patient **each shift** ~~by 1300 and 0100~~ or the task will be noted as overdue.
   a. There are care intensity and ADL indicators.
      i. The care Intensity indicator is defined by minimal, moderate, high, 1:1 and 2:1 levels.
      ii. The ADL indicator is defined by minimal, moderate and high.
      iii. Each care intensity and ADL indicator is unit specific based on the patient population and has a weight associated to it that assists in determining the acuity of the patient.
3. The **Nursing Leadership**~~ANM~~ or designee is responsible to verify that all acuities are completed each shift.

C. **PROCEDURE FOR THOSE UTILIZING CENSUS BASED TRACKING (EMERGENCY DEPARTMENT AND LABOR & DELIVERY):**

1. The coder will document on the Acuity Daily Report the Emergency Department census at 0700 and 1900. A daily Emergency Department (ED) Activity Log is generated at 0700 for the previous 24 hours which reflects the total patients seen, Patients Left Without Treatment, ICU admissions and hospital admissions in the last 24 hours. Emergency Severity Index (ESI) acuity levels are documented in Firstnet when patients arrive in Triage.
2. The Labor and Delivery **Nursing Leadership**~~ANM~~ or designee will document on the Daily Staffing Sheet the Labor & Delivery census at 0700 and 1900. ~~The~~ **Nursing Leadership**~~ANM~~ or designee will fax this 24 hour retrospective report to staffing by 0900 for filing.

D. **INTER-RATER RELIABILITY PROCESS:**

1. The purpose of this process is to ensure the consistency among the registered nurses in the interpretation and use of the Patient Classification (Acuity) powerform.

Department Review	Clinical Policies & Procedures	Nursing Leadership ~~Executive Council~~	Medical Staff Department / Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
11/12, 07/16, 04/20	12/12, 07/16, 04/20	12/12, 07/16, 05/20	n/a	n/a	4/12, n/a	05/20	04/13, 08/16, n/a	04/13, 08/16

2. Each shift the **Charge Nurse** ~~ANM~~ or designee will complete an Acuity Validation on patients within their department.
   ~~a. Two (2) patients per department for 1N, 2P, 4P, BHU & Rehab.~~
   ~~b.~~a. ~~One (1) patient per custom location for ICU, Tele Mother Baby and Inpatient Progressive Care Unit.~~
3. This information will be monitored on a monthly basis and reported as appropriate.

E. RELATED DOCUMENT(S):

~~3.~~1. **Women and Newborn Services NICU: Patient Assignment NICU**

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 02/01 **SUBJECT:** Safe Surrender

REVISION DATE(S): 05/02, 05/03, 04/04, 12/05, 09/06, 11/09, 02/13, 04/14, 03/18

Patient Care Services Content Expert~~Department~~ Approval:	~~11/17~~02/20
Clinical Policies & Procedures Committee Approval:	~~12/17~~03/20
Nursing Executive Committee:	~~01/18~~04/20
Pharmacy and Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~02/18~~04/20
Administration Approval:	05/20
Professional Affairs Committee Approval:	~~03/18~~ n/a
Board of Directors Approval:	03/18

A. **PURPOSE:**

1. To provide guidance for Tri-City Healthcare District (TCHD) employees accepting custody of newborns up to 72 hours old who are voluntarily surrendered by a parent or other person with legal custody.
2. To implement the requirements of the Safely Surrendered Baby Law.

B. **POLICY:**

1. In compliance with Senate Bill 1368, TCHD has designated the Emergency Department (ED) as the safe surrender site within the facility and the employees on duty in the ED to receive abandoned newborns.
2. Any officer, employee or medical staff member on duty at the hospital must accept physical custody of an abandoned newborn up to 72 hours old.
3. No person or entity that accepts a surrendered newborn will be subject to civil, criminal, or administrative liability for accepting and caring for the child in the good faith belief that action is required or authorized by this law. This includes situations where the child may actually be older than 72 hours, or where the surrendering person did not have lawful physical custody of the infant.

~~4. Notify ED registration to provide confidential ID number.~~
~~a. The coded, confidential ID number should not be a Medical Record number.~~

~~5.~~4. The consent of the parent or other relative surrendering the newborn is not required for the Medical Screening Exam (MSE).

~~6.~~5. Newborns abandoned in accordance with law are eligible for MediCal coverage.

~~7.~~6. When a newborn is surrendered, the registered nurse (RN) will:

- **a.** Follow ED Standard for triage of patients **using Baby Doe.** A MSE and any necessary medical care must be provided. (See Administrative Policy: EMTALA: Emergency Medical Screening 506)
- ~~a.~~**b.** **Document number of coded newborn bracelet and matching coded ID arm bracelet of the person surrendering the newborn, as well as any information the surrendering individual provided regarding newborn. (i.e. age, health history, or other pertinent information.)**
- ~~b.~~**c.** Access an abandoned newborn packet (~~Stored in the~~ **Located at** ED Triage, Charge Desk, and Radio Room.)
  - i. Contents of the packet must include a coded, confidential identification (ID) ankle bracelet; a matching coded arm ID bracelet; a coded, confidentially identified family medical history questionnaire (English and Spanish versions); campaign

brochure and law fast facts sheet (English and Spanish) and a stamped envelope addressed to TCHD.

~~c.~~**d.** Place the coded ID bracelet on the newborn.

~~d.~~**e.** Make a good faith effort to give the matching coded ID arm bracelet to the person surrendering the newborn. This will facilitate reclaiming the infant later.

~~e.~~**f.** Make a good faith effort to give the person surrendering the newborn a coded, confidential family medical history questionnaire, campaign brochure, law fast facts sheet, and a stamped addressed envelope.

~~f.~~**g.** Notify Child Protective Services (CPS) of the surrender as soon as possible and in no event later than 48 hours. CPS must assume temporary custody of the newborn immediately on receipt of notification, and must investigate.

~~g.~~**h.** Notify Social Services Department. ~~Send appropriate paperwork for processing and keeping statistics~~.

~~8.~~**7.** If a person surrendering a newborn request that TCHD returns the newborn to her/him, the hospital must do so if **TCHD**~~it~~ still has custody and if the dependency petition has not been filed. Contact Administration or Legal Services prior to returning newborn.

~~9.~~**8.** If a health practitioner at TCHD reasonably suspects that the child has been the victim of abuse or neglect, he/she must notify CPS rather than returning the child. Voluntary surrender of a newborn in accordance with law is not in and of itself a basis for reporting abuse or neglect. The statute does not provide immunity from personal injury or wrongful death, including malpractice claims. Legal counsel should be consulted immediately with questions.

~~10.~~**9.** If a dependency petition has already been filed through CPS, the person surrendering the newborn may reclaim the child within fourteen (14) days of the surrender. If TCHD still has physical custody of the newborn, a copy of the court order should be obtained, reviewed, and referred to legal counsel before releasing the child.

~~11.~~**10.** Any identifying information that pertains to a parent or individual who surrenders a newborn pursuant to the Safely Surrendered Baby Law that is obtained as a result of the questionnaire or in any other matter, must not be disclosed by any personnel of a Safe Surrender site that accepts custody of an infant.

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

1. Safely Surrendered Baby Medical Questionnaire – English: http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC861.pdf
2. Safely Surrendered Baby Medical Questionnaire – Spanish http://www.cdss.ca.gov/cdssweb/entres/forms/Spanish/SOC861SP.pdf
3. Safely Surrendered Baby Campaign Brochure http://www.cdss.ca.gov/Portals/9/FMUForms/M-P/PUB400.pdf?ver=2017-10-26-110106-193
4. Safely Surrendered Baby Law Fast Facts – English http://www.cdss.ca.gov/Portals/9/OCAP/PDFs/Fact%20Sheets/2_ENG_SSBFactSheet.pdf?ver=2017-09-05-161625-780
5. Safely Surrendered Baby Law Fast Facts – Spanish http://www.cdss.ca.gov/Portals/9/OCAP/PDFs/Fact%20Sheets/Fast%20Facts%20SP.pdf?ver=2017-09-05-161628-437

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

1. Administrative Policy: EMTALA: Emergency Medical Screening 506

E. **REFERENCE(S):**

1. California Hospital Association (201~~7~~). *California Hospital Consent Manual*. Sacramento, CA: California Hospital Association.
2. Safely Surrendered Baby Law; Senate Bill No. 1368, Chapter 824
3. Cal. Health and Safety Code (HSC) § 1255.7 (1973).

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**TRANSPORTING ~~VENTILATOR~~ PATIENTS ON A VENTILATOR**
Purpose:	Establish a standard of care for transporting ~~continuous~~ ventilator patients.
Supportive Data:	~~AARC Clinical Practice Guideline (RespirCare 2002), Intra-hospital transport of Critically Ill ventilated patients; 2005 Nov; Critical Care Medicine, Guidelines for the inter- and intra-hospital transport of critically ill patients; 2004 Jan; Critical Care Medicine. Egan's Fundamentals of Respiratory Care, 2013, 10th edition, pgs 1038-1039/~~
Equipment:	1. Manual resuscitator bag with reservoir 2. mask and PEEP attachment (if needed) 3. pulse oximeter 4. **ETCO2 monitoring** and cardiac monitor depending on patient's condition 5. Full oxygen cylinder 6. gas source in the area to which patient is being transported 7. Suction source in the area to which patient is being transported 8. Transport vent, if applicable.

A. **PROCEDURE:**

1. Registered Nurses (RNs) and Respiratory Care Practitioners (RCPs) competent to care for ~~the~~ ventilated patients are authorized to perform this procedure.
2. Two people are required to transport a ~~ventilator~~ patient **on a ventilator~~,~~; one being** a qualified RN and ~~RCP~~**the other must be a RCP/anesthesiologist**.
3. The responsibilities of the RCP shall include:
   a. Ensure a resuscitator bag and mask is available.
   b. Ensure adequate oxygen in cylinder for transport.
   c. Attach a PEEP valve to the resuscitator bag or the transport vent if greater than 5 cmH20 PEEP **is** required ~~is~~.
   d. Attach resuscitation bag or transport ventilator to the patient, ventilating patient at previously noted rate and minute volume.
   ~~d.~~**e. Maintain airway security and patency during transport.**
   f. **C**onnect ventilator to **oxygen and air** gases **(as applicable)** and **plug into electrical** Power **source** ~~At~~ **at** destination **and upon returning to unit,. All vents should be plugged into red emergency power outlets unless none available.**~~,~~ ~~if applicable~~.
   ~~e.~~**g.** Ensure ventilator is functioning properly and patient is being adequately ventilated.
   ~~f. Maintain airway security and patency.~~
   ~~g.~~**h.** Provide the RN with RCP ~~pager number or~~ cell phone number.
   ~~h.~~**i.** Document ~~in the medical record~~ **both the transport and the ventilator check in the electronic health record (EHR)**.
   ~~i. Disconnect the ventilator air and oxygen hoses and electrical cord after the patient is connected to the manual resuscitator.~~
   ~~j. Move the ventilator to the designated area.~~
   ~~k. Connect oxygen, air (if available), and electrical sources must be connected to red emergency power outlet.~~
4. The responsibilities of the RN shall include:
   a. Oversee the transport.
   b. Ensure cardiac monitoring, pulse oximetry monitoring and ETCO2 monitoring (as applicable) during the transport to ensure patient safety.

~~Revision Dates~~Patient Care Services Content Expert	Clinical Policies & Procedures Committees	~~Nursing~~ Nurse Executive ~~Council~~Committee	Division of Pulmonary	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
7/88,7/97,7/03, 4/04, 4/06, 6/09, 12/14, ~~2/19~~**03/19**	08/11, 12/14, **03/19**	08/11, 12/14, **03/19**	08/15, **03/20**	**n/a**	10/11, 09/15, **04/20**	**05/20**	11/11, 10/15, **n/a**	12/11, 10/15

~~a.~~c. Stay with the patient throughout the procedure unless a qualified RN is present (i.e.: Interventional Radiology, Cardiac Cath Lab).
~~b.~~d. Monitor patient safety **at all times.**
~~c.~~e. Document ~~in the medical record~~ **the transport and all applicable vital signs in the EHR.**

~~B. REQUIRED OBSERVATIONS AND DOCUMENTATIONS~~
~~1. RN and RCP to document the transport in the electronic health record (EHR). The RCP will chart the ventilator check in the EHR.~~

B. REFERENCE(S):

1. **AARC Clinical Practice Guideline (RespirCare 2002), Intra-hospital transport of Critically Ill ventilated patients; 2005 Nov**
2. **Critical Care Medicine, Guidelines for the inter- and intra-hospital transport of critically ill patients; 2004 Jan**
3. ~~**Critical Care Medicine. Egan's Fundamentals of Respiratory Care, 2013, 10th edition, pgs 1038-1039/**~~
4. **Egan's Fundamentals of Respiratory Care, 2017, 11th edition, pgs 1013-1014.**
~~2.~~5. **Respiratory Care, Blakeman, TC; Inter-and Intra- Hospital transport of the Critically Ill, June 2013 pgs. 1008-1023..**

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**ULTRASOUND GUIDED PERIPHERAL INTRAVENOUS (IV) ACCESS**
Purpose:	To outline the process of insertion of peripheral IV catheters with ultrasound guidance by appropriately trained and competent Registered Nurses
Supportive Data:	See References
Equipment:	1. IV supplies per standard peripheral IV protocol. Note: A longer length of catheter may be needed. 2. Portable Ultrasound machine 3. Probe cover 4. Sterile water based gel 5. Local anesthetic (optional)
Issue Date:	~~NEW~~**02/16**

A. **POLICY**

1. Ultrasound is an aid to placement of a peripheral intravascular venous (IV) access.
   a. Appropriate patient and site selection using ultrasound remains the same as the traditional landmark approach.
2. To be used for those patients with difficult access (more than two unsuccessful attempts), or those with anticipated difficult access (patients with obesity, edema, hypovolemia, or history of repeated venipuncture).

B. **PROCEDURE:**

1. Insertion
   a. Place tourniquet
   b. Perform preliminary ultrasound scan to find preferred site and adjust machine settings
   c. Release tourniquet
   d. Prepare the probe with application of a small amount of gel then apply probe cover.
   e. Scrub area of insertion (about 3 inches in diameter from selected site) with chlorhexidine.
   f. Reapply tourniquet
   g. Apply sterile gel distal to the site of insertion
   h. Apply the probe onto the gel and slide proximally while identifying the vein. Attempt to maintain sterility of the catheter and prepared site. The insertion site should be dry and free of gel.
   i. Inject 1% lidocaine without epinephrine (local anesthetic) under skin at point of catheter puncture site as needed if ordered by physician ~~or per Patient Care Services Standardized Procedure: Local Anesthetic Prior to Intravenous Insertions .~~ (optional step)
   j. Insert catheter per **Online**~~Mosby's Nursing~~ Skills Intravenous Therapy: Initiation.
   k. Apply dressing per standard peripheral IV protocol.
2. Documentation
   a. Document insertion of peripheral IV in the IVIEW Peripheral IV section.
   b. Document use of ultrasound for IV placement, catheter size, length, location And site condition.

C. **RELATED DOCUMENTS**

1. **Online**~~Mosby's Nursing Skills~~ Intravenous Therapy: Initiation

D. **REFERENCE(S):**

1. Constantino, T et al. Ultrasonography-Guided Peripheral Intravenous Access Versus Traditional Approaches in Patients With Difficult Intravenous Access. *Annals of Emergency Medicine 2005, 46(5):456-461.*

Department Review	Clinical Policies & Procedures Committee	Nurse Executive Committee	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
06/15, 11/19	09/15, 12/19	09/15, 02/20	n/a	11/15, 03/20	01/16, 04/20	05/20	02/16, n/a	02/16

2. Doniger, S et al. Randomized Controlled Trial of Ultrasound-Guided Peripheral Intravenous Catheter Placement Versus Traditional Techniques in Difficult Access Pediatric Patients. *Pediatric Emergency Care 2009, 25(3)154-159.*
3. Miles, G et al. Implementation of a Successful Registered Nurse Peripheral Ultrasound-Guided Intravenous Catheter Program in an Emergency Department. *Journal of Emergency Nursing 2012; 38(4):353-356.*
4. White, A et al, Developing and Sustaining an Ultrasound-Guided Peripheral Intravenous Access Program for Emergency Nurses. *Advanced Emergency Nursing Journal 2010, 32(2):172-188.*

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 3/02 **SUBJECT:** Utilization of Staff, Staffing Patterns

REVISION DATE: 6/03; 8/05; 5/06; 8/08; 6/09; 7/12 **POLICY NUMBER:** VIII.A

Patient Care Services Content Expert~~Department~~ Approval:	**~~09/16~~02/20**
Clinical Policies & Procedures Committee Approval:	**~~09/16~~04/20**
Nursing Leadership~~Executive Committee~~ Approval:	**~~09/16~~05/20**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**~~10/16~~ n/a**
Board of Directors Approval:	**11/16**

A. **POLICY:**

1. Staffing patterns shall follow mandatory state regulations. In addition, patient acuity shall be assessed to ensure appropriate staffing levels.
2. The **Nursing Leadership**~~Director/Manager~~ has accountability for staffing and work schedules.
3. Nursing staff to assist the Registered Nurse (RN) in the provision of patient care may be utilized as follows:
   a. Administrative Supervisor (AS):
      i. Assumes responsibility for supervision of staff as a representative of Administration.
      ii. Assumes administrative authority for the level of patient care and standards of care.
      iii. Acts as liaison between all hospital staff, patients, families, physicians, directors, and administration for routine administrative decisions for their shift.
      iv. Manages internal and external supplemental staff in the absence of the Director, Education, Clinical Informatics, and Staffing.
   b. **Charge Nurse**~~Assistant Nurse Manager (ANM)~~/designee:
      i. Works under the direction of ~~the~~ **Nursing Leadership**~~Clinical Nurse/Operations Manager and/or Director~~.
      ii. Oversees direct and indirect patient care assignments.
      iii. Ensures patient care assignments are in writing and based on the following:
         1) Patient - Level of care (intensity of care needs, treatments, and medications, as determined by the Patient Classification System).
         2) Environment: unit geography, location of assigned patients in relation to each other, and safety.
         3) Technology: hemodynamic equipment, respiratory support equipment, and frequency of required monitoring activities.
         4) Supervision: staff competence, skills/abilities, staff mix, and workload ability.
         5) Competency of delegating RN to carry out clinical and managerial responsibilities.
         6) Availability of delegating RN for appropriate supervision of assigned staff in relation to activity of unit and patient assignment of charge personnel.
         7) Regular staff members are responsible for overseeing students, per diem, registry staff, and orientees.

iv. Document patient assignments each shift and include the following:
1) Name of **Charge Nurse**~~Assistant Nurse Manager~~/designee.
2) Name of RN responsible to supervise and/or orient any RN or non-RN personnel performing patient care, students, registry or traveler staff, or private duty nurses.
3) Name of each caregiver by licensure category and specific assignments listed by individual patient.
4) Assigned break coverage for each licensed staff member to ensure minimum staffing ratios are maintained at all times.
a) Documentation of break coverage shall include specific time of break relief.
b) The same licensure or higher is required for break relief coverage.

v. Cerner staff assignment information will be electronically maintained in the "Staffing Acuity" shared drive folder.

c. Registered Nurse (RN):
i. Works under the direct supervision of the **Charge Nurse, Nursing Leadership**~~Clinical Nurse Manager Assistant Nurse Manager~~/designee.
ii. Plans, supervises, and evaluates the care of all patients by using the nursing process.

d. Procedural Nurse:
i. RN whose primary responsibility is to assist with invasive procedures.
1) Additional duties may be assigned by the Clinical Manager/designee based on the hospital needs.
ii. If census and activity is low throughout the day, staff may be flexed.

e. Unit Secretary (US):
i. A clerical worker who enters information into the computer system and assists with reception duties.
ii. The US works under the direction of the RN and is supervised by a charge nurse or clinical manager on duty.

f. Monitor Technician:
i. A trained person**nel** who has demonstrated competency in recognition of cardiac arrhythmias.
ii. Works under the direction of the RN and is supervised by an ANM or designee on duty.

g. CNA/ACT/Nursing Assistant~~/Mental Health Worker (MHW)~~:
i. A trained person**nel** who has been taught to perform tasks involving direct care services for patients.
ii. Works under the direction of the RN and is supervised by a **Charge Nurse** ~~a~~ ~~ANM~~ or designee on duty.

h. Technicians:
i. A trained person**nel** who demonstrates competency in caring for patients in designated area of specialty.
ii. Works under the direction of the RN and is supervised by the ANM or designee on duty.

i. Psychiatric Liaison:
i. A trained person**nel** (for example licensed MFT/LCSW) who is primarily responsible to complete ~~LPS~~ patient assessments and provides ~~complete~~ crisis intervention, including admission/transfer to an **appropriate level of care** ~~Crisis House and or inpatient Behavioral Health Unit if~~**as** necessary.
~~ii. Works under the direction of the Psychiatric Liaison Supervisor who reports directly to the Behavior Health Unit Manager.~~

4. Volunteers, student nurses, patient-acquired private duty staff, externs, and patient safety technicians may be utilized per policies.
5. Shift-To-Shift Staffing (if applicable)

a. Acuity Measurement - A Patient Classification assessment is conducted once per shift for patients in all nursing units.
   i. Labor & Delivery & Emergency Department are excluded and utilize census only numbers.
b. The **Charge Nurse** ~~Assistant Nurse Manager~~/designee ensures all Patient Classification are completed for their units by 1400 and 0200.
c. The ~~Assistant~~ **Charge Nurse** ~~Nurse Manager~~/designee then completes the staffing needed for the next shift based on the acuity of the patients, minimum staffing ratios and the expected patient volume.
d. This information is communicated to the Staffing Office.
e. Staffing Office Representatives shall place calls as requested by the Administrative Supervisor or designee.
f. After all TCMC available resources have been effectively utilized, the **Charge Nurse**~~Assistant Nurse Manager~~/designee shall evaluate staffing the units using the TCMC tool.
   i. Staffing needs or staffing reductions due to periods of decreased census and patient requirements shall be coordinated by the Staffing Office, Managers, Directors, and/or Administrative Supervisors. This includes ensuring rotations are fair and equitable and specialized unit needs are covered.

B. **RELATED DOCUMENTS:**
1. Patient Care Services (PCS) Policy: Allied Health Students in the Patient Care Areas
2. PCS Policy: Nursing Students in Patient Care Areas
3. PCS Policy: Volunteers, Patient Care Services Departments

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: ~~06/08~~05/92 **SUBJECT: Visiting Guidelines**

REVISION DATE: 05/92, 09/94, 10/96, 01/99, 05/02, 05/03, 12/03, 12/05, 07/07, 02/09, 03/11, 07/14 ~~**POLICY NUMBER: 8610 – 301**~~

Patient Care Services Content Expert~~Department~~ Approval: ~~12/16~~02/20
Clinical Policy & Procedures Committee Approval: ~~01/17~~04/20
Nursinge Leadership~~Executive Council~~ Approval: ~~02/17~~05/20
Medical Staff Department/Division Approval: n/a
Pharmacy and Therapeutics Approval: n/a
Medical Executive Committee Approval: n/a
Administration Approval: 05/20
Professional Affairs Committee Approval: ~~03/17~~ n/a
Board of Directors Approval: 03/17

A. **PURPOSE:**
1. To promote patient and family focused care in a healing environment while maintaining patient and staff safety, privacy and infection control measures.

B. **POLICY:**
1. Visiting is determined by the healthcare needs of the patient.
   a. Family members/significant others are encouraged to participate in care planning through regular interaction with the patient and the health care team.
   b. Limitations may need to be made due to the clinical condition of the patient or at the patient's request.
2. Recognizing the positive contribution made by patients' family/significant others; the Medical Center is open for visiting 24 hours a day.
3. Special Considerations: Visiting hours may be restricted for medical or emergency situations. All exceptions or restrictions are at the discretion of the Chief Nurse Executive or designee.
   a. Adult supervision is required for children in all areas of the facility. Visitors under the age of 14 must be accompanied at all times by an adult other than the patient when visiting a patient unit.
   b. To provide privacy and confidentiality, visitors may be requested to wait in designated waiting areas during physician examinations, nursing care, and the performance of tests or procedures.
   c. In order to allow opportunity for medical care to be provided and to ensure adequate rest and privacy for patients.
      i. In rooms with adjoining beds (semi-private), 2 visitors per patient at a time are allowed.
   d. To ensure patient safety and infection control, family members/significant others and visitors are not allowed in the bed with a patient; nor allowed in an unoccupied patient care bed.
4. The following areas have special visiting policies. Visitors must check in at the nursing station in the following departments:
   a. Intensive Care Unite
   b. Women~~'s~~ **and& ~~Children's~~ Newborn~~'s~~** Services
   c. Neonatal Intensive Care Unit
   d. Emergency Department

~~e. Inpatient Behavioral Health~~
~~f.~~e. Surgical Services

5. Visitor responsibilities include but are not limited to:
   a. Observing the visiting hours for the area that they are visiting and leaving the patient room or care area when asked by hospital staff.
   b. Refraining from behavior that may cause annoyance, inconvenience and/or lack of consideration and assisting with the control of noise and the number of visitors.
   c. Consideration of the rights of patients and hospital staff by treating them with courtesy and respect.
   d. Maintenance of patient confidentiality and privacy.
   e. Refrain from damaging or removing any article or property belonging to TCMC.
   f. Refrain from bringing any food, alcohol or medications to the patient without prior approval from the physician.
   g. Reporting any concerns or complaints to the **Charge Nurse,** ~~Assistant Nurse Manager~~, **Nursing Leadership**~~Manager~~ or designee.
   h. Use hand sanitizer or soap and water to wash hands.
6. Violent or aggressive behavior by visitors:
   a. The hospital will not tolerate violence or aggression by visitors towards staff, patients or other visitors.
   b. The following items and behaviors are prohibited at TCMC:
      i. Alcoholic beverages
      ii. Disruptive or violent behavior
      iii. Smoking/electronic smoking devices
      iv. Street drugs
      v. Weapons (see Administrative Policy: **Weapons on Medical Center Campus # 284**)
   c. For the safety of our patients, visitors and staff - visitors who do not comply with safe conduct regulations may be asked to leave or will be escorted off hospital grounds.

C. **RELATED DOCUMENT(S):**
1. Administrative Policy~~:~~: Weapons on Medical Center Campus 284

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE ~~POLICY MANUAL~~
DISTRICT OPERATIONS

ISSUE DATE: 06/94 **SUBJECT: Control of Locks and Keys**

REVISION DATE: 05/03; 02/06; 01/09; 02/11; 06/14 03/17 **POLICY NUMBER:** 8610-243

Administrative Content Expert~~Department~~ Approval:	**~~02/17~~03/20**
Administrative Policies & Procedures Committee Approval:	**~~02/17~~04/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**~~03/17~~ n/a**
Board of Directors Approval:	**03/17**

A. **PURPOSE:**

1. To set forth a uniform and systematic control for locks and keys at Tri-City Healthcare District (TCHD).

B. **POLICY:**

1. All locks and keys at Tri-City Medical Center (TCMC) are the responsibility of the Director of Facilities **or designee**.
2. Locks:
   a. All door locks in TCMC shall be keyed to the same master keyed system and shall comply with all applicable codes and standards.
   b. Door locks are to be keyed or re-keyed only by approval of the Department Director, Director of Facilities **or designee**, or area Executive.
   c. Offsite door locks are managed through the Engineering Department.
   d. Any lock that is removed from the Master Key MUST be approved by the Chief Executive Officer or Area Vice President.
3. Keypad combination locks are to be used only where absolutely necessary such as the number of keys to be issued would be impractical. All applicable codes and standards shall be adhered to for installation of keypad combination locks.
   a. Keypad combinations for door locks will be coordinated whenever possible provided hospital security is not compromised.
   b. Department Directors or Managers shall be responsible to ensure the integrity of the door code, and to change/update the code whenever there is a potential security risk.
4. Keys:
   a. Keys will be issued to employees on an as needed basis upon approval of the Key Request form by Department Director or Manager, Director of Facilities **or designee**, Area Vice President or CEO.
   b. Keypad combinations and keys for medical staff will be distributed through the Medical Staff Office.
   c. All keys and keypad combinations issued to physicians and employees are to remain protected/confidential with the physician/employee and are not to be shared with anyone else.
   d. Any employee who terminates employment or transfers to another Department shall turn-in the keys with exiting Department Director or Manager who will notify Engineering Department.
5. Electronic access control systems: The proximity card readers can only be installed with the approval of the CEO or COO.

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE ~~POLICY MANUAL~~
DISTRICT OPERATIONS

ISSUE DATE: 01/87

SUBJECT: Equipment/Medical Device Reporting/Sequestering

REVISION DATE: 12/91, 08/94, 05/96, 01/99, 05/02, 02/03, 04/06, 02/11, 08/14

POLICY NUMBER: 8610-201

Department Approval:	04/17
Administrative Policies & Procedures Committee Approval:	04/17
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	05/20
Professional Affairs Committee Approval:	~~06/17~~ n/a
Board of Directors Approval:	06/17

A. **PURPOSE:**

1. To assure that safe medical device reporting/sequestering is implemented. To assure that medical devices on the market are safe and effective through user facility reporting, identification, tracking and corrective actions. For purposes of this policy, the Risk Manager is designated as the hospitals official contact for the Food and Drug Administration (FDA).

B. **DEFINITIONS:**

1. Patient – A "patient" of a facility is (1) an individual being diagnosed, or treated, or receiving medical care under the auspices of the facility, from medical personnel working in, for or who are otherwise affiliated with a device user facility; or (2) an employee of the facility who suffers death, serious illness, or serious injury from a device used at or by the facility, and, as a consequence, becomes a patient.
2. Affiliated – Affiliated is defined to include medical personnel who are associated with a device user facility and is interpreted to include physicians with admitting privileges.
3. Medical Device – An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part or accessory which is:
   a. Not a drug or biologic.
   b. Recognized in the official national formulary, or the USP, or any supplement to them.
   c. Intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment or prevention of disease, in man or other animals, or;
   d. Intended to affect the structure of any function of the body, or other animals, and which does not achieve its primary intended purposes through chemical action within, or on, the body of man or other animals; and which is not dependent upon being metabolized for the achievement of its primary intended purposes.
      i. (Per Safe Medical Devices Act (SMDA) 1990 and Medical Device Amendments, 1992)
4. Examples of Devices – Anesthesia machines, defibrillators, pacemakers, hemodialysis machines, heart valves, catheters, thermometers, patient restraints, contact lenses, hearing aids, blood glucose monitors, x-ray machines, tampons, ventilators, wheelchairs, bedside commodes, infusion pumps, laser, electrosurgery, etc.
5. Serious Illness and Serious Injury – An illness or injury that a) is life threatening, b) results in permanent impairment of a body function or permanent damage to a body structure, c) necessitates immediate medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure.

C. **POLICY:**

1. In compliance with Safe Medical Devices Act, all incidents that reasonably suggest that there is a probability that a medical device or user error caused or contributed to a death, serious illness or serious injury of a patient or employee of the facility, will be reported to the appropriate persons and/or organization.

D. **STAFF RESPONSIBILITY:**

1. In the event of a patient death, serious injury or illness, whether it is due to equipment/product failure or user error the staff member responsible for the patient shall follow these procedures.
   a. Immediately notify the Department Director or Supervisor of the occurrence who will then notify Administration and Risk Management.
   b. Immediately sequester the equipment/product.
   c. Preserve evidence.
   d. Maintain control settings as existed at the time of injury (if applicable), i.e., power settings, gas flow
      i. Device is not to be cleaned or processed.
      ii. Universal precautions to be used in handling all accessory components, or related equipment.
      iii. Device will be kept intact for impoundment.
2. Sequestering the Equipment/Device (to preserve evidence):
   a. Notify Biomedical Engineering of equipment failure. Notify Risk Management of all sequestering, whether a product or equipment.
   b. Maintain the equipment/device in a secure place under the care of an individual who will be able to testify that the device has been preserved in its original condition until arrangements are made with Risk Management for further safekeeping through off-site or on-site storage as needed.
   c. When the decision to sequester is made, the equipment/supplies shall be disconnected from the patient and power supply without changing any control settings or turning the equipment off (if possible). No cleaning or processing of the equipment/supplies shall occur until the Risk Manager has identified if these processes will hinder subsequent investigation. All equipment and associated supplies shall be preserved as found. The equipment/supplies will be sequestered by the user department, biomedical engineer, or Risk Manager as appropriate.
   d. Whenever any piece of equipment is to remain sequestered, the Department Director will provide for replacement of the equipment and notify physicians who use this equipment.
      i. Preserve original packaging of the device if possible.
   e. Complete Quality Review Report, which includes:
      i. Name of patient
      ii. Date and time of patient injury
      iii. Description of event in detail and patient outcome
      iv. Description of malfunction and condition of device upon removal
      v. Biomed Data Control number if possible and manufacturer, model name, serial or lot number
      vi. Verification of notification to supervisor
      vii. Notations of settings as existed at the time of injury
   f. Risk Management and Biomedical Engineering (if equipment) will determine if the product/equipment is to be returned to the manufacturer (if patient injury).
   g. Equipment, instruments or supplies potentially involved in a patient's adverse occurrence are not to be returned to the manufacturer, or discarded until authorization is given by the Risk Manager.

E. **RISK MANAGEMENT DEPARTMENT REPORTING RESPONSIBILITY:**

1. Risk Management will report patient deaths, serious illness and injury or user error resulting from a medical device to the Food and Drug Administration (FDA) within 10 work days, California Department of Public Health (CDPH) within 5 days, and to the manufacturer, if known.
2. The Risk Management Director will also notify the professional liability carrier and Administration.

F. **REPORTING SCHEDULE:**

1. A facility will be treated as first becoming aware of information when medical personnel, who are employed by or otherwise formally, affiliated with the facility, become aware of information with respect to a device in the course of their duties.
2. The Risk Manager shall determine if the event is reportable under the SMDA. Reports will be sent to:
   a. The manufacturer of the device for incidents involving serious illness, serious injury, or death.
   b. The FDA if the event resulted in death or for any serious outcome where the manufacturer is unknown.
3. If determined to be reportable, the Medwatch Form 3500A will be completed by the Risk Manager according to SMDA regulations, starting from when the hospital first became aware that the device may have caused or contributed to the event.
4. Each device user facility is required to submit to FDA, on a semiannual basis (January 1 and July 1), a summary of the reports that it has submitted to the FDA and to manufacturers. If no reports have been submitted, no summary need be sent.
5. Reporting Format: The Risk Management Director will, at a minimum, include information such as the identity of the reporting facility, product name, model, serial number, name of manufacturer, if known, and a description of the event.
6. The Risk Manager shall be responsible for maintaining a separate "File of Device Reportable Incidents." See Attachment A

G. **U.S. Food and Drug Administration (FDA) CONTACT WITH THE HOSPITAL:**

1. If an FDA inspector visits the hospital for any purpose related to medical devices, he/she will be directed to the Risk Manager. The Risk Manager will ask for, review, and record the inspector's credentials prior to providing requested information.
2. Written or telephone inquiries from FDA representatives will be directed to the Risk Manager for response.

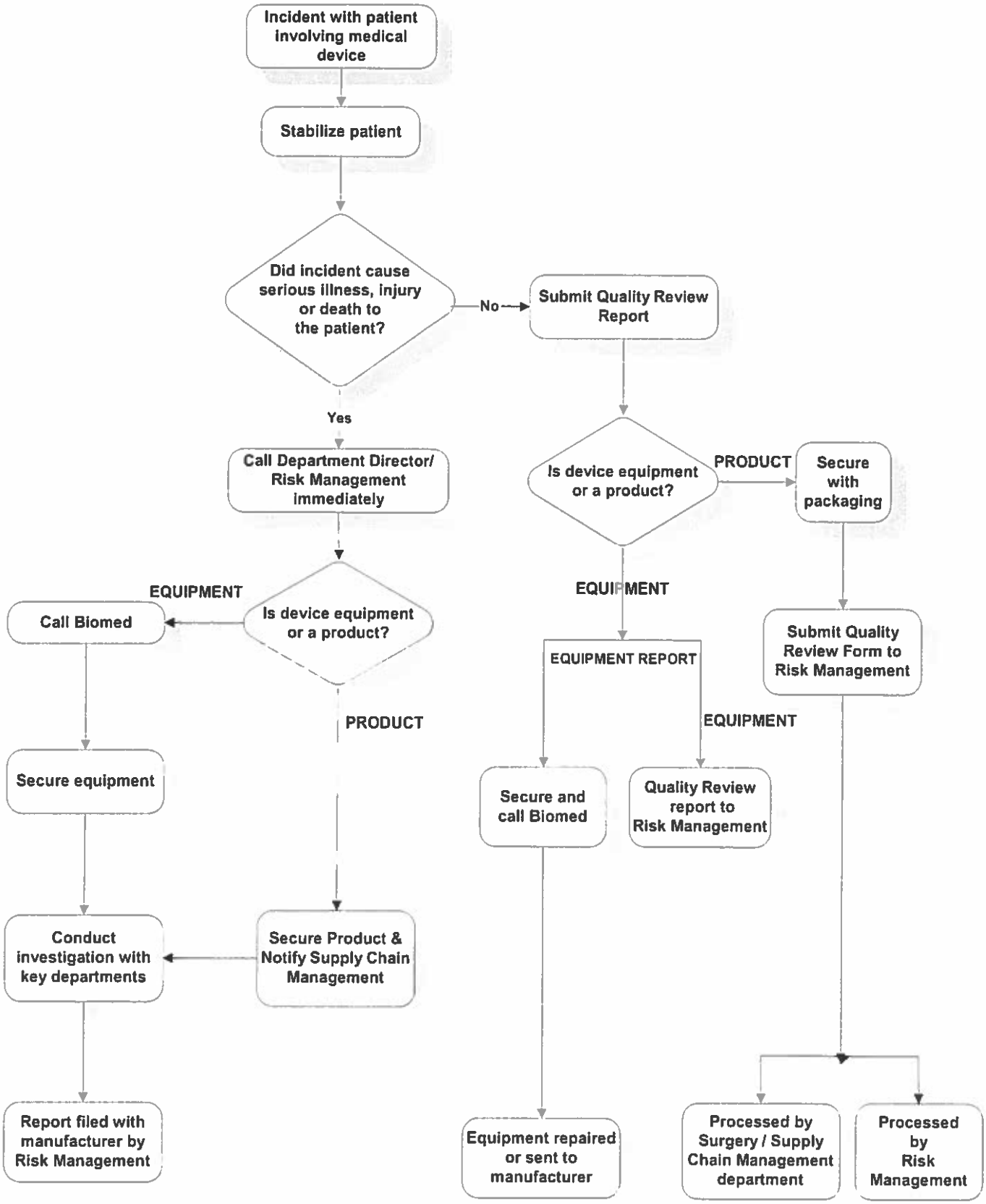
H. **RELATED DOCUMENT~~ATTACHMENT~~(S):**

1. Tri City Medical Device Incident Flow Chart

I. **REFERENCE:**

1. Administrative Policy #501, Adverse Events, Mandatory Reporting of
2. Medical Device Amendments, 1992
3. Patient Care Services Patient Owned/Supplied Equipment Brought into the Facility
4. The Safe Medical Device Act 1990 (SMDA), Medical Device Reporting for User Facilities. Retrieved from: https://www.fda.gov/downloads/MedicalDevices/.../UCM095266.pdf

TRI-CITY MEDICAL CENTER
MEDICAL DEVICE INCIDENT FLOW CHART



Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
DISTRICT OPERATIONS

ISSUE DATE: 01/81 **SUBJECT:** Helicopters on District Property

REVISION DATE: 05/89; 08/93; 10/97; 10/99; 05/03; 01/09; 09/10; 06/14 **POLICY NUMBER:** 8610-207

Administrative Content Expert~~Department~~ Approval:	**~~02/17~~03/20**
Administrative Policies & Procedures Committee Approval:	**~~02/17~~04/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**~~03/17~~ n/a**
Board of Directors Approval:	**03/17**

A. **PURPOSE**
1. To maintain a safe environment for all personnel on the helipad.

B. **POLICY**
1. The patient's physician shall request helicopter transport.
2. Departments requesting helicopter transport shall notify the Emergency Department (ED) as to the estimated time of arrival.
3. The Emergency Department (ED) Mobile Intensive Care Nurse (MICN) shall make appropriate in-house arrangements for landing and take off.
4. The ED MICN shall be notified by the Aeromedical Dispatcher of helicopter landing.
   a. The ED MICN shall notify Security via the radio in radio room of estimated time of arrival of helicopter.
   b. The Security Department will respond to the elevator alcove (and must turn off air handlers temporarily by pushing red button) to standby in case the fire suppression system needs to be activated. The elevator shall be kept in the locked position, available to the flight crew.
      i. If the patient is incoming, an ED technician shall meet the helicopter with a gurney, oxygen tank and I.V. pole and, when directed, assist the flight crew in the transfer of the patient and equipment.
5. The following safety rules shall be followed at all times.
   a. No running on the helipad.
   b. Doors to the helipad shall remain closed at all times (except during patient transfers to or from the helicopter).
   c. Visitors are not allowed on the helipad unless accompanied by the flight crew or TCMC Security personnel.
   d. Gurneys with mattresses, linens, or IV poles are not permitted within 50 feet of the aircraft when the blades are turning. Make sure all loose objects (i.e., MAST suits; debris) are secured on the helipad.
   e. Oxygen cylinders must be properly secured at all times (designated cylinder cart or underneath the gurney in the cylinder slot). At no time may cylinders be left unsecured.
   f. Wait for the pilot's approval before approaching or exiting the aircraft. Approach or exit the aircraft from the front in view of the pilot.
   g. Do not approach the helipad until the aircraft has landed on or lifted off the pad.
   h. Do not approach or exit the aircraft when the blades are turning. Do not allow ancillary personnel to approach the aircraft until the rotors have stopped turning.
   i. Tri City Medical Center heliport weight restriction for all medical air transportation is 10k

pounds maximum with a blade diameter of no more than 36 feet.

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE ~~POLICY MANUAL~~
DISTRICT OPERATIONS

ISSUE DATE: 07/86 **SUBJECT: Signage**

REVISION DATE: 5/88; 6/94; 5/03, 8/06, 5/09, 8/12 **POLICY NUMBER:** 8610-215

Administrative Content Expert~~Department~~ Approval:	**~~07/16~~04/20**
Administrative Policies & Procedures Committee Approval:	**~~07/16~~04/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**~~08/16~~ n/a**
Board of Directors Approval:	**08/16**

A. **PURPOSE:**

1. To act in accordance with applicable statutory or regulatory requirements, Tri-City Healthcare District (TCHD) will post or display signs and informational notices within the facility. To provide consistent signage, while ensuring a safe and aesthetically pleasing environment for our patients, guests and employees.

B. **DEFINITIONS:**

1. Permanent signage/signs: Signs that are mounted with the intention of being a permanent or long term fixture. Examples: Directional way-finding signs, wall pictures, no smoking signs, regulatory signage.
2. Temporary signage/signs: Signs or postings that are put up with the intention of being in place for a limited amount of time. Examples: Educational class notices, Foundation or Auxiliary fundraising events, temporary detour directional signs, seasonal flu advisory notices.

C. **POLICY:**

1. TCHD will post and maintain signage as required by the California Department of Public Health, Title 22 California Code of Regulations, other California law, and The Joint Commission and Medicare Conditions of Participation requirements.
2. All requests for permanent signage/signs must be approved by the Chief Operating Officer (COO)/designee.
3. Prior to any signs being posted in the facility, whether permanent or temporary they will need to be approved by the Environment of Care/Safety Officer to ensure they meet approved specifications and regulatory requirements. (Exceptions listed below: 4.a-c)
4. All advertising and marketing materials designed for an internal or external audience, that contain the Tri-City Healthcare District or Tri-City Medical Center name and logo must be created and/or approved by the Chief Marketing Officer/designee. This includes all brochures, calendars, fliers, handouts, pamphlets, stationary, website and broadcast production, etc.
   a. Education related flyers used to promote educational opportunities, classes, Hot Topics, etc. only require the approval of the Director of Education~~, Clinical Informatics and Staffing~~.
   b. Union Materials: No material shall be posted until approved and initialed by the ~~Chief~~ Human Resources **Leadership**~~Officer (CHRO)~~/designee. Approved postings are to be displayed on designated bulletin boards. Postings outside of designated areas are prohibited.
   c. Temporary signs/flyers posted within department break rooms, lounges, and educational boards only require the approval of the Department **Leadership** ~~director, manager~~ or ~~departmental~~ designee.

5. The Facilities department is responsible for the installation and maintenance of all permanent signage/signs.
6. Paper signage may not be posted in fire corridors unless it is laminated, framed, or printed on fully synthetic paper. Contact the Environment of Care/Safety Officer for guidance and clarification.

D. **REFERENCES:**

1. California Department of Public Health, Title 22 California Code of Regulations
2. The Joint Commission and Medicare Conditions of Participation

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE ~~POLICY MANUAL~~
INFORMATIONAL TECHNOLOGY

ISSUE DATE: 12/00

SUBJECT: Access to Restricted, Financial, Employee, or Other Non-Patient Electronic Information by TCHD Authorized Business Partners

REVISION DATE: 05/03, 06/06, 05/09, 07/12

POLICY NUMBER: 8610-608

Information Technology Department Approval:	**~~10/15~~07/~~17~~04/20**
Administrative Policies & Procedures Committee Approval:	**~~06/12~~10/~~15~~04/20**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**~~07/12~~ n/a**
Board of Directors Approval:	**07/12**

A. **PURPOSE:**

1. To provide access to Restricted Electronic Information by Tri-City Healthcare District (TCHD) Authorized Business Partners. Restricted Electronic Information is provided to those Authorized Business Partners who receive approval from a member of the TCHD Executive Council.

B. **DEFINITION(S):**

1. Restricted Electronic Information includes all electronic information that is not known by or generally available to, the public at large and which concerns the business or affairs of TCHD. This includes patient specific information; information contained in existing TCHD systems; intellectual property of TCHD; actual or proposed terms of any contract between TCHD and vendors; and any other proprietary information reasonably identified by TCHD as restricted.
2. Authorized TCHD Business Partners include authorized physicians, vendors and other persons engaged in legitimate business at TCHD.
3. This Policy addresses Financial, Employee or Other Non-Patient Electronic Information.
   a. TCHD is defined as "Covered Entity", according to the terms of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and regulations promulgated there under by the U.S. Department of Health and Human Services (the "HIPAA Regulations").
   b. If the TCHD Authorized Business Partner is to receive access to HIPAA – defined "Protected Health Information (PHI) from TCHD, and is defined as a "Business Associate" under HIPAA, the TCHD Authorized Business Partner must submit to all the terms of **Administrative Policy:** # 511 ~~"HIPAA~~ Business Associate Agreement~~"~~, ~~**Information Technology**~~**Administrative Policy: 8610-622 Business Associate Agreement, Clinical Information System (Cerner) Access, Physicians and Physician Office Employees: Onsite and Remote** and must sign a Business Associate Agreement with TCHD.
4. Access to Restricted Electronic Information is provided via:
   a. Sharing of TCHD restricted electronic information to a vendor that requires that information to complete engagements with TCHD
   b. Exchange of TCHD restricted electronic information with a business partner for the purposes of financial analysis
   c. Or other sharing of TCHD restricted electronic information as identified in an agreement between TCHD and the Business Partner

C. **POLICY:**

1. The Authorized TCHD Business Partner:
   a. Will Hold The Restricted Electronic Information In Confidence, Exercising At Least The Same Care With Respect Thereto As It Exercises With Respect To Its Own Confidential Information Of Like Kind, And Will Not Without TCHD's Written Consent Disclose Any Portion Thereof To Any Third Party, Except Pursuant To A Validly Issued Subpoena Or Court Order;
   b. Will Restrict Dissemination Of The Restricted Electronic Information Within Authorized TCHD Business Partner's Organization To Those Persons Who Have A Need To Know Such Information, And;
   c. Will Not Use The Restricted Electronic Information For Any Purpose Other Than The Assistance Of TCHD
   ~~c.~~**d. Will Notify TCHD when contract is terminated and access is no longer required.**
2. TCHD:
   a. May Monitor Access To Restricted Electronic Information By Authorized TCHD Business Partners
   b. Reserves The Right, Without Notice, To Limit And/Or Restrict Any Access To Restricted Electronic Information By Authorized TCHD Business Partners, And To Inspect, Copy, Remove Or Delete Any Unauthorized Use
   c. Reserves The Right To Use And Disclose Any Information Regarding Access To Restricted Electronic Information By Authorized TCHD Business Partners, Including To Law Enforcement Officials
   d. **Will Disable Access Upon Notification Of Termination Of Contract.**
   ~~e.~~**e. Will Automatically disable access if not active for a period of 90 days.**
3. All TCHD policies and practices apply to Access to Restricted Electronic Information by Authorized TCHD Business Partners, including those policies regarding intellectual property protection, privacy, misuse of TCHD resources, sexual harassment or other unlawful harassment, information and data security, and confidentiality.
4. Each Authorized TCHD Business Partner granted Access to Restricted Electronic Information is provided with a written copy of this policy. The Authorized TCHD Business Partner must complete a Data Use Agreement.
5. While Access to Restricted Electronic Information may offer significant benefits, it can also expose the TCHD computer systems to risks and compromise if appropriate security measures are not strictly followed. Each Authorized TCHD Business Partner is accountable for any action that results in a breach of TCHD security or confidentiality. **(See Administrative Policy: 8610-630Security Measures Required to Comply with HIPAA~~management Policy 8610-630~~)**
6. Access to Restricted Electronic Information by an Authorized TCHD Business Partner must not be used knowingly to violate the laws and regulations of the United States or any other nation. Use of any TCHD resources for illegal activity is grounds for corrective action or immediate dismissal, and we will cooperate with any legitimate law enforcement activity.

D. **PROCEDURE:**
1. An Authorized TCHD Business Partner who has a legitimate need for Access to Restricted Electronic Information should request it in the following manner:
   a. Obtain a Data Use Agreement (Instructions, Agreement, and Application attached to this Policy).
   b. Obtain necessary signatures from the appropriate department director and TCHD Vice President
   c. Submit the **System Access ~~r~~Request Form** to Information Technology.
   d. An Information Technology representative will determine the technical and electronic information requirements for the request.

E. **MANAGEMENT AND ADMINISTRATION:**
1. The TCHD Information Technology Department is responsible for assuring security of the TCHD network. The Information Technology Department provides all network access, and must approve all requests to provide access to TCHD Restricted Electronic Information by TCHD

Authorized Business Partners.

2. To prevent unauthorized access to Restricted Electronic Information, TCHD's Information Technology Department may require encryption, authentication, or other protections, particularly if Access to Restricted Electronic Information is via the File Transfer Protocol (FTP), Internet access, or other similar method.
3. Official Records
   a. All messages, audit reports, and records of Access to TCHD Restricted Electronic Information by TCHD Authorized Business Partners are official records and are the property of TCHD. TCHD reserves the right to access and disclose, at any time, all documentation of Access to TCHD Restricted Electronic Information by TCHD Authorized Business Partners.
4. Copyrighted Materials
   a. Computer programs are copyrighted material, and may not be copied without adhering to the requirements listed on the purchased product's software licensing agreement.
5. User IDs and Passwords
   a. User IDs and passwords help maintain individual accountability for Internet usage.
      i. The Information Technology Department will assign a single password to a person to be used for Network Services, Email and Internet access. Any employee of an Authorized Business Partner who obtains a password or ID must keep that password confidential. Company policy prohibits the sharing of passwords.
6. Security
   a. TCHD has installed a variety of firewalls, proxies, Internet address screening programs, and other security systems to assure the safety and security of the networks.
      i. Any TCHD Authorized Business Partner that attempts to disable, defeat or circumvent any security facility will be subject to appropriate corrective action.
   ~~i.~~**b. Any sensitive information being sent via external email must be encrypted prior to sending. (See Email Security Encryption Instructions~~Attachment A~~)**
7. Violations
   a. Adherence to this policy is neither voluntary nor optional. Violation of this policy is grounds for disciplinary action up to, and including, termination of employment or contractor status. If necessary, TCHD also reserves the right to advise appropriate legal officials of any illegal violations.
8. Legal Notice
   a. California Penal Code 502 states that unauthorized use of a computer in the state of California is a felony.
9. Notification of Improper Use
   a. Each employee or Authorized Business Partner is expected to report unauthorized use or violation of this policy to the privacy office or security officer.

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

~~a.~~**1. Email Security Encryption Instructions~~Attachment A: How to Send Encrypted Email~~**

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

1. Business Associate Agreement – HIPAA Business Associate – Data Use Application
2. Business Associate Agreement – Instructions Data Use Application
3. Business Associate Agreement – HIPAA Business Associate Addendum
~~3.~~**4. System Access Request Form (SAR) ~~Employee et.al~~ Non-Provider**

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

1. **Administrative Policy: 511 Business Associate Agreement**
2. **Administrative Policy: 8610-622 Business Associate Agreement, Clinical Information System (Cerner) Access, Physicians and Physician Office Employees: Onsite and Remote**
3. **Administrative Policy: 8610-630Security Measures Required to Comply with HIPAA**

4. California Penal Code 502
5. Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, HIPAA

Attachment A: How to Send Encrypted Email

Email Security Encryption
MS Outlook or MS Outlook Web Access

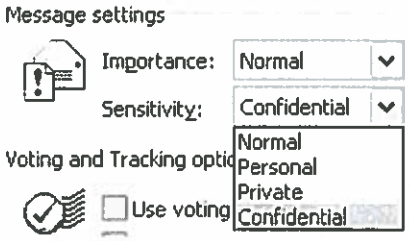
Compose New Email

Type in the Subject field: ENCRYPT *Add subject after the ENCRYPT*

e.g ENCRYPT Let go get some food

Click Options in the tool bar

Click Sensitivity drop down menu
Click Confidential
Click Close



Type an **external email account**: example **@yahoo.com or @gmail.com**

Click Send
Your email notice will look like this:

A message sent by you has been held by the MailControl message scanning service for secure retrieval. The recipient(s) will require the following password to retrieve the message. YOU MUST COMMUNICATE THIS PASSWORD TO THE RECIPIENT.

Message Details

Password : *Provide the* Password *to your recipient to view the email.*

Your recipient of your email will see this:

Awaiting retrieval

mikedt@tcmc.com

A message had been held for you to retrieve from the MailControl message scanning service.
You will need a password to retrieve the message. THE PASSWORD CAN ONLY BE PROVIDED BY THE SENDER.

Message Details

Link :	Click here

The recipient Click Here to enter the Password *you sent.*

Parked message

Please enter the password supplied to you by the sender of this message.

Password:

View

Type in the **Password** you send them and **click View** will be able to view the content of the email body.

~~Business Associate Agreement – HIPAA Business Associate – Data Use Application~~

~~HIPAA Business Associate – Data Use Application~~

~~Principal Recipient of Protected Health Information~~

~~Company Name and Contact:~~

~~Addres~~

~~Phone~~

~~E-mail:~~

~~This Ap~~ ~~ditional specific~~ ~~Health Informa~~

~~1.~~ ~~Health Informa~~

Link to current documents in MCN

~~2.~~

~~3.~~

~~4. **Safeguards** that prevent unapproved use or disclosure:~~

~~5. The **plan (how and when) to destroy** the Designated Data Set of Protected Health Information:~~

~~6. **Additional Terms.** [This section may include specifications for disclosure format, method of transmission, use of an intermediary, use of digital signatures or PKI, authentication, additional security or privacy specifications, de-identification or re-identification of data and other~~

~~additional terms.]~~ _____

_____

_____

_____

_____

_____

~~7. Person Completing This Application:~~

~~Signature:~~ _____

~~Print Name:~~ _____

~~Title:~~ _____

~~Date Signed:~~ _____

~~Business Associate Agreement – Instructions Data Use Application~~

~~Instructions – Data Use Application~~
~~Tri-City Healthcare District (TCHD)~~

~~TCHD may Disclose a Designated Data Set of Protected Health Information (PHI) according to a Business Associate Addendum, if TCHD obtains satisfactory assurance that the recipient of the PHI will Use or Disclose the information only for limited purposes.~~

~~Please complete the Data Use Application, explaining your receipt and use of TCHD PHI, by answering the following questions:~~

- ~~St~~ ~~ill be us~~
- ~~Pr~~
- ~~Ide~~
- ~~Pr~~ ~~se or Di~~
- ~~Ide~~

Link to current documents in MCN

~~Business Associate Agreement – HIPAA Business Associate Addendum~~

~~HIPAA BUSINESS ASSOCIATE ADDENDUM~~

~~This HIPAA BUSINESS ASSOCIATE ADDENDUM ("**Addendum**") is entered into as of _____, 20___ (the "*Execution Date*"), by and between Tri-City Healthcare District, a health care district organized under the Local Health Care District Law of the State of California ("**Hospital**") and _____ ("**Contractor**").~~

~~A. Hospital owns and operates a general acute care hospital that is located at 4002 Vista Way, Oceanside, California.~~

~~B. Hosp~~ntability Act of 1996, Public~~s~~ associate" contrac~~in either~~ paper or electronic~~pital and~~ Contractor, dated ~~ave~~ access to patient r~~by the~~ Health Information~~TECH~~ Act") and their imp~~or as~~ otherwise amende~~gulations~~ shall hereinafter b~~("CMIA"),~~ contained in the C~~ords Act~~ ("PAMRA") contai~~fornia~~ Health and Safety~~vacy~~ laws.

Link to current documents in MCN

~~NOW, THE~~ contained, the par~~.~~

~~1. Defi~~

~~(a) same~~ meaning as those~~e HIPAA~~ Regulations, means the section of the Code of Federal Regulations (CFR) as in effect or as amended, and for which compliance is required.

~~(b) Unauthorized or Unlawful Access shall mean the inappropriate review or viewing of patient medical information without a direct need for diagnosis, treatment or other lawful Use as permitted by HIPAA, CMIA or by other statutes or regulations governing the lawful access, Use or Disclosure of medical information.~~

~~(c) Designated Data Set is a group of records, from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the Individual, and which is used to make decisions about the Individual.~~

~~(d) Data Use Application describes the purpose, controls and safeguards agreed to by the Contractor and Hospital.~~

2. Billing and Collecting. If Contractor provides billing and collecting services to Hospital or otherwise conducts any Standard Transactions on behalf of Hospital, Contractor shall comply with this Section. Contractor shall comply with 45 CFR Parts 160 and 162 (the "**Transaction Rule**"), including: (a) Contractor shall not change the definition, data condition, or use of a data element or segment in a standard of the Transactions Rule (a "**Standard**"); (b) Contractor shall not add any data elements or segments to the maximum defined data set; (c) Contractor shall not use any code or data elements that are either marked "not used" in the Standard's implementation specification or are not in the Standard's implementation specification(s); and (d) Contractor shall not change the meaning or intent of the Standard's implementation specification(s).

3. Contractor's Obligations

(a) Contractor acknowledges and agrees that all Protected Health Information that is created or received by Hospital and Disclosed or made available in any form, including paper record, audio recording, and electronic display by Hospital or its operating units to Contractor, or is created, received, maintained or transmitted by Contractor on Hospital's behalf, shall be subject to the Agreement and this Addendum.

(b) Contractor shall not Use or Disclose Protected Health Information in any form, including electronic form ("**PHI**"), other than as permitted or required by this Addendum or required by law.

(c) Contractor shall not permit Unauthorized or Unlawful Access to PHI.

(d) Except as otherwise limited in this Addendum, Contractor may Use or Disclose PHI to perform functions, activities, or services for, or on behalf of, Hospital as specified in the Agreement or for Contractor's internal operational purposes, provided that such Use or Disclosure would not violate the HIPAA Regulations or California law if done by Hospital.

(e) The Contractor shall not further Disclose any PHI (including to subcontractors) received from the Hospital or maintained by the Contractor, unless permitted by this Addendum and, in such cases, only if such Disclosure is required or permitted under California law.

(f) The Contractor shall not Disclose PHI to a health plan for payment or health care operations purposes if the Individual has requested this special restriction and has paid out of pocket in full for the health care item or service to which the PHI solely relates.

(g) Except as otherwise provided for in this Addendum, Business Associate may use Protected Health Information for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate. (See 45 C.F.R. §164.504(e)(4)(i)).

(h) Except as otherwise provided for in this Agreement, Business Associate may Disclose Protected Health Information for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that Disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is Disclosed that it will remain confidential and Used or further Disclosed only as Required By Law or for the purpose for which it was Disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been Breached. (See 45 C.F.R. §164.504(e)(4)(ii)).

(i) To the extent that Contractor is to carry out one or more of Hospital's obligations under Subpart E of 45 CFR Part 164, Contractor shall comply with the requirements of Subpart E that apply to Hospital in the performance of the obligations.

4. Disclosure Accounting. In the event that Contractor makes any Disclosures of PHI that are subject to the accounting requirements of 45 CFR Section 164.528, Contractor promptly shall report such Disclosures to Hospital in writing. Such notice shall include the name of the individual and company affiliation to whom the PHI was Disclosed and the date of the Disclosure. Contractor shall maintain a record of each such Disclosure, including the date of the Disclosure, the name and, if available, the address of the recipient of the PHI, a brief description of the PHI Disclosed and a brief description of the purpose of the Disclosure. Contractor shall maintain this record for a period of six (6) years and make such records available to Hospital upon request in an electronic format so that Hospital may meet its Disclosure accounting obligations under 45 CFR Section 164.528.

5. Access to PHI by Individuals. Contractor shall cooperate with Hospital to fulfill all requests by Individuals for access to the Individual's PHI that are approved by Hospital. Contractor shall cooperate with Hospital in all respects necessary for it to comply with 45 CFR Section 164.524. If Contractor receives a request from an Individual for access to PHI, Contractor immediately shall forward such request to Hospital, who shall be solely responsible for determining the scope of PHI and Designated Record Set with respect to each request by an individual for access to PHI. If Contractor maintains PHI in a Designated Record Set on behalf of Hospital, Contractor shall permit any Individual, upon notice by Hospital, to access and obtain copies of the individual's PHI in accordance with 45 CFR Section 164.524. Contractor shall make the PHI available in the format requested by the Individual and approved by Hospital. If Business Associate maintains the PHI in a Designated Record Set in electronic form and an Individual requests a copy of such information in electronic format, Business Associate shall provide such information in electronic format to Hospital in order for it to comply with its obligation. Contractor shall not charge Hospital or the Individual any fees for such access to PHI. If Contractor does not hold any information as part of a Designated Record Set, this Section shall not apply to Contractor.

6. Amendment of PHI. Contractor shall incorporate all amendments to PHI received from Hospital within five (5) business days of receipt. Contractor shall provide written notice to Hospital within five (5) business days of completing such amendment(s). Such notice shall confirm that Contractor has made the amendment(s) to PHI as directed by Hospital and shall contain any additional information necessary for Hospital to provide adequate notice to the Individual in accordance with 45 CFR Section 164.526. If Contractor does not hold any information as part of a Designated Record Set, this Section shall not apply to Contractor.

7. Access to Contractor's Books and Records. Contractor shall make its internal practices, books and records relating to the Use and Disclosure of PHI received from, or created or received by Contractor on behalf of Hospital, available to the Secretary of the Department of Health and Human Services ("Secretary") for purposes of determining Hospital's compliance with the HIPAA Laws. Contractor shall provide to Hospital a copy of any PHI that Contractor provides to the Secretary concurrently with providing such PHI to the Secretary. Contractor also shall make its internal practices, books and records available within five (5) business days of a request by Hospital for inspection for purposes of determining compliance with this Agreement.

8. Security Safeguards. Contractor shall implement a documented information security program that includes administrative, technical and physical safeguards designed to prevent the accidental or otherwise unauthorized Use or Disclosure of PHI. Contractor shall require any agents, affiliates, subsidiaries or subcontractors, with access to electronic PHI related to Hospital in any way,

~~to agree in writing to the same requirements under this Section. Moreover, Contractor shall implement administrative, physical, and technical safeguards and policy, procedure, and documentation requirements consistent with the requirements of 45 CFR Sections 164.308, 164.310, 164.312, and 164.316.~~

~~9. Reporting and Mitigating. Contractor shall immediately report, but in no event later than 24 hours, any Security Incident including any Unauthorized or Unlawful Access, Use or Disclosure of PHI or Breach of Unsecured PHI not provided for or permitted by this Addendum of which the Contractor becomes aware. Moreover, in the event that Contractor becomes aware that PHI has been or reasonably believes has been accessed, acquired or Disclosed as a result of a "Breach," or Unauthorized or Unlawful Access as those terms are defined by the HIPAA Laws or Section 1280.15, Contractor will notify Hospital of the Breach and/or Unauthorized or Unlawful Access, Use or Disclosure, including the identification of each Individual who has been or is reasonably believed to have been affected thereby. Contractor's notification to Hospital shall be provided in accordance with HIPAA Laws and Section 1280.15 and guidance as it may be provided by the Secretary and the California Office of Health Information Integrity. Contractor shall use its best efforts to mitigate the deleterious effects of any Unlawful Access, Use or Disclosure of PHI not authorized by this Addendum or any Security Incident.~~

~~10. Term and Termination.~~

~~(a) The Term of this Addendum shall be effective as of the Execution Date and shall terminate when all of the PHI provided by Hospital to Contractor, or created or received by Contractor on behalf of Hospital, is destroyed or returned to Hospital, or, if it is infeasible to return or destroy the PHI, protections are extended to such information, in accordance with Section 11 below.~~

~~(b) If Hospital becomes aware of any material breach of this Addendum by Contractor, Hospital shall provide Contractor with written notice of such breach and such breach shall be cured by Contractor within thirty (30) business days of such notice. If such breach is not cured with such time period, Hospital shall immediately terminate this Addendum.~~

~~(c) If Contractor becomes aware of any material breach of this Addendum by Hospital, Contractor shall provide Hospital with written notice of such breach and such breach shall be cured by Hospital within thirty (30) business days of such notice. If such breach is not cured with such time period, Contractor shall immediately terminate this Addendum.~~

~~(d) Contractor acknowledges and agrees that Hospital may be required by HIPAA Laws to report a Breach to the Secretary of the U.S. Department of Health and Human Services and Unauthorized or Unlawful Access, Use or Disclosure of PHI to the State.~~

~~(e) The Agreement shall automatically terminate upon termination of this Addendum for any reason whatsoever.~~

~~11. Effect of Termination.~~

~~(a) Upon termination or expiration of this Addendum, Hospital shall direct Contractor to either return or destroy all PHI that Contractor obtained, created or maintained pursuant to the Agreement on behalf of Hospital. If Hospital determines at that time that the return or destruction of PHI is not feasible, Contractor shall extend the protections provided under this Addendum to such PHI, and limit further Use or Disclosure of the PHI to those purposes that make the return or destruction of the PHI infeasible.~~

(b) Upon termination or expiration of this Addendum, Contractor shall recover all PHI that is in the possession of Contractor's agents, affiliates, subsidiaries or subcontractors. If Contractor believes at that time that it is infeasible for the Contractor to recover all PHI in the possession of Contractor's agents, affiliates, subsidiaries or subcontractors, Contractor shall provide written notice to Hospital regarding the nature of the unfeasibility. Upon a determination by Hospital that such recovery is infeasible, Contractor shall require that its agents, affiliates, subsidiaries and subcontractors agree to the extension of all protections, limitations and restrictions required of Contractor hereunder. If Hospital determines that it is feasible to make such recovery, Contractor shall recover all PHI in the possession of Contractor's agents, affiliates, subsidiaries or subcontractors.

(c) If Contractor or Contractor's agents, affiliates, subsidiaries or subcontractors retain any PHI pursuant to this Section 11, the terms of this Addendum shall continue to apply to the PHI retained by Contractor or any of Contractor's agents, affiliates, subsidiaries or subcontractors, even after termination of the Agreement.

12. Prohibition of Sale of PHI. Contractor may not directly or indirectly receive remuneration in exchange for any PHI without a valid Authorization specifically indicating that the PHI may be sold to the entity receiving the PHI unless the sale is otherwise authorized by the HIPAA Laws.

13. Indemnification. Each party, to the extent allowable under the California Tort Claims Act, shall indemnify, defend and hold harmless the other party and its agents, employees, contractors, officers and directors against: (i) any and all liability arising out of such party's failure to comply with the terms of this Addendum, and any injury, loss, fines, claims, or damages arising from the negligent operations, acts, or omissions of such party or its employees relating to or arising out of this Addendum; and (ii) any and all costs and expenses, including reasonable legal expenses, incurred by or on behalf of the other party in connection with the defense of such claims.

14. Contractor's Compliance with HIPAA. Hospital makes no warranty or representation that compliance by Contractor with this Addendum, the HIPAA Laws or California law will be adequate or satisfactory for Contractor's own purposes or that any information in Contractor's possession or control, or transmitted or received by Contractor, is or will be secure from unauthorized Use or Disclosure. Contractor is solely responsible for all decisions made by Contractor regarding the safeguarding of PHI.

15. Continuing Agreement. Except as expressly modified by this Addendum, the Agreement shall continue in full force and effect. In the event of any conflict between any provision of this Addendum and any provision of the Agreement, the provision of this Addendum shall control.

16. Assignment; Binding Effect. This Addendum shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and assigns. Unless otherwise provided in the Agreement, Contractor may not assign the rights or obligations under the Agreement without the express written consent of Hospital; however, Hospital may assign its rights and obligations under this Agreement to any successor or affiliated entity without the consent of Contractor.

17. Affiliates, Agents, Subsidiaries and Subcontractors. Contractor shall require any agents and subcontractors which creates, receives, maintains or transmits PHI related to Hospital on its behalf, to agree in writing to the same Use and Disclosure restrictions and conditions imposed on Contractor by this Addendum including the requirement that such agents and subcontractors

implement reasonable and appropriate administrative, physical and technical safeguards to protect such PHI. Business Associate shall incorporate, when applicable, the relevant provisions of this Addendum into each subcontract to such agents and subcontractors including the requirement to report Security Incidents, Breaches and Unauthorized or Unlawful Access, Use and Disclosures to Business Associate. Unless the Agreement permits Contractor to subcontract its services, Contractor shall not subcontract any of its services under the Agreement without first obtaining Hospital's prior written consent.

18. Compliance with Laws. The parties shall comply with all applicable laws, ordinances, codes and regulations of federal, state and local governments, applicable to the performance of the Agreement and this Addendum.

19. Governing Law. Unless provided otherwise in the Agreement, this Addendum shall be construed in accordance with and governed by the laws of the State of California, except the conflicts of laws provisions which would require the application of the laws of any other jurisdiction.

20. Headings. The headings in this Addendum are intended solely for convenience of reference and shall be given no effect in the construction or interpretation of this Agreement.

21. No Third-party Beneficiary Rights. Unless provided otherwise in the Agreement, the parties do not intend to confer and this Addendum shall not be construed to confer any rights or benefits to any person, firm, physician, corporation or entity other than the parties.

22. Data Ownership. Contractor acknowledges and agrees that all PHI that Contractor obtains, creates or maintains pursuant to the Agreement, on behalf of Hospital or for Contractor's internal use, is the property of Hospital and Contractor has no ownership rights with respect thereto.

23. Severability. If any provision of this Addendum is determined to be illegal or unenforceable, that provision shall be severed from this Addendum and/or the Agreement, as applicable, and such severance shall have no effect upon the enforceability of the remainder of the Agreement.

24. Counterparts. This Addendum may be executed in one or more counterparts, each of which shall be deemed to be an original, and all of which together shall constitute one and the same instrument.

25. Data Use Application. If Contractor requests a "Designated Data Set" from Hospital, Contractor must complete a Data Use Application (Instructions and Application attached to this Addendum) and submit a completed Data Use Application with this signed Addendum. The Data Use Application may be modified or amended by mutual agreement of the parties at any time without amending the Agreement or this Addendum.

IN WITNESS WHEREOF, the parties have executed this Addendum as of the Execution Date.

HOSPITAL
Tri-City Healthcare District, a health care district organized under the Local Health Care district Law of the State of California

By: _____
Chief Executive Officer

~~CONTRACTOR~~

~~Signature:~~_____

~~Print Name:~~_____

~~Title:~~_____

~~System Access Request Form (SAR) – Non-Provider~~

Tri-City Medical Center ADVANCED HEALTH CARE FOR YOU

TRI-CITY HEALTHCARE DISTRICT
System Access Request Form (SAR)

Link to current documents in MCN

Managed Care (Alliance)		Transcription (3M)	
Materials Management (Proclick / Reptrax)		WFAN	
Other:			

I am aware of and agree to abide by the privacy and security policies of Tri-City Healthcare District and its affiliates as it applies to the protected health information as well as organizational information. I understand that I must only access that information which is the minimum necessary for me to carry out my duties within the organization and any other access is strictly forbidden.

- *Never share my password or access information that is not required for my assigned duties.*
- *Always log in and off appropriately when using a workstation.*
- *Never access or disclose organizational or protected health information except within the scope of my position.*
- *Only copy information from the organizational data bases as authorized.*
- *Always take reasonable precautions when originating, receiving or transferring database information (virus).*
- *Never remove organizational or protected health information from the organization (paper or electronic) unless authorized.*

I understand that violations of Tri-City Healthcare District (TCHD) privacy and security policies are grounds for disciplinary action to include, but not limited to loss of privileges, termination, or possible criminal prosecution.

_____ _____

Account User Signature **Date**

MANAGER/SUPERVISOR APPROVAL OF REQUEST

I authorize the above named individual to have access to the information. Additionally I have reviewed with this individual organizational privacy and security policies and the consequences of failure to comply.

_____ _____

Signature **Date**

_____

Print Name

PLEASE EMAIL THE COMPLETED FORM TO: SARIT@TCMC.com

INFORMATION SYSTEMS REVIEW & IMPLEMENTATION OF REQUEST

Implemented by: (IT representative) _____ **Date:** _____

Staff Member Notified/Educated as to Log In Process/Password Selection

IT USE ONLY:
Initial User Login Name and Password_____**Entered by:** _____ **Date:**_____

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE ~~POLICY MANUAL~~
INFORMATION TECHNOLOGY

ISSUE DATE: 3/04 **SUBJECT:** Remote or Portable Computing

REVISION DATE: 02/05; 05/12; 607/12 **POLICY NUMBER:** 8610-623

Administrative Content Expert:	02/20
Administrative Policies & Procedures Committee Approval:	~~06/12~~03/20
Medical Executive Committee Approval:	04/20
Administration Approval:	05/20
Professional Affairs Committee Approval:	~~07/12~~ n/a
Board of Directors Approval:	07/12

A. **PURPOSE:**

1. To provide Remote or Portable Computing, while meeting audit and regulatory requirements for confidentiality and security of information, to each Authorized Remote or Portable Computing User ("User") associated with Tri-City Healthcare District ("TCHD"), including employees and other persons engaged in legitimate business at TCHD.
2. Wireless Computers On Wheels (WOWs) used throughout TCHD are permanently located within a TCHD department, and are therefore not considered Remote or Portable Computers for the purposes of this policy. WOWs are addressed in **Administrative Information Technology** Policy: ~~624—~~Wireless **Network** Communication **624**.

~~a.~~3. Included in the definition of Remote or Portable Computers are Aany ~~other~~ remote or portable **electronic** devices attached to the TCHD Network~~:~~

~~b. A laptop provided to an employee on a temporary or permanent basis~~
~~c. A PC provided to an employee for remote access to the TCHD Network~~
~~d. Authorized remote access to the TCHD network from an employee's home PC~~
~~e. An employee Personal Digital Assistant (PDA) which synchronizes with Outlook~~
~~f. Remote access provided to vendors that support TCHD hardware or software~~
~~g. Any other remote or portable devices attached to the TCHD Network~~

B. **POLICY:**

1. Remote or Portable Computing is provided to authorized employees and other persons who need remote or portable access to the TCHD Network.
2. Remote or Portable Computing is intended for TCHD business related purposes only. Each User has a responsibility to use Remote or Portable Computing in a productive and legal manner.
3. All TCHD policies and practices apply to Remote or Portable Computing, including those policies regarding Network Access, Email Access, Internet Access, intellectual property protection, privacy, misuse of TCHD resources, sexual harassment or other unlawful harassment, information and data security, and confidentiality.

~~4. Each individual granted Remote or Portable Computing must complete and sign the Remote or Portable Computing Agreement form.~~

~~5. While use of Remote or Portable Computing offers significant benefits, it can also expose the TCHD computer systems to risks and compromise if appropriate security measures are not strictly followed. Each User is personally accountable for any action that results in a breach of TCHD security or confidentiality.~~

~~6.~~4. A User must not use Remote or Portable Computing knowingly to violate the laws and regulations of the United States or any other nation. Use of any TCHD resources for illegal activity is grounds for corrective action, up to and including immediate dismissal. TCHD will cooperate with any legitimate law enforcement activity.

C. **PROCEDURE:**

1. An employee who has a legitimate need for Remote or Portable Computing should request it in the following manner:
   a. Obtain a Remote or Portable Computing Agreement form from Information Technology or the TCHD intranet. Fill out the form, obtain approval from the Department Director, and submit the Agreement to the Information Technology Department.
   b. If a System Access Request form (Policy 602 – Network Access & Policy 607 – Access to Applications) has not been submitted to the Information Technology Department prior to requesting remote access, complete and submit the form at the same time that the Remote or Portable Computing Agreement form is submitted.
   c. If equipment is needed, an Information Technology representative will review specifications and assist the department with purchasing the equipment.
   d. To reinforce this and other confidentiality policies, each employee must sign the TCHD Confidentiality Agreement annually on his/her review date.

D. **MANAGEMENT AND ADMINISTRATION:**

1. The Information Technology Department is responsible for assuring security of the TCHD network. The Information Technology Department must approve all Remote or Portable Computing Requests.
   a. Portable Computer (Laptop, PDA, Tablet)
      i. A User must meet all of the requirements of the Remote or Portable Computing Agreement before receiving a Portable Computer from TCHD.
      ii. A User will receive instructions from the Information Technology Department regarding the security controls for the Portable Computer (these include physical security with lockdown devices or cables, password security for the laptop, and other security measures determined by the Information Technology Department to be appropriate). The User must secure the Portable Computer according to directions provided by the Information Technology Department
      iii. A User will not leave the Portable Computer unattended unless it is in a secured location.
      iv. A User will receive instructions from the Information Technology Department regarding the method to connect to the TCHD Network from the Portable Computer. The User is entrusted with access to the TCHD Network, and this is the sole method to be used to connect to the TCHD Network.
      v. The Portable Computer is to be used for TCHD business purposes. Most business computing using the Portable Computer will require access to the TCHD Network, where the Information Technology Department assumes responsibility for maintaining and backing up computer programs and data. Any programs or data, either business or personal, stored on the Portable Computer by the User, are the sole responsibility of the User. TCHD strongly recommends that the User either not store data or programs on the Portable Computer, or initiates steps to backup that data in the event of the loss or destruction of the Personal Computer.
      vi. To access the TCHD Network, the User will necessarily have to access the Internet. While the TCHD Information Technology Department provides security controls for TCHD Network access, there are many potential dangers inherent in Internet access. A User will receive instructions from the Information Technology Department regarding the use and regular updating of anti-virus and firewall software to protect the Portable Computer. These instructions must be followed in order to protect both the Portable Computer and the TCHD Network.
      vii. At the User's request, the Information Technology Department will order and install all business software and hardware for the Portable Computer. Any hardware or software installed by the User is the sole responsibility of the User.
      viii. Effective April 14, 2003, the Privacy Regulations of the Health Insurance Portability

and Accountability Act of 1996 (HIPAA) are in effect. As of this date, no patient Protected Health Information (PHI) may be transmitted outside of TCHD's Local Area Network without the approval of the Information Technology Department. Therefore, no PHI should be stored on the Portable Computer. In addition, any TCHD Confidential information should not be stored on the Portable Computer because of the risk if the Portable Computer is lost or stolen.

ix. The User is the only individual authorized to use the Portable Computer.

x. The portable computer must have encryption enabled on the device

b. Remote Computing (PC remote access to the TCHD Network)

i. A User must meet all of the requirements of the Remote or Portable Computing Agreement before receiving approval for Remote Computing.

ii. A User will receive instructions from the Information Technology Department regarding security controls for Remote Computing. The User must secure the Remote Computing PC according to directions provided by the Information Technology Department

iii. A User will receive instructions from the Information Technology Department regarding the Remote Computing method to connect to the TCHD Network. The User is entrusted with access to the TCHD Network, and this is the sole method to be used to connect to the TCHD Network.

iv. Business computing using the Remote Computing PC will require access to the TCHD Network, where the Information Technology assumes responsibility for maintaining and backing up computer programs and data. Any programs or data, either business or personal, stored on the Remote Computing PC by the User, are the sole responsibility of the User. TCHD strongly recommends that the User initiate steps to backup that data in the event of the loss or destruction of the Remote Computing PC.

v. To access the TCHD Network, the User will necessarily have to access the Internet. While the TCHD Information Technology Department provides security controls for TCHD Network access, there are many potential dangers inherent in Internet access. A User will receive instructions from the Information Technology Department regarding the use and regular updating of anti-virus and firewall software to protect the Remote Computing PC. These instructions must be followed in order to protect both the PC and the TCHD Network.

vi. Effective April 14, 2003, the Privacy Regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are in effect. As of this date, no patient Protected Health Information (PHI) may be transmitted outside of TCHD's Local Area Network without the approval of the Information Technology Department. Therefore, no PHI should be stored on the Remote Computing PC. In addition, any TCHD Confidential information should not be stored on the Remote Computing PC because of the risk if the PC is lost or stolen.

vii. The User is the only individual authorized to use the Remote Computing PC.

c. Security

i. The TCHD Information Technology Department may periodically perform a security audit of Remote and Portable Computing.

ii. Authorized Users should not assume transmission of network files is totally secure. If network files are being sent to an external entity via File Transfer Protocol (FTP) or other method, the Authorized Network User must obtain assistance from the TCHD Information Technology Department to assure that data transmission is secure.

iii. Effective April 14, 2003, the Privacy Regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are in effect. As of this date, no patient Protected Health Information (PHI) may be transmitted outside of TCHD's Local Area Network without the approval of the Information Technology Department.

iv. TCHD has installed a variety of firewalls, proxies, Internet address screening

programs, and other security systems to assure the safety and security of the networks. An Authorized Remote Access User who attempts to disable, defeat, or circumvent any security facility will be subject to appropriate corrective action as defined by policies.

d. Violations
   i. Adherence to this Policy is neither voluntary nor optional. Violation of this policy may constitute grounds for formal counseling, up to and including termination, as described in Administrative Policy 424, section 2.3.2. If necessary, TCHD also reserves the right to advise appropriate legal officials of any illegal violations.

e. Legal Notice
   i. California Penal Code 502 states that unauthorized use of a computer in the state of California is a felony.

f. Notification of Improper Use
   i. Each Authorized Remote Access User is expected to report unauthorized use or violation of this policy to a District manager, to a District Vice President, or to the Information Technology Department.

E. **FORMS:**

~~Remote or Portable Commuting Agreement located on the Intranet.~~

1. **System Access Request (SAR) Form Employee**
2. **System Access Request (SAR) Form Physician Provider Office**

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

1. **Administrative Information Technology Policy: Wireless Network**

DELETE – no longer required

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE ~~POLICY MANUAL~~
~~MANAGEMENT OF~~ INFORMATION TECHNOLOGY

ISSUE DATE: 12/00 **SUBJECT:** Telephone Authorization Code

REVISION DATE: 5/03; 2/05 **POLICY NUMBER:** 8610-600

Administrative Content Expert Approval:	04/20
Administrative Policies & Procedures Committee Approval:	~~11/08~~04/20
~~Operations Team Committee Approval:~~	~~12/08~~
Medical Executive Committee Approval:	n/a
Administration Approval:	05/20
Professional Affairs Committee Approval:	~~01/09~~ n/a
Board of Directors Approval:	01/09

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

~~1. To provide appropriate long-distance telephone access to authorized individuals working at Tri-City Healthcare District (TCHD), including internal and external case managers, physicians engaged in daily practice at TCHD, and other authorized employees, physicians, and other persons engaged in legitimate business at TCHD. Authorization codes are provided to those individuals who receive approval from a Department Director.~~

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

~~1. **Telephone authorization code** – a code used by those individuals who are authorized to access the hospital telephone system from any extension to use long distance telephone services.~~

~~C. **POLICY:**~~

~~1. A telephone authorization code for long distance access is intended to be used by a small group of employees, case managers and physicians who must use telephones throughout TCHD to facilitate information exchange with patient families and other outside agents. Use of a telephone authorization code for long distance access is limited to patient care or other TCHD business-related purposes only.~~

~~2. All TCHD policies and practices apply to the use of telephone authorization codes for long distance access, including those policies regarding intellectual property protection, privacy, misuse of TCHD resources, sexual harassment or other unlawful harassment, information and data security, and confidentiality.~~

~~3. All those who use telephone authorization codes for long distance access must complete and sign the Telephone Authorization Code Usage Agreement form that includes the following statement:~~

~~a. "I have received a written copy of TCMC's Telephone Authorization Code policy. I fully understand the terms of this policy and agree to abide by them. I understand that TCMC records, by Telephone Authorization Code, the phone number, and the duration of each call, and that this information is provided regularly to TCMC management. I acknowledge that any use of my Telephone Authorization Code will be for patient care or other TCMC business related purposes only. I know that any violation of this policy could lead to corrective action, dismissal or even criminal prosecution."~~

~~D. **PROCEDURE:**~~

~~1. An employee, external case manager or medical staff member who believes he/she has a legitimate need for a telephone long distance authorization code should request it in the following manner:~~

a. Obtain a Telephone Authorization Code Agreement form from Information Technology.
b. Complete the justification section providing reasons for the request.
c. Obtain necessary signatures from the appropriate Department Director. Submit the request to Information Technology.

2. An Information Technology representative will assign the telephone authorization code and will provide the code to the requestor. Instructions on how to use the code will also be provided.
3. TCHD records, by Telephone Authorization Code, the phone number and the duration of each call. This information is provided regularly to TCHD management. TCHD management may use the information from these reports to assure that each Telephone Authorization Code is being used solely for the purposes of patient care or other TCHD business-related purposes.

INFORMATION SERVICES
Telephone Authorization Code Agreement

I _____ request a Telephone Authorization Code to
(Please print your name) be used for the following reasons.

_____

_____

_____

_____

I have received a written copy of TCHD's Telephone Authorization Code policy. I fully understand the terms of this policy and agree to abide by them. I understand that TCHD records, by Telephone Authorization Code, the phone number and the duration of each call, and that this information is provided regularly to TCHD management.

I acknowledge that any use of my Telephone Authorization Code will be for patient care or other TCHD business-related purposes only.

I know that any violation of this policy could lead to corrective action, dismissal, or even criminal prosecution.

_____ _____ _____
Signature Date Department or Company

_____ _____
Director's signature Date

_____ _____
Information Technology Review Date

_____ _____
Completed Date

Tri-City Medical Center
Oceanside, California

DELETE, follow Patient Care Service Policy: Glucose Monitoring During Therapy for Diabetic Patients

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 10/93

SUBJECT: Glucose Monitoring and Exercise Therapy for Diabetic Patients

REVISION DATE: 6/97, 2/03, 04/06, 01/08, 12/12

Cardiac Rehabilitation Approval:	02/20
Division of Cardiology Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	05/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~A. **PERSONNEL:**~~

~~1. All staff members of Cardiac Rehabilitation with specific training for use of the "Sure-Step Flexx" glucose monitoring system.~~

~~B. **PURPOSE:**~~

~~1. To provide safe, therapeutic care for diabetic patients while exercising.~~

~~C. **POLICY:**~~

~~1. All non insulin dependant diabetic patients shall bring their own glucose monitoring equipment and shall check their blood glucose levels prior to and immediately following the first three exercise sessions. If their blood sugars are stable they do not need to continue checking blood sugars at every visit. If their blood sugars are unstable, continue testing. Insulin dependant diabetics shall test their blood sugars before and after each exercise session for the entire course of Cardiac Rehabilitation.~~

~~D. **PROCEDURE:**~~

~~1. Patient shall bring his/her glucose monitor to Cardiac Rehab and check his/her own blood glucose.~~

~~2. Each patient shall check their own glucose and report findings to rehab staff before initiation of exercise therapy. Blood glucose levels shall be checked before exercise and after exercise. Follow immediately with action based on results.~~

~~3. If blood glucose is less than 100 mg/dL, the patient shall eat a pre exercise snack of 15gm carbohydrate which they are instructed to bring to every session. Low sodium crackers, peanut butter and juice are kept in the department in case the patient did not bring his/her own snack.~~

~~4. For patients with a pre exercise blood sugar less than 100 who have eaten a 15 gm carbohydrate snack, monitor blood glucose level half way through exercise. If blood glucose level remains low despite snacks, stop exercise and notify physician. If blood glucose level is 100 300 mg/dL, exercise may be continued~~

~~5. If blood glucose is greater than 300 mg/dL, patient may not exercise unless approved by his/her physician or the cardiac wellness supervising physician. Notify physician if patient is unable to exercise due to elevated blood glucose level.~~

~~6. For blood sugars less than 70 with complaints of nausea, anxiety, dizziness, shakiness and/or diaphoresis. Provide fast acting carbohydrates such as:~~

~~a. Four ounces of juice~~

~~b. 4 glucose tabs which provide 16 grams of carbohydrate.~~

~~Following intervention, continue to observe the patient for recurrent hypoglycemia and recheck blood sugar in 15 minutes. If repeat blood sugar is less than 70, repeat treatment and retest in 15 minutes. Notify the physician for repeated low blood sugar levels.~~

~~7. If the patient is driving him/herself, the post exercise blood sugar should be 100 or greater. If the post exercise blood sugar is less than 100 they should have a snack of 15 grams of carbohydrate and retest in 15 minutes and repeat until 100 or greater before discharged home.~~

Tri-City Medical Center	Emergency Department	
PROCEDURE:	**WANDERING SYSTEM (ELOPEMENT PREVENTION)**	**7010-017**
Purpose:	Detailed information on use of Accutech Wandering System.	
Supportive Data:	Accutech Quick Reference Guide.	
Equipment:	Accutech Wandering System, arm bands, LT22/LT23 tags.	
Issue Date:	**04/06** ~~Revision Date(s): 04/06; 02/11; 02/20~~	

A. **DEFINITIONS:**

1. The Accutech Wandering System is a patient monitoring system to help the Emergency Department staff ensure the safety and well-being of patients at risk for elopement in the Emergency Department. The system is designed to monitor patients with a small plastic tag attached to a bracelet that the patient wears while being treated in the Emergency Department. The tag **is** programmed into the wandering system and if the patient gets too close to an exit the Emergency Department staff is notified with a loud beeping noise (doors automatically lock for 10-15 seconds) or alarm sound if the doors are open. There are two (2) monitoring screens and one (1) monitoring computer located throughout the Emergency Department for the staff to view which exit the patient is trying to elope through.

B. **POLICY:**

1. All Patients at risk for wandering outside of the Emergency Department treatment area will have an Accutech wrist band attached. At risk patients include but not limited to 5150, minor children without parental supervision, **confused** patients **and/or patients** with dementia ~~and/~~or Alzheimer's.

C. **PROCEUDRE:**

1. **Activating/Deactivating Tags:**
   a. With no tag in the TAD unit, slide the power switch to the "ON" position. The TAD power LED illuminates. If it doesn't, check the TAD's 9-volt battery. **Note:** If a tag is in the receptacle and the power to the TAD is cycled, the tag may be turned on or off unintentionally.
   b. Place the tag into the tag receptacle on the back of the TAD unit in proper orientation for the tag (meaning the tag with the name "Accutech" is facing the receptacle and the name is face up).
   c. The signal strength LEDs on the TAD indicates the current state (on or off) of the tag.
   d. To turn on or off the tag, press and release the TAD button. The WAIT LED will illuminate for about a second (do not remove the tag while the WAIT LED is on) and the signal strength LEDs will change accordingly.
   e. Once activated, if the "low battery" LED on the TAD blinks, this indicates the tag should not be used and should be replaced.
   f. After turning on or off the tag, make sure to turn off the TAD unit to save the battery. **It is essential that the tags be turned off in between patients to save the internal batteries.**
2. **How to Attach LT22/32 Tags:**
   a. With the bracelet snaps facing in the same direction as the Accutech logo, slide the plastic bracelet through the slots on the tag.
   b. Adjust the band length to the nearest accommodating hole for a comfortable fit around the patient's extremity. **Note:** Once the bracelet is secured it cannot be adjusted.
   c. Put the male part of the snap through the selected hole, fold over the female part of the snap and secure to the male part by squeezing until it snaps together.
   d. ~~u~~Using scissors, carefully trim off any excess bracelet material.

Department Review	Department of Emergency Medicine	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
04/20	n/a	n/a	n/a	05/20	n/a	04/06, 02/11

~~A. APPROVAL PROCESS:~~
~~1. Emergency Department Medical Director~~
~~2.~~1. ~~Board of Directors~~

Tri-City Medical Center	Home Care
PROCEDURE:	**UNNA BOOT APPLICATION**
Purpose:	For patients with chronic eczema and dermatitis requiring moderate compression for the treatment of venous insufficiency and/or venous leg ulcers.
~~Supportive Data:~~	
Equipment:	Unna Boot wrap Gauze wrap Clean gloves Normal saline or wound cleaner Cast padding if needed Dressing supplies if needed
Issue Date:	2004

~~A. GENERAL INSTRUCTIONS:~~

~~1. This is an aseptic procedure. (See aseptic procedure policy).~~
~~2. All Clinicians will follow MD orders for Una boot application.~~
~~3. Patient must be assessed to rule out arterial disease by MD.~~

A. DEFINITIONS:

1. Unna Boot-an inelastic compression wrap impregnated with zinc oxide covered by gauze. Provides low compression therapy when ambulating.

B. POLICY

1. A physician order is required for an Unna boot application.
2. Patient must be assessed by the physician to rule out arterial disease prior to application of the Unna Boot.
3. Protect very thin legs/bony prominences from pressure by adding additional padding.
4. Promptly remove the wrap and notify the physician if the patient develops pain or pale, cool or numb tows and foot, or signs and symptoms of heart failure.
5. Discontinue if redness, itching or deterioration of the wound occurs and notify the physician.
6. Do not use for patients:
   a. With known sensitivity or allergy to zinc or other ingredients in bandage.
   b. With known active heart failure.
   c. In the presence of untreated lower limb skin or wound infection.

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

1. **Apply gloves and c~~C~~lean the wound ~~leg~~** with normal saline or wound cleanser.
~~4. Assess ulcer and skin and complete wound assessment sheet.~~
2. Position the patient's leg in a slightly flexed position, with toes pulled toward shin.
3. **Start at the base of the toes, using no tension and an overlap of 50%, loosely wrap the bandage around the foot, heel and ankle all the way up just below the knee using a spiraling method. Ensure that all areas are covered. Do not spiral back downward**
4. **If needed, wrap the foot and leg with cast padding in a loose spiral; ensuring that all bony prominences are protected.**
5. **Wrap with gauze and secure with tape.**
~~2.~~**6. If needed, apply a non-compression type stocking for further securement of the boot.**
~~5. Apply the Una boot in a spiral motion starting from the first metatarsal with a 50% overlap. Do not apply tightly and include heel when wrapping.~~

Department Review	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
11/06, 02/20	n/a	04/20	05/20	n/a	

~~6. Continue wrapping to just below the knee. (Ends below tibial tubercle of knee). Do not spiral back downward.~~

~~7. Cover the boot with a cohesive bandage (Coban) at 50% overlap for compression.~~

7. The Una boot may be changed 1-2 times a week~~,~~ or per MD order.~~,~~

~~8. or when needed to manage wound drainage.~~

a. If slippage occurs it may be changed sooner.

8. Instruct patient to remove the wrap and notify the agency if the following occur:

a. Shortness of breath.

b. Wrap slippage.

c. Pain, numbness, tingling, discoloration or swelling of toes.

~~B. PATIENT INSTRUCTIONS:~~

~~1. Observe for signs of impairment. Patient to notify agency if color change on toes or if decreased sensation.~~

~~2. Patient to loosen if these signs occur between visits.~~

~~3. Patient needs to continue to elevate legs to prevent edema.~~

~~B.~~D. REFERENCES:

1. **British Columbia Provincial Nursing Skin & Wound Committee (2016). *Guideline: Application of Compression Therapy to Manage Venous Insufficiency and Mixed Venous/Arterial Insufficiency.***

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL

ISSUE DATE: 03/02 **SUBJECT:** Risk Assessment and Surveillance Plan

REVISION DATE(S): 07/13, 08/14, 05/16, 03/17, 02/18, 03/19

Infection Control Department Approval:	~~01/20~~03/20
Infection Control Committee Approval:	~~01/20~~03/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~01/20~~04/20
Administration Approval:	~~02/20~~05/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/20

A. **PURPOSE OF RISK ASSESSMENT:**

1. Sound epidemiological principles must be considered in the formation of the surveillance program designed to provide maximum information and identify opportunities to reduce disease. Measures directed toward cost effective care must include best practice and technology to prevent infection. The economic impact of an efficient and flexible infection control plan is especially relevant in times of changing reimbursement and payment patterns. Tri-City Healthcare District's (TCHD) plan outlines how this may be accomplished within the confines of resources, external regulatory guidelines, and medical staff requirements.

B. **PURPOSE OF SURVEILLANCE:**

1. The foundation of and most important purpose of this program is to decrease the risk of infectious complications for all patients, healthcare workers, visitors and staff. Ongoing epidemiological information assists with identifying at risk populations and opportunities to interrupt prevent or reduce the occurrence of healthcare associated infections. Surveillance will be compared to nationally recognized benchmarks such as the National Healthcare Safety Network (NHSN) rates whenever possible.

C. **RESPONSIBILITY:**

1. Successful creation of an organization-wide infection control program requires collaboration with all relevant components/functions. Individuals within the hospital who have the power to implement plans and make decisions related to prevention and control of risks related to infections are included in the design and coordination of processes. In consultation with the Medical Staff, Directors, Medical Director of Infection Control, Environmental Health and Safety Committee, ~~Patient~~ Safety Officer and the Infection Control Committee, the Infection Preventionist (IP) shall **identify and have oversight to ensure all hospital practices are performed in a manner which prevents cross contamination. The infection control risk assessment and surveillance plan will** implement a systematic process for monitoring and evaluating the quality and effectiveness of the infection control program. Significant deviations are discussed in Infection Control Committee, Quality Improvement Medical Staff Committees as needed, Environmental Health and Safety Committee, ~~and the~~ ~~Patient~~ Safety Committee and **QAPI Committee** ~~referred to appropriate councils and committees~~ for **further** action **and follow up**.
2. Infection Prevention and Control Services is staffed with an Infection Preventionist. There are computer resources with Internet connection, Microsoft Office software, NHSN National internet based database, a real-time electronic data mining surveillance tool and access to the hospital's

electronic medical records (Cerner and Affinity). Telephone with voice mail, and fax access is provided. The office is located within the Surgical Scheduling office.

3. Infection Control Services works in conjunction with others, as a consultant and resource for best practices. We support system changes and an interdisciplinary focus to improving care. We believe that all our employees, medical staff, and volunteers play an important role in preventing and controlling infections. Ultimately, the leadership team within the district is responsible for adopting and ensuring compliance with appropriate policies and practices.

D. **LINKS WITH INTERNAL SOURCES:**

1. On at least an annual basis, the IP department will meet with the affected departments (i.e. Medical Staff and Employee Health) to assess whether the goals and priorities have been achieved and what steps are required to implement any indicated changes. The goals are shared with and reviewed by the Infection Control Committee. Education on infection control goals and priorities will be included with quarterly reports and during individual meetings with the hospital leadership. The IP staff reports to Infection Control Committee quarterly and attends other medical staff and hospital committees as requested, regulatory requirements and department specific Quality Reports are reviewed.

E. **LINKS WITH EXTERNAL SOURCES:**

1. The San Diego County Public Health Department, state health authorities, the Division of Occupational Safety and Health, and other recognized infection control specialists, for example, the Centers for Disease Control and Prevention (CDC), Association for Professionals in Infection Control and Epidemiology (APIC), Society for Healthcare Epidemiology of America (SHEA), and the California Healthcare Association (CHA) are important links between the district and outside resources. Infection Control department subscribes to automatic notifications available via email from the CDC, San Diego County Public Health (CAHAN) and California Department of Health and Human Services. Infection surveillance covers a broad range of processes and activities with potential for intervention and these organizations assist with the where, when, and how of targeting.
2. Healthcare associated infections (HAI) are reported by the IP staff to the external healthcare organizations when the infection was not known at the time of transfer. TCHD receives reports from outside organizations when a patient develops an infection that might meet criteria for a healthcare associated infection. Home Health/Hospice quality review staff report directly to Infection Control Committee.
3. The following conditions will be reported to external healthcare organizations with the intent to satisfy The Joint Commission IC 02.01.01(and recorded in the patient's electronic medical record (EHR) . The Infection Surveillance Report will document notification to the referring healthcare organization within 7 days of discovery by the TCHD Infection Prevention and Control Staff:
    a. Positive culture from a surgical site and surgery performed at another facility.
    b. Influenza rapid test is positive and patient was discharged to another healthcare facility prior to results being known.
    c. Positive C difficile toxin test known after the patient was discharged to another healthcare facility.
    d. Positive MDRO culture known after the patient was discharged to another healthcare facility and the patient had no history of the same MDRO.
    e. Unusual occurrences based on the opinion of the Infection Prevention staff in consultation with the Infection Control Medical Director and Director of Regulatory Compliance.

F. **PERTINENT RISK FACTORS:**

1. Each facility is unique and we considered the following factors in our planning.

a. National and international published scientific studies, community standard of care, professional recommendations and regulatory requirements.
b. A review of hospital specific surveillance data from years past.
c. Medically fragile and at-risk populations such as newborns and those with invasive devices.
d. The increasing antibiotic resistance in our facility and across the United States and the nation (as reported by the CDC in NHSN).
e. The vaccination/immunity rates of the community and employees.

G. **EPIDEMIOLOGICAL FACTORS: INTERNAL AND EXTERNAL:**

1. TCHD is impacted by factors such as location, population served, community health, financial status, population age, clinical focus, and healthcare worker demographics and these were included in our planning.
2. The hospital's geographic location is in northern San Diego County. San Diego County is the second most populous of California's 58 counties, and the fifth largest county in the United States. San Diego is -home to 3.34 million residents, as of July 1, 2018.
3. Located within the North County geographic region are 3 college campuses along with a Marine Corp Base (Camp Pendleton).
4. San Diego County is becoming increasingly bicultural due to its close proximity to Mexico. In addition, the county is already ethnically diverse, and will be increasingly so. The largest San Diego County racial/ethnic groups are White (64.7%) followed by Hispanics (33.5%) & Asian (16.79%). Approximately 21.5% of the county's populations are immigrants, including refugees, who come from other countries, speak many different languages, and have a variety of needs as they assimilate into their new environment. 38.8% of people in San Diego County speak a non-English language. The senior and disabled populations are growing disproportionately compared to the rest of the population. Since 2015, San Diego County has become the 4th largest population of homeless individuals in the US.
5. Demographic information (as of 2017) on the three cities most often served by TCHD is listed below.

City	Median income	Total # residents	White	Hispanic	Asian & Pacific Islander	African American
Oceanside	$ 71,609	176,193	46.9%	36.2%	7.8%	4.9%
Vista	$ 68,130	101,568	40%	52.4%	3.4%	2.7%
Carlsbad	$ 101,6461	115,330	72.2%	14.3%	7.8%	0.9%

a. http://www.city-data.com/city/Oceanside-California.html
b. http://www.city-data.com/city/Vista-California.html
c. http://www.city-data.com/city/Carlsbad-California.html

6. Enteric illness represents a significant burden of disease in the US and because of this the San Diego County Health and Human Services Agency conducts outbreak investigation and education to reduce the medical and cost-related impact of these diseases in the community. Food borne illnesses largely result from the ingestion of food or water contaminated by fecal matter or ingestion of infected animal products. Hospitals play an important role in early intervention by the identification and reporting of significant bacteria. The most common mandated reported enteric illnesses in SD County are Campylobacter, Hepatitis A, Salmonella and Shigella.
7. In San Diego, overall rates for Chlamydia and Gonorrhea have increased since 2018, while cases of early Syphilis have decreased slightly. National trends were reflective at the local level, including high rates of STD's among young women and MSM (men who have sex with men). San Diego County has the third largest number of HIV & AIDS cases in California.

8. In 2018, San Diego County reported 226 new active TB (tuberculosis) cases, compared with 237 in 2017. In 2018, San Diego County's annual TB incidence was 6.8 cases per 100,000 persons, which is higher than the California state rate of 5.3, and more than twice the national rate of 2.8.
9. An estimated 80% of active TB cases are due to the progression of LTBI (latent tuberculosis infection) to active TB.
10. TB drug susceptibility information was available for 197 cases (99%) of 198 culture proven cases for 2018 in San Diego. Resistance to at least one of the 4 major first line drugs was found among 41 (21%) of these specimens. A multidrug-resistant (MDR TB) strain was found in 3 (1.5%) of the cases. Vigilance in diagnosing MDR TB and close monitoring of treatment is of extreme importance because of the complexity of treating such patients and the risk of spread within the community.
11. At TCHD, most AFB positive smears and cultures grow organisms that are not communicable person to person. In 2018, there were 3 patients with pulmonary TB and 1 with extrapulmonary TB. An additional 14 cases were reported as rule out TB in 2018. In 2019, 12 patients were confirmed with TB, 2 of those cases were MDR TB. An additional 20 cases were reported as rule out TB. The number of active TB patients seen annually at TCHD varies from 5 –12.
12. Tri City Medical Center Financial Characteristics for Fiscal Year 2019
    a. The top six insurance coverage are as follows:

MEDICARE	25%
MEDI-CAL HMO	21%
MEDI-CAL	21%
Medicare SR HMO	11%
Other Governmental	6%
HMO	4%

    b. Patient Census:

	Average. Daily Census	Average. Length of Stay*	Total Pt. Days
Acute Care (excludes all below)	117.5	4.02	42,894
ICU*	15.6	2.76	5,691
BHU	2.7	8.51	979
NICU	10.2	8.92	3.736
Rehab Serv.	6.5	14.63	2,356

        i. *ICU ALOS includes discharges, transfers out, and expirations. All other areas are based only on discharges.

    c. In acute care FY 19, the three largest age groups are 66-75 year olds (16%), 26-35 year olds (15.4%), and 56-65 year olds (15.3%).
    d. Twelve percent (6,849/56,437) of Emergency Department patients are admitted to the hospital.
13. The total number of employees working at TCHD FY 2019 is approximately 2,701 with about 1,729 (64%) staff providing direct patient care. This number includes 482 employees which were terminated at some point during FY2018.
14. TCHD's primary focus is on basic community services. The top ten major diagnostic categories (DRGs) are the following:
    a. Obstetrics
    b. Musculoskeletal & Connective Tissue
    c. Infectious & Parasitic Diseases
    d. Circulatory System
    e. Newborns & Neonates
    f. Nervous System
    g. Respiratory
    h. Digestive System

i. Kidney & Urinary Tract
j. Hepatobiliary System & Pancreas

15. Top five Inpatient Surgical Procedures (Fiscal Year 2019): Cesarean section (CSEC), spinal fusion (FUSN), hip prosthesis (HPRO), cholecystectomy (CHOL), and knee prosthesis (KPRO).

16. Home Care Services provides skilled, intermittent care to individuals in a home setting. The restorative, rehabilitative services are provided by Registered Nurses, Licensed Vocational Nurses, Masters of Social Work, Licensed Clinical Social Workers, Certified Home Health Aides, Physical Therapists, Occupational Therapists, Speech Therapists and/or Dietitians. For FY 2019 in Home Care:

Average LOS	Top Payers	Top Primary DX Categories
3 days	Medicare- 54.65% HMO/PPO 27.36%	-Factors influencing Status/Sup Class -Injury/Poisoning -Circulatory (not HTN, HF or CVD) -Respiratory (COPD) -Musculoskeletal/Connective Tissue -Respiratory (not COPD) Circulatory-CVD Genitourinary

17. General Process
    a. Infection Prevention staff will regularly review, information from internal sources (case manager, RLs) or external sources (other IC practitioners, home health/hospice, or nursing homes) and the positive microbiology reports (furnished by the clinical laboratory). The following are some of the patterns or issues that are evaluated:
        i. Clusters of infections by the same organism, in the same ward or service or infections after undergoing the same procedure.
        ii. Infections due to unusual or highly resistant/significant organisms such as MRSA, VRE, ESBL, CRE, and/or C.difficile Infection.
        iii. All cases of reportable communicable diseases as mandated by Title 17. These shall be reported in accordance with the ordinances of the County of San Diego Department of Health.
    b. Unusual or problem situations shall be brought to the Infection Control Committee for review and discussion. See Epidemiologic Investigation of a Suspected Outbreak policy.
    c. In the absence of the Infection Prevention staff, hospital staff can direct questions to Employee Health Services or the Medical Director of Infection Control and/or Chair of the Infection Control Committee.

H. TARGETED AND FOCUSED SURVEILLANCE FOR FY 2019:

1. Infection control surveillance activities are systematic, active, concurrent, and require ongoing observation while meeting mandated reporting requirements. Our efforts are directed towards high risk, high volume and device/procedure associated infections. (such as urinary tract infections, selected surgical site infections, ventilator-associated events , and central line bacteremia) Goals will include limiting unprotected exposure to pathogens throughout the organization, Enhancing hand hygiene and limiting the risk of transmission of infections associated with procedures, medical equipment and supplies and medical devices.
2. Surgical Site Infections:
    a. Due to ever-decreasing lengths of stay, the majority of postoperative infections are not seen while the patient is in the hospital. Further, the increasing trend toward more outpatient surgery and shorter postoperative hospital stays limits the ability of infection control practitioners to detect infections.
    b. Surgical Site Infections that occur within 30 to 90 days (based upon the individual NHSN definitions). Surgical patients are risk stratified using the methods described in the CDC's NHSN surgical site component.

c. Case finding methods include a review of all microbiology cultures, and ICD coding for post-operative infection. Potential cases have a chart review performed by Infection Prevention staff using the most recent NHSN definitions (Centers for Disease Control and Prevention).

d. Infection rates are identified using the NHSN definitions and are reported to the California Department of Public Health through NHSN. In accordance with California senate bill requirements: facilities are required to report surgical site infections on 29 surgical procedures. Tri City Medical Center performs and reports on 25 of the procedures, they are listed below:

AAA	Abdominal aortic aneurysm repair	Resection of abdominal aorta with anastomosis or replacement
APPY	Appendix surgery	Operation of appendix (not incidental to another procedure)
BILI	Bile duct, liver or pancreatic surgery	Excision of bile ducts or operative procedures on the biliary tract, liver or pancreas (does not include operations only on gallbladder)
CARD	Cardiac surgery	Open chest procedures on the valves or septum of heart; does not include coronary artery bypass graft, surgery on vessels, heart transplantation, or pacemaker implantation
CBGB	Coronary artery bypass graft with both chest and donor site incisions	Chest procedure to perform direct revascularization of the heart; includes obtaining suitable vein from donor site for grafting.
CBGC	Coronary artery bypass graft with chest incision only	Chest procedure to perform direct vascularization of the heart using, for example, the internal mammary (thoracic) artery
CHOL	Gallbladder surgery	Cholecystectomy and cholecystectomy
COLO	Colon surgery	Incision, resection, or anastomosis of the large intestine; includes large-to-small and small-to-large bowel anastomosis; does not include rectal operations
CSEC	Cesarean section	Obstetrical delivery by Cesarean section
FUSN	Spinal fusion	Immobilization of spinal column
FX	Open reduction of fracture	Open reduction of fracture or dislocation of long bones that requires internal or external fixation; does not include placement of joint prosthesis
GAST	Gastric surgery	Incision or excision of stomach; includes subtotal or total gastrectomy; does not include vagotomy and fundoplication
HPRO	Hip prosthesis	Arthroplasty of hip
HYST	Abdominal hysterectomy	Removal of uterus through an abdominal incision
KPRO	Knee prosthesis	Arthroplasty of knee
LAM	Laminectomy	Exploration or decompression of spinal cord through excision or incision into vertebral structures
NEPH	Kidney surgery	Resection or manipulation of the kidney with or without removal of related structures
OVRY	Ovarian surgery	Operations on ovary and related structures
PACE	Pacemaker surgery	Insertion, manipulation or replacement of pacemaker

REC	Rectal surgery	Operations on rectum
SB	Small bowel surgery	Incision or resection of the small intestine; does not include small-to-large bowel anastomosis
SPLE	Spleen surgery	Resection or manipulation of spleen
THOR	Thoracic surgery	Non cardiac, nonvascular thoracic surgery; includes pneumonectomy and hiatal hernia repair or diaphragmatic hernia repair (except through abdominal approach.)
VHYS	Vaginal hysterectomy	Removal of the uterus through vaginal or perineal incision
XLAP	Abdominal surgery	Abdominal operations not involving the gastrointestinal tract or biliary system. Includes diaphragmatic hernia repair through abdominal approach.

e. GOAL#1: The combined surgical site infection rate will not be statistically significantly higher than the most recent published NHSN rates, using the standardized infection ratio (SIR).

f. GOAL#2: Each individual surgical site infection rate (that is able to be calculated) will not be statistically significantly higher than the most recent published NHSN rates, using the standardized infection ratio (SIR).

3. Antibiotic Resistant Bacteria

a. Antibiotic resistance is an ongoing concern. Multiple studies have documented increased costs and mortality due to infections caused by multidrug resistant organisms. Data will be collected using positive cultures on patients with community acquired and hospital acquired methicillin resistant Staphylococcus aureus (MRSA), Vancomycin resistant enterococci (VRE), Extended spectrum-beta-lactamase (ESBL), *and Carbapenem-resistant Enterobacteriaceae (CRE)*. MDRO and C.difficile infection risk assessment is performed annually to determine need for additional interventions, resources, and surveillance. In addition, positive blood cultures with MRSA or VRE and positive C.difficile infections are reported to CDPH through NHSN Multi-Resistant Organism & Clostridium difficile Infection Module (LabID Event Reporting).

b. GOAL#1: The number of healthcare associated MRSA infections will remain below the Institute for Healthcare Improvement's (IHI) published rate of 3.95 hospital acquired infections per 1000 patient days for the calendar year.

$$\frac{\text{\# Patients with + MRSA and/or VRE cultures}}{\text{1000 patient days}}$$

c. GOAL#2: The MRSA and VRE Lab ID events (Blood culture specimen) rate will not be statistically higher than the most recent NHSN published rates (using the SIR).

4. Clostridium difficile (C. difficile) surveillance is performed utilizing the Multi-Resistant Organism and Clostridium difficile Infection Module (LabID Event Reporting).

a. All positive C. difficile results are entered into NHSN. Increases in hospital onset (HO) cases will be reviewed and action taken if they are epidemiologically associated.

b. GOAL #1: The C. difficile hospital onset (HO) rate will not be more than expected based upon NHSN SIR Rates.

5. Ventilator Associated Event – Adult Critical Care Unit

a. VAE is conducted on persons in the ICU who had a device to assist or control respiration continuously through a tracheostomy or by endotracheal tube within the 48 hour period before the onset of infection (inclusive of the weaning period). Current CDC/NHSN VAE definitions are followed. The definition has three tiers: ventilator associated condition (VAC), infection related ventilator associated condition (IVAC), and possible ventilator

associated pneumonia (PVAP). All PVAP cases will be reviewed & reported to Critical Care Committee and the Infection Control Committee.

i. GOAL #1: There will be less PVAP cases than the prior year. The number of PVAP cases will trend lower than the prior year.

ii. GOAL #2: The NHSN standardized utilization ratio (SUR) will be less than 1.0 (PVAP- Tier 3).

6. Central Line Associated Bloodstream Infection (CLABSI) –
   a. Patients with a central line (defined by NHSN as a vascular access device that terminates at or close to the heart or one of the great vessels) and a primary bloodstream shall be counted. If a bloodstream infection occurs while a central line is in place or if a central line was inserted > than two calendar days before the onset of infection a chart review will be performed. Current CDC/NHSN definitions are used to determine CLABSI events.
   b. GOAL #1: Using NHSN definitions for CLABSI, the CLABSI rate for ICU patients will not be statistically higher than the NHSN standardized infection ratio (SIR).
   c. GOAL #2: Using NHSN definitions for CLABSI, the CLABSI rate for non-ICU patients will not be statistically higher than the NHSN standardized infection ratio (SIR).
7. Catheter Associated Urinary Tract Infection (CAUTI)
   a. Symptomatic urinary tract infection – Patients with positive urine cultures and indwelling foley catheters are reviewed. Current CDC/NHSN definitions are used to determine CAUTI events.
   b. GOAL #1: Using NHSN definitions for catheter associated urinary tract infection (CAUTI), the CAUTI SIR for ICU patients will not be statistically higher than the NHSN standardized infection ratio (SIR).
   c. GOAL #2: Using the NHSN definitions for CAUTI, the CAUTI SIR for non ICU patients will not be more than expected based upon the NHSN standardized infection ratio (SIR).
8. Hand Hygiene
   a. Hand hygiene compliance rates are collected by manual observation performed by unit staff on a monthly basis. The Hand Hygiene compliance rates are reported to the Managers, Directors, Regulatory Compliance Committee, and the Infection Control Committee. Tri City Medical Center follows the World Health Organization's 5 Moments model for hand hygiene.
   b. GOAL #1: Overall hand hygiene compliance rate will be at least 90% per quarter.
9. Environmental and Patient Care Rounds
   a. **Multidisciplinary e**~~E~~nvironment of c~~C~~are rounds are performed monthly and overseen by the **Safety Officer and reported out to the** Environmental Health & Safety (EHSC) Committee **and Infection Control Committee. From these rounds, Infection Control will assess & prioritize potential risks for infection, contamination and exposures to help eliminate and mitigate such risks.** These rounds will identify risks associated with, but not limited to, medical equipment and supplies. In addition, tracers are performed monthly on a schedule throughout the patient care areas.
   b. GOAL #1: Infection Control ~~assessments~~ will be represented 100% of the time during scheduled environmental rounds.
   c. GOAL #2 Infection Control ~~assessments~~ will be represented 100% of the time during scheduled tracers.
   d. GOAL #3: Engineering staff in collaboration with Infection Control will complete an Infection Control Construction Permit 100% of the time for projects that require a Class III or higher containment.
10. Reportable Diseases
    a. Assisted by the Microbiology Laboratory and Emergency Department, required reporting to Public Health is performed by phone, fax or mail using the California Confidential Morbidity Report or other special form as directed by the County of San Diego

Department of Health. Case finding is done through review of microbiology reports and calls from hospital staff (including physicians).

b. GOAL: Required reportable disease will be sent to the local health department within the required time frame 100% of the time.

11. Employee Health collects and reports the following:
    a. GOAL#1: There will be 10% less needle stick injuries from the previous calendar year
        i. Number of needle sticks injuries and details of department involved, device, and cause.
    b. GOAL#2: 100% of employees will complete the annual tuberculosis screen
        i. # Staff completing annual TB screening (PPD, blood test or survey)/ # employees in whom compliance is required.
    c. GOAL #3: Greater than 90% of Tri City Medical Center staff (per NHSN definition) will receive influenza vaccine.
        i. # Employees and who received influenza vaccine/# employees who worked at least one day during the flu season.
    d. GOAL #4: Greater than 90% of Tri City Medical Center inpatient Acute Rehab unit staff (per NHSN definition) will receive influenza vaccine.
12. Home Care, collects and reports the following:
    a. GOAL #1: CAUTI and CLABSI rates will be monitored and reported to the Infection Control Committee quarterly.
    b. GOAL #2: There will be less than two CAUTI infections in the calendar year.
        i. # UTI cases with foley catheter/Total # device days.
    c. GOAL #3: There will be no infections related to central lines in the calendar year.
        i. # BSI cases with Central Line/Total # device days.

I. RELATED DOCUMENT(S):

1. Infection Control Policy: Philosophy
2. Infection Control Policy: Epidemiologic Investigation of a Suspected Outbreak
3. Infection Control Risk Assessment 2020

J. REFERENCE(S):

1. County of San Diego Public Health & Human Services Agency, Public Health Services. Retrieved from http://www.sandiegocounty.gov/hhsa/programs/phs/
2. Centers for Disease Control and Preventions, National Healthcare Safety Network (NHSN) Tracking Infection in Acute Care Hospitals/Facilities. (2017) http://www.cdc.gov/nhsn/acute-care-hospital/index.html
3. County of San Diego Tuberculosis Control and Refugee Health Program.) TB Statistics-Fact Sheet 2016 (March 2017). Retrieved from http://www.sandiegocounty.gov/hhsa/programs/phs/tuberculosis_control_program/
4. Friedman, C. (2014). Infection Prevention and Control Programs in P. Grota (Ed.), APIC Text of Infection Control and Epidemiology (4th ed). Washington DC; 2014
5. The City of San Diego (2017), Economic development: Population **https://www.sandiego.gov/economic-development/sandiego/facts**
6. **https://datausa.io/profile/geo/san-diego-county-ca/**

Infection Control Risk Assessment: 2020

Potential Risks/Problems	Probability					Risk/Impact (Health, Financial, Legal, Regulatory)					Current Systems/Preparedness					Score
	Expected	Likely	Maybe	Rare	Never	Catastrophic Loss (life/limb/ function/	Serious Loss (Function/ Financial/	Prolonged Length of Stay	Moderate Clinical/ Financial	Minimal Clinical/ Financial	None	Poor	Fair	Good	Solid	≥ 10 Hi 7-9 Med ≤ 6 Lo
	4	3	2	1	0	5	4	3	2	1	5	4	3	2	1	
Multi-Drug Resistant Organisms (MDRO)																
MRSA		X							X					X		7
C Diff			X						X					X		6
CRE				X					X					X		5
VRE				X					X					X		5
ESBL/other Gram Negative bacteria				X					X					X		5
Prevention Activities																
Lack of Hand Hygiene Compliance			X						X					X		6
Lack of Respiratory Hygiene/ Cough Etiquette				X					X					X		5
Lack of Patient Influenza Immunization			X					X							X	6
Lack of LIPs Influenza Immunization			X					X						X		7
Isolation Activities																
Lack of Adherence to Standard Precautions			X						X					X		6
Delayed Identification of airborne transmissible diseases			X						X					X		6
Policy and Procedure																
Failure to follow established policy or procedure- TB discharge approval				X					X					X		5
Emergency preparedness																
Ebola Preparedness				X			X							X		7
Influx of Infectious Patients				X					X					X		5
Pandemic Influenza				X					X					X		5

Potential Risks/Problems	Probability					Risk/Impact (Health, Financial, Legal, Regulatory)					Current Systems/Preparedness					Score
	Expected	Likely	Maybe	Rare	Never	Catastrophic Loss (life/limb/ function/ financial)	Serious Loss (Function/ Financial/ Legal)	Prolonged Length of Stay	Moderate Clinical/ Financial	Minimal Clinical/ Financial	None	Poor	Fair	Good	Solid	≥ 10 Hi 7-9 Med ≤ 6 Lo
	4	3	2	1	0	5	4	3	2	1	5	4	3	2	1	
Healthcare Associated Infections (HAI)																
Central Line Associated Blood Stream Infections				X			X							X		7
Catheter Associated Urinary Tract Infections				X					X					X		5
Surgical Site Infections				X			X							X		7
Ventilator Associated Event (PVAP) in ICU				X			X							X		7
Lice and Scabies				X						X					X	3
Norovirus				X					X					X		5
Influenza				X					X					X		5
Bloodborne Pathogens				X					X					X		5
Environment																
Legionella Disease				X			X							X		7
Air Handling				X					X				X			6
Cleaning/ Disinfection			X						X					X		6
Monitoring Negative Air Pressure Rooms				X					X					X		5
Lack of Negative Pressure Rooms				X					X					X		5
Infection Related to Construction/ Renovation				X			X							X		7
Employee Health																
Lack of Staff Influenza Immunization			X						X					X		6
Lack of Staff Immunization, other			X						X					X		6
New hire health screen				X						X					X	3
Exposure to Bloodborne Pathogens			X				X							X		8
Exposure to infectious disease			X						X					X		6
Annual TB screening of staff			X						X						X	5
Pertussis				X					X					X		5
Lack of LIP Screening			X							X				X		5
Other																
Risk of Community Outbreak				X					X					X		5

The Infection Control (IC) Risk assessment grid is a visual tool to develop IC program priorities and stratify infection risks based on our geography, location in the community, our patient population and the review of our previous IC data analysis. The annual IC Plan is developed based on these risks.

The IC Risk assessment is an ongoing, continual process. A more focused review is done on an annual basis after reviewing the quarterly and annual reports with the Infection Control committee.

Risk Assessment Completed on: Jan. 2020

ID MD, ICC Chair	IP	EH	RN	MD	Quality	Lab	Administration	
Pharmacy	EOC	OR	Housekeeping	Engineering		PSO		

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY

ISSUE DATE: 05/08	**SUBJECT:** Influenza Vaccination of Physicians and Allied Health Professionals (AHP)
REVISION DATE: 05/08, 08/12, 06/17	**POLICY NUMBER:** 8710 – 547

Medical Staff Department Approval:	07/12, 03/17, 02/20
Infection Control Committee Approval:	07/12, 04/17, 03/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	08/12, 05/17, 04/20
Administration Approval:	05/20
Professional Affairs Committee Approval:	~~06/17~~ n/a
Board of Directors Approval:	05/08, 08/12, 06/17

A. **PURPOSE:**

1. To increase influenza vaccination rates of healthcare workers to provide a healthier work environment and reduce adverse patient outcomes The Centers for Disease Control recommends that all health care workers receive an annual influenza vaccination to prevent transmission to patients. Influenza immunization rates among health care workers remain low, with only 36%-40% of health care workers reporting influenza vaccination each year. Influenza vaccination is an important patient safety issue because unvaccinated staff can spread influenza to patients, coworkers, and family members, leading to influenza-related illness and death. When health care workers become ill with influenza, absenteeism and disruption of care may result. When health care workers transmit influenza to patients, some of them may experience serious, even life-threatening complications or secondary pneumonias. California SB739 states the following: "Each general acute care hospital shall require its employees to be vaccinated, or if the employee elects not to be vaccinated, to declare in writing that he or she has declined the vaccination." This requirement applies to all health care workers, including physicians.

B. **POLICY:**

1. All active physicians and Allied Health Professionals (AHP) at Tri-City Healthcare District (TCHD) will participate in the Annual Influenza Vaccination or Declination program.

C. **PROCEDURE:**

1. The program requires physicians and AHP to either sign the Influenza Vaccine Declination Statement or be vaccinated by November 30 each year, unless the vaccine is unavailable.
2. Physicians and AHP who begin work at TCHD after November 30 and before April 1 will have 14 days after they begin to sign the Influenza Vaccine Declination Statement or be vaccinated.
3. If the physicians and AHP fails to be vaccinated at TCHD, or submit a signed declination pursuant to 4.6-5, the practitioner's reappointment application will be considered incomplete and the practitioner shall be deemed to have resigned membership in the medical staff within 30 days past the due date.

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

1. Employee Health & Wellness: Immunization Policy
2. Infection Control: Aerosol Transmissible Diseases and Tuberculosis Control Plan IC 11

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 02/01	**SUBJECT:** Standards for Endovascular Repair of Aortic Aneurysms
REVISION DATE(S): 09/07, 04/17	**POLICY NUMBER:** 8710 – 503

Department Approval ~~Date~~:	03/17, 02/20
Division of GVS Approval ~~Date~~:	03/17, 03/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval ~~Date~~:	03/17, 04/20
Administration Approval ~~Date~~:	05/20
Professional Affairs Committee Approval ~~Date~~:	~~04/17~~ n/a
Board of Directors Approval ~~Date~~:	04/17

A. **STANDARDS:**

1. All cases involving endovascular repair of aortic aneurysms must meet the following minimum criteria for adequate facilities and physician skills.
   a. The minimum criterion for the facility is:
      i. Digital subtraction angiography with roadmap capabilities.
      ii. A large Field of View image intensifier (15 or 16 inches) * with a 1024 matrix.
      iii. Power injector for contrast administration.
      iv. Appropriate supply of balloons, guidewires, stents, coils and other embolic materials.
      v. Appropriate level of sterility.
      vi. Adequate space and facilities for anesthesia
      vii. Interventional Physician and Surgical Registered Nurses.
      viii. Interventional technologist.

      *When combined intraoperative access and endoluminal graft is performed in the operating room, a smaller image intensifier may be acceptable when agreed upon by the involved physicians.
   b. The criterion for physician skills is:
      i. Interventional Physician must have current independent (has been released from proctoring) Tri-City Healthcare District (TCHD) privileges for catheter-based peripheral vascular interventional procedures.
      ii. Interventional Physician must have met the minimum criteria for device- specific training/certification as defined by the manufactures of the device.
      iii. Vascular Surgeons must have current independent (has been released from proctoring) TCHD privileges for open repair of abdominal and/or thoracic aortic aneurysm repair.
2. During all cases, at least one physician credentialed in Interventional Radiology and one physician credentialed in Vascular Surgery must be present.
3. Proctoring Criteria:
   a. Five cases performed during the first six months after granting of the privilege will be proctored. The proctor must be privileged for the procedure that he/she is proctoring.
4. Reappointment Criteria:
   a. Maintenance of Endovascular Repair of Aortic Aneurysm requires ongoing experience in performing these procedures with acceptable success and complication rates.
   b. In order to qualify for reappointment, the minimum number of cases (5) to be performed in a two-year period.

Tri-City Medical Center	Women and Newborn Services Neonatal Intensive Care Unit (NICU)
PROCEDURE:	**FORMULA, PREPARATION AND STORAGE OF**
Purpose:	Powered specialty formula and fortification of formula will be prepared in the NICU in an aseptic manner to assure sterility.
Equipment:	1. **Graduated**~~Sterile~~ Container 2. **Food Grade** Disinfecting Wipes for Cleaning 3. Non-Sterile Gloves ~~4. Patient Identification Label~~ ~~5. Powdered Specialty Formula~~ ~~6.~~4. Single-Use Scoop

A. **POLICY:**

1. Breast milk is recognized as the feeding of choice for most infants, however, when breast milk is not available for use, or its use is contraindicated due to infant and/or maternal condition, or mother chooses to use formula, formula (artificial milk) will be available per physician/allied health professional (AHP) order for supplementary use for infant feedings.
2. Formula preparation and fortification are the responsibility of the Registered Nurse in the NICU. Caloric density and type of formula must be verified with the physician/AHP order prior to preparation.
3. The preparation of formula will be carried out in a designated area away from the bedside to decrease the risk of contamination.
~~3.~~4. **Formula fortification shall be done using standardized recipes provided by the NICU registered dietician.**

B. **PROCEDURE:**

1. **Storage**
   a. **Formula will be stored in a designated formula storage area and kept in sealed containers until use.**
~~B.~~2. **Fortifying ready to feed formula**
   a. Verify physician/AHP's order for formula.
   ~~1.~~b. **Sterilize milk preparation work surface with hospital approved food grade disinfecting wipes.**
   ~~2.~~c. Perform hand hygiene**, don non sterile gloves** and gather necessary equipment and supplies in designated **milk**~~formula~~ preparation area.
   ~~3.~~d. ~~Sanitize work surface, perform hand hygiene, and put on non-sterile gloves.~~
   ~~4.~~e. Measure formula into **graduated** ~~sterile~~ container to desired volume.
   ~~5.~~f. **Using aseptic technique and single use scoop,** Aadd powdered/liquid specialty formula into container with formula **to achieve desired caloric density** as per physician/AHP's orders:
      ~~a. Use single-use scoop only.~~
      ~~b. Transfer appropriate number of scoops required for caloric density to sterile container~~
   ~~c.~~ **Mix thoroughly and label container with patient label, date and time of fortification and content description.**~~Cap and shake vigorously to mix.~~
   ~~d. Label container appropriately with contents.~~
   ~~6.~~g. Fortified/mixed formula should be prepared fresh for each feed.
   ~~7.~~h. Refer to manufacturer guidelines for storage of unused formula.
   i. Clean area after completion, wiping surface down with **food grade disinfecting**~~antiseptic~~ wipes.
3. **Preparing Powdered Formula**

NICU Department Review	Perinatal Collaborative Practice	~~Division of Neonatology~~	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/14, 05/17, 03/20	06/14, 06/17, 03/20	~~n/a~~	n/a	n/a		08/14, 07/17	08/14, 07/17

a. **Powdered formula should only be used when a ready-made liquid product is not available**

b. **Follow preparation technique described above using sterile water to reconstitute the powdered formula per manufacturer's or registered dietician's standardized recipe.**

~~8.~~c. **Store unused reconstituted powdered formula per manufacturer's guidelines.**

C. **REFERENCE(S):**

1. American Academy of Pediatrics (AAP) and American College of OB and GYN (ACOG). (2012). Guidelines for Perinatal Care, 7th ed.
2. California Code of Regulation, Title 22: Social Security, Volume 28, Revised, November 29, 1996. Barclays Law Publishers, South San Francisco, CA.
~~2.~~3. **Steele, C., & Collins, E. A. (2019). *Infant and pediatric feedings: guidelines for preparation of human milk and formula in health care facilities* (3rd ed.). Chicago, IL: Academy of Nutrition and Dietetics.**

Tri-City Medical Center	Distribution:

DELETE RCP's no longer intubate (including in the NICU).

PROCEDURE:	**INTUBATION**
Purpose:	To outline the trained NICU RCP in performing e
Supportive Data:	Endotracheal intubation is the placement of an endotracheal tube for the purpose of establishing access to the airway to assist ventilation. The procedure may be performed by a RCP who provides a completion of certificate for endotracheal intubation and a current NRP card. This procedure may be performed after a supervising physician has validated competency. Proctoring includes the observation of five successful intubations by the Neonatologist. Maintenance of competency requires a minimum of 2 procedures to be performed annually. Ongoing competency is validated through supervision and the annual performance appraisal process. The qualified NICU RCP may perform this procedure in the Delivery Rooms, NICU and ER department.
Equipment:	1. Laryngoscope with Miller size O blade for pre-term infants 2. Laryngoscope with Miller size 1 for term infants 3. Eye shield, gloves and a mask (recommended) 4. Laryngoscope and appropriate size blade 5. Endotracheal tube: appropriate for age and size 6. Endotracheal tube stylet (optional) 7. Suction equipment 8. Appropriate tube securing device (tape)

A. INDICATIONS:

1. The indications for orotracheal intubation include the following:

   a. Prolonged positive pressure ventilation
   b. Ineffective bag and mask ventilation
   c. Meconium Aspiration

B. PROCEDURE:

1. Place the patients in the "sniffing" position (nose pointing vertically).
2. Pre-oxygenate and/or ventilate the patient with bag and mask ventilation.
3. Hold the laryngoscope in the left hand; insert the blade into the right side of the mouth. Move blade to center of mouth, pushing the tongue to the left side. This creates an unobstructed channel in the right one third of the mouth through which the endotracheal tube will be passed.
4. Once positioned, traction is placed upward along the axis of the handle. (Care must be taken to avoid using the upper gum or teeth as a fulcrum against which the laryngoscope is rocked back toward the intubator).
5. Insert the tracheal tube from the right corner of the mouth to avoid obscuring the view of the glottic space.
6. The intubator should be able to visualize the tube as it passes between the vocal cords. Each attempt at intubation should be limited to 20 seconds to prevent hypoxemia.
7. Hold tube in place and gently withdraw laryngoscope.
8. Determine proper positioning of the endotracheal tube immediately:
9. Auscultate equal breath sounds over each chest wall
10. Observe chest rise with bag inflation
11. Observe the presence of mist in the endotracheal tube during expiration
12. Note the absence of breath sounds over the stomach
13. Optional use end tidal CO_2 cap
14. If these criteria cannot be confirmed, the endotracheal tube must be removed and bag and mask ventilation resumed.
15. Confirm endotracheal tube position with a radiograph.
16. Remove gloves and wash hands.
17. Documentation of procedure (post intubation) should include:

Issued:	Reviewed:	Department Revised:	Perinatal Collaborative Practice Division of Neonatology	Division of Pulmonary	Pharmacy & Therapeutics Committee	Medical Executive Committee	Board Approved:	Administration
6/06	12/08	12/08, 9/09, 6/11, 4/15, 03/20	03/20	n/a	n/a	03/20	6/06, 1/10, 5/12	

a. Size of tube
b. Placement mark (cm atgum)
c. Number of intubation attempts
d. Document if cords visualized and tube passed through cords
e. Breath sounds heard, and if equal
f. Document absence of breath sounds over stomach
g. Document chest rise and color change in baby post-intubation
h. Document if misting of tube occurred
i. End tidal CO_2 cap color change

Tri-City Medical Center	Women's and Children's Services Manual - NICU
PROCEDURE:	**NICU DISASTER PROCEDURE**
Purpose:	Disasters in the NICU will be handled in a safe, orderly process.
Equipment:	a. Color-coded Triage bands b. Evacuation Vest c. Evacuation Back packs

A. **POLICY:**

1. Refer to ~~hospital policy for additional information (Code Orange).~~**Disaster Plan Activation Hospital Wide Policy (#4071) and Emergency Operations Procedure Manual for additional information.**
2. ~~All areas of the hospital have posted floor plans, which include fire exits, stairwells, alarm stations, and extinguishers. Every employee and volunteer working these areas should review the diagrams.~~
3. ~~If hospital evacuation becomes necessary, the order comes from the incident commander.~~**The incident commander will issue the order for evacuation if necessary.**
4. If an area of the NICU is in immediate danger the NICU L**l**eadership t**T**eam **or designee**~~/NICU charge nurse~~ may initiate **and direct** evacuation **in coordination with the neonatologist.** .
5. ~~The persons in charge of carrying out the NICU evacuation are the attending neonatologist and the NICU leadership team nurse.~~
6. ~~Each infant is assigned a color-coded triage band for evacuation purposes.~~
7. **Infants will be triaged for evacuation utilizing the "Triage by Resource Allocation for IN-patients [TRAIN]" process. Infants should be assessed and assigned a color triage band daily, as indicated by colored magnet on assignment board.** Triage bands for each infant will be identified daily by the charge nurse.
8. ~~A colored magnet delineating the correct color triage band will be placed by the infant's name on the assignment board.~~

B. **PROCEDURE:**

1. The NICU l**L**eadership team~~/charge nurse~~ **(or designee) shall**:
   a. Send a ~~designated staff member~~**representative** to the incident command center. ~~The command center designates a disaster leader who will be responsible for the triage and utilization of staff for evacuation of the infants.~~
   b. Initiate the disaster call list.
   c. ~~Consult with the neonatologist in charge to review the patients and determine the order of evacuation based on acuity.~~**Review patients with neonatologist, determining if any babies can be discharged to home.**
   ~~c.~~**d. Determine evacuation order in conjunction with neonatologist per TRAIN algorithm and evacuate to designated area.**
   ~~i. Evacuation to the designated area will occur in the following order per Triage by Resource Allocation for IN-patients (TRAIN):~~**Evacuation order:**

      ~~ii.~~**1)** Blue bands - evacuate ~~to designated area~~ and discharge ~~patients~~ home as appropriate. ~~If infant must be transported~~**Infant** may be transported in a car/**car**-seat.

      ~~iii.~~**2)** Green bands - evacuate ~~to designated area~~ and transport to another facility **via ambulance (BLS)**~~as appropriate, via wheel chair or stretcher.~~

      ~~iv.~~ Yellow bands – evacuate ~~to designated area~~ and transfer to another facility ~~via wheelchair or stretcher~~ **via ambulance (ALS)**

Department Review	Perinatal Collaborative Practice~~Division of Neonatology~~	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
12/14, 2/20	03/20	n/a	n/a	05/20	4/15, n/a	4/15

~~v.~~3) Orange bands - evacuate ~~to designated area~~ and transfer to another facility **via critical care transport with RN +/- RT +/- MD**~~via transport rig~~

~~vi.~~4) Red bands – ~~last to be evacuated to designated area~~**evacuate and transport** ~~and first to be transferred to another facility~~ via ~~transport rig~~**ambulance or military with specialized transport team and equipment.** ~~These infants may need specialized equipment for transport.~~

5) ~~Teddy Bear White~~**Purple** bands~~final evacuation from the NICU.~~ ~~Evacuated~~ **Transported** to the designated morgue area.

6) **Infants with red and orange bands should be evacuated last but transferred to another facility first when possible.**

7) **Injured staff is to be evacuated with the first evacuated infants.**

ii. **Utilize the evacuation routes designated in the hospital disaster plan to evacuate the NICU. Evacuation may be:**

1) **Horizontal –infants may be transported on their warming tables, isolettes, and cribs.**

~~vii.~~2) **Vertical –Employ the evacuation vests and backpacks to evacuate infants; least sick infants may be placed in aprons**

e. **Designate roles:**

i. **Ancillary Staff:**

1) **Take emergency supplies to evacuation site.**~~Designate ancillary staff to assist in taking emergency supplies to the evacuation site~~.

2) **Maintain clear aisles for mobilization of equipment and supplies during evacuation**

ii. **Nursing Coordinator:**

1) **Accompany first infant to designated evacuation site**

2) **Provide oversight at evacuation site**

3) **Reevaluate infants as they arrive to evacuation site**

4) **Reband infants with appropriate color if condition has changed**

iii. **Neonatologist:**

i) **Assist with evacuation of sicker infants.**

2) **If second neonatologist is available, he or she should be stationed at the evacuation site to receive and evaluate infants upon arrival.**

iv. **Unit Secretary or other staff designee:**

1) **Assist with communication and telephone calls under the direction of NICU Leadership/designee.**

2) **Prepare and send all patient medical charts (preferably accompanying each infant) to evacuation site.**

~~b.~~3) **Bring patient census/assignment sheet to evacuation site when personally evacuated.**

~~c. Designate a nursing coordinator for the evacuation site and instruct that person to go to the site with the first infants.~~

~~i. The nursing coordinator will reevaluate infants once they have reached the evacuation site.:~~

~~ii. If infant condition changed during the evacuation the nursing coordinator will reband the infant at that time with the appropriate colored band.~~

~~iii. If the infant condition is unchanged band originally place on the infant will remain in place~~

~~d. Injured staff is to be evacuated with the first evacuated infants.~~

~~2. Attending Neonatologist:~~

~~a. Collaborate with the NICU leadership team charge nurse in triaging infants.~~

~~b. Assign neonatologist coordinator to go to the evacuation site with the first infants if available.~~

~~c. Assist with the evacuation of the sicker infants.~~

~~3. Unit Secretary:~~

~~a. Assist with communication and telephone calls under the direction of the NICU leadership team/ charge nurse.~~
~~b. Bring patient census/assignment sheet and ensure patients' medical charts are taken to the evacuation site when ordered to leave the NICU.~~
~~4. Support Staff:~~
~~a. Report to NICU leadership team / charge nurse to receive instructions for assisting with evacuation.~~
~~b. Attend to maintaining clear aisles for mobilization of equipment and supplies needed for evacuation.~~

~~5.~~v. Respiratory Care Department:

~~a. Organize oxygen and compressed air cylinders for the evacuation site and for shutting off the zone valves as the areas are evacuated.~~
~~b. Immediately shut off the compressed air and oxygen zone valves to the area in the event of a fire.~~
~~i.~~a) ~~Patients requiring oxygen or mechanical ventilation must be switched to E cylinder oxygen.~~ **Refer to Disaster Plan Pulmonary Department for specifics**

~~6. Preparing infants for evacuation:~~
~~a. Ensure each infant has identification band on limb.~~
~~b. Assign triage band as appropriate and place on each infant.~~
~~c. Discontinue continuous nasogastric feeding, aspirate stomach and clamp tube.~~
~~d. Disconnect from all monitoring devices.~~
~~e. If situation is critical, disconnect all peripheral IVs, arterial, and percutaneous lines. Attach syringes with flush solution. Ensure that all connections are secure to prevent infant from bleeding during evacuation.~~
~~f. Attempt to bring IV pumps to maintain/resume fluid delivery.~~
~~g. Disconnect chest tube drainage system from suction and place on Heimlich valve seal.~~
~~h. Take patient chart with patient.~~
~~Employ the evacuation vests and backpacks to evacuate infants if a vertical evacuation is ordered.~~
~~Utilize the evacuation routes designated in the hospital disaster plan to evacuate the NICU. Evacuation may be:~~
~~Horizontal – from one area to another on the same floor, infants may be transported on their warming tables, isolettes, and cribs.~~
~~Vertical – from one floor to another floor or outside of building, least sick infants may be transported using apron.~~
~~Evacuate patients in the following order:~~
~~Infants requiring 1:3 level of care (blue and green triage bands)~~
~~Infants requiring 1:2 level of care (yellow and orange triage bands)~~
~~Infants requiring 1:1 level of care (red triage bands)~~
~~For evacuation to another facility, transfer orange and red banded infants first depending on availability of medical transportation..~~

2. Do not use elevators for evacuation unless authorized by on-the-scene Fire Department personnel.
3. Remain at designated evacuation site and do not return to the evacuated area unless ordered to do so by the incident commander.
4. Assess and stabilize infants as soon as evacuation site has been reached.
5. Make arrangements to transport to other NICUs as soon as possible.

~~7. Protect patients' medical records and move them to evacuation site. When possible, patients should have their medical record with them when moved to another location. If not, NICU leadership team/ charge nurse is to delegate the unit secretary or another person to gather the charts and remove them to a safe area.~~

6. Reassure all patients and visitors that the emergency plan is in operation and not to be alarmed.
~~8.~~7. –Keep calm and follow directions.

6.8. **In the event of a power failure or medical gas failure:**Care of the NICU (power failure or medical gas failure)

a. Notify Bio Engineering, Respiratory Care Department, and the neonatologist at the first indication of problems with electrical power or medical gases.

Communication – Utilize walkie-talkies in the event in-house phone lines are down.

b. Lighting—Use flashlights located in the unit whenever power is out and**if** visibility is impaired.

c. Ventilation:

RN/RCP to i Initiate hand ventilation by the RN or RCP for all infants requiring mechanical ventilation in the event of power failure.

i. RN will initiate and Respiratory Care will provide necessary back up.

d. Suction:

i. Use battery operated suction devices for ETT suctioning **(if available)** of intubated patients or use DeLee suction traps if wall suction is not operational.

ii. Maintain chest tube system to Heimlich valve**Place chest tube to water seal**.

e. Thermoregulation:

ii.**i.** —c**C**over infant with blankets. If unable to maintain temperature, place infant on covered chemical mattress or cover infant with thermal blanket and plastic wrap.

e.**f.** Maintaining infusion:

i. Check pump power. If it is not working, locate another pump with a functional battery.**Replace infusion pumps low on battery with a new pump.**

ii. Give slow IV pushes of appropriate IV fluids to maintain IV patency not to exceed the hourly IV rate if no battery-powered pumps are available.

iii. Advance continuous feedings manually.**Manually administer feedings as appropriate.**

f.**g.** Monitoring vital signs:

i. Use battery powered monitors and pulse oximeters **(if available)** for infants who require continuous monitoring.

ii. Assess respiratory status and heart rate with a stethoscope, assess infant's color**Obtain vital signs manually as indicated**.

g.**h.** Once power and/or gases are restored – ensure that patients are safely attached to support devices and that all equipment is functional.

9. **Mass Evacuation/Disasters:**

iii.**a.** In the event of a mass evacuation, as with disasters,**Refer to online resource Southern California Perinatal Transport System (SCPTS)** should be contacted for assistance **in determining bed availability at surrounding hospitals.** .

1) Note: SCPTS is only available during regular business hours. In the event that a mass evacuation is occurring outside of regular business hours, then the NCPTS should be called.

i. SCPTS or NCPTS should be notified with as much advance notice as possible in the event of a disaster (e.g. fires, etc.). This will allow more optimal disaster preparedness and utilization of county and state resources.

ii. SCPTS (Monday – Friday during normal business hours): 562.945.6484 NCPTS (non-business hours): 650.723.6307

2) In the event of high volume transfer, as with closure of unit due to infectious disease issues or facility issues, SCPTS or NCPTS should also be notified. If the local transport teams are unable to meet the needs of transferring or evacuating neonates and infants, SCPTS or NCPTS will assist in allocation of resources to assist.

C. **DOCUMENTATION:**

1. **Patient documentation per downtime protocol.**

9. Complete patient assessment with a description of interventions used to maintain life support during disaster and/or power/gas failure.

10. Documentation is completed on paper.

D. **RELATED DOCUMENTS:**

~~11.~~1. Triage by Resource Allocation for IN-patient (TRAIN)

E. **REFERENCES:**

1. ~~TCMC Disaster Manual~~**TCMC Emergency Operations Procedure Manual**
~~1.~~2. **California Neonatal and Pediatric Coalition & Loma Linda Children's Hospital (2013). Pediatric/neonatal disaster reference guide [PDF].** ***Pediatric-Neonatal Disaster & Surge Network*****. Retrieved from https://docs.google.com/viewer?a=v&pid=sites&srcid=ZGVmYXVsdGRvbWFpbnxwZWRpbmVvbmV0d29ya3xneDo2ZTJhNzRhZDk1NmM3OTE3**
~~2. Cohen,R., Murphy,B., Ahern,T., & Hackel, A. (2010). Regional disaster planning for neonatalogy. Journal of Perinatology, 30:709-711.~~
3. **Lin, A., Taylor, K., & Cohen, R. S. (2018). Triage by resource allocation for INpatients: A novel disaster triage tool for hospitalized pediatric patients.** ***Disaster Medicine and Public Health Preparedness, 12*****(6), 692-696. doi:http://dx.doi.org.lopes.idm.oclc.org/10.1017/dmp.2017.139).**
~~12. Franck L., Epstein B., & Adams S. (1993). *Disaster preparedness for the ICU: Evolution and testing one unit's plan.* Pediatric Nursing., 19, 122-127.~~
~~13. Phillips, P, Niedergesaess,Y, Powers, R, Brandt, R. Disaster preparedness: Emergency Planning in the NICU. Neonatal Network. 2012;31(1) 5-15.~~
~~Prade K. (1998). Development of an NICU – Specific Disaster And Evacuation Plan—One Hospital's Experience. Neonatal Network, 17, 65-69.~~

Triage by Resource Allocation for IN-patients [TRAIN™]

Neonatal/Pediatrics

Transport	[redacted]	[redacted]	*Yellow/ALS*	*Orange/CCT*	[redacted]
Life Support	Stable	Stable +	Minimal	Moderate	Maximal
Mobility	Car/Carseat	Wheelchair or Stretcher	Wheelchair or Stretcher	Transport rig	Incubator or Immobile
Nutrition	All PO	Intermittent Enteral	Continuous Enteral or Partial Parenteral	TPN Dependent	
Pharmacy	PO Meds	IV Intermit meds	IV Fluids	IV Drip x1	IV Drip ≥2

Life Support	Stable + =	Low flow oxygen
	Minimal =	Oxygen hood, chest tube, etc.
	Moderate =	CPAP/BiPAP/Hi-Flow, Conventional Ventilator, Peritoneal Dialysis, Externally paced, continuous nebulizer treatments, etc.
	Maximal =	Highly specialized equipt., e.g., Neonatal Ventilator, HFOV, ECMO, iNO, CVVH, Berlin Heart, wt ≤ 1.5 kg, specialized medical personnel, etc.
Mobility	Car/Carseat =	Able to ride in automobile with age-appropriate restraints
	Incubator =	Transport incubator with equipment for connecting to ambulance
	Immobile =	Unsafe to move without special equipment e.g., neurosurgical/bariatric

~~14.~~

DELETE – no longer needed

PROCEDURE: PRIMARY NURSE ASSIGNMENT

Purpose:
1. To promote continuity and efficiency of care in order to optimize outcomes for the patient and their family.
2. To promote developmentally age appropriate, individualized, family-centered care for the NICU infant and family.
3. To promote and increase family satisfaction and enhance morale of the NICU Registered Nurse.

~~**DEFINITIONS:**~~

~~1. Primary Nurse:~~
- ~~a. Must work a minimum of 5 shifts in a pay period on a regular basis (FTE ≥ 0.8).~~
- ~~b. Must have a minimum of six month's experience as a Neonatal Intensive Care Unit (NICU) Registered Nurse (RN).~~
- ~~c. Must be a Tri-City Medical Center staff member.~~

~~B. STANDARD OF PRACTICE:~~
1. ~~Nurses shall provide care in a manner that is developmentally age appropriate, individualized, and family centered.~~
2. ~~Nurses shall provide care in a manner which maximizes continuity, efficiency and optimal outcomes.~~

~~C. POLICY:~~
1. ~~All infants with an expected stay greater than 7 days may be assigned a primary nurse.~~
2. ~~Any qualified NICU RN may volunteer to serve as primary nurse to any unassigned, primary-qualified infant who does not have a primary nurse within the first 48 hours of stay.~~
3. ~~During the 48 hours after admission of the primary qualified infant, any qualified NICU RN may sign up to be primary nurse to the infant, unless that RN is already serving as primary nurse to another patient.~~
4. ~~At 48 hours of stay, if no qualified NICU RN has volunteered to serve as primary nurse for the infant, the Supervisor or designee will facilitate the assignment of a primary nurse to the patient. The following criteria will serve as guidelines in the assignment of a primary nurse to a specific patient:~~
   - ~~a. The RN must not currently be serving as primary nurse to another patient.~~
   - ~~b. The assignment will be rotated, with the qualified NICU RN who has had the longest break from serving as a primary nurse preferentially assigned to the next infant qualifying for primary nursing, unless another qualified NICU RN voluntarily chooses to serve within 48 hours after the infant's admission.~~
   - ~~c. If the NICU RN who is first in the rotation is not on duty, and is to be off from work for more than three days following the assignment, the next NICU RN in the rotation will be assigned to the patient.~~
   - ~~d. It is acceptable to "pass over" an RN under special circumstances with the consent of the supervisor/nurse manager.~~
5. ~~It is the responsibility of the primary nurse to:~~
   - ~~a. Evaluate the needs of the infant and family, including teaching/learning issues.~~
   - ~~b. Formulate, in conjunction with the multidisciplinary team and the family, an individualized plan of care, inclusive of short term and discharge goals, for the infant and family.~~
   - ~~c. Communicate plan of care to other caregivers; ensure plan is carried out.~~
   - ~~d. Evaluate effectiveness of plan of care in achieving goals and alter plan of care as needed.~~

Department Review	Perinatal Collaborative Practice~~Division of Neonatology~~	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
12/15, 02/20	~~n/a~~02/20, 03/20	n/a	n/a	05/20	04/16, n/a	6/11; 8/12, 04/16

a. Evaluate the need for family conferences at least every two weeks and prn. These are to include at a minimum, one of the parents and/or primary caregiver, the attending physician, the primary or associate nurse, and the infant's social worker.

2. The primary nurse serves as primary to only one patient at the time, unless she/he chooses to serve as primary nurse to two infants of a multiple birth.
3. The primary nurse may serve as associate nurse to one infant in addition to the infant for whom they serve as primary nurse.
4. It is optimal that each infant who qualifies for primary nursing care will also have an associate nurse on the shift opposite of the shift worked by the primary nurse (additional associate nurses may also serve on the team as available and indicated).
5. The associate nurse is a NICU RN who has successfully completed the NICU orientation period.
6. The responsibilities of the associate nurse(s) are to:
   a. Continue identification of problems and potential interventions.
   b. Aid in evaluating the effectiveness of the plan.
   c. Communicate the above to the primary nurse.
   d. Carry out plan of care, including family teaching.
   e. Support the plan of care with the family and other team members.
   f. Serve as the primary nurse if the original primary nurse is not available for ≥ 4 days.
7. Any RN caring for any patient in the NICU at any time is responsible for performing the duties of an associate nurse except for that of consistently caring for a specific patient.
8. The primary nurse and the associate nurse(s), in this order, will be preferentially staffed with the infant on whose team they are serving unless safe staffing of the NICU requires otherwise. A further exception may occur either when the team member requests a brief break from caring for the infant or the primary nurse is assigned as relief charge.

B. PROCEDURE:

1. Supervisor and/or designee:
   a. As each patient is admitted, determine the expected stay of the infant. If the expected stay is greater than seven days:
      i. Ask the admitting RN (if qualified), if they wish to be assigned as primary nurse to the infant. If so, place the admitting RN's name in the Kardex and primary nurse board as primary nurse.
   b. If at 48 hours after admission the patient does not yet have a primary nurse signed up, facilitate the assignment of a primary nurse to the patient.
   c. Post the primary nurse's name in the patient Kardex and primary nurse board.
   d. Ensure that the primary nurse is preferentially assigned to bedside care of their primary patient whenever safe unit staffing needs allow.
   e. The newly assigned primary nurse should be assigned to bedside care of the primary patient on the first working day after being designated as primary nurse.
2. Bedside/Relief Nurse:
   a. Explain the concept of primary nursing to the family if not already done and tell them the day when the primary nurse will be back to work.
3. Primary Nurse:
   a. Review the infant's chart, discuss the case with the team, and initiate contact with the parents no later than the first day on duty after being assigned the infant as primary.
   b. Formulate an initial plan of care in conjunction with the team and the family.
   c. Continue duties as outlined above.

C. REFERENCES:

1. Miles, M.S. & Holditch-Davis, D. (1997). Parenting the prematurely born child: Pathways of influence. *Seminars in perinatology*, 21 (3), 254-266.
2. Scharer, K. & Brooks, G. (1994). Mothers of chronically ill neonates and primary nurses in the NICU: Transfer of care. *Neonatal Network*, 13 (5), 37-46.
3. Smith, S.J. (1987). Primary nursing in the NICU: A parent's perspective. *Neonatal Network*, February, 25-27.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: ~~Admission to Inpatient Behavioral Health Unit~~**Psychiatric Evaluation for Higher Level of Care**

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 09/17

Department Approval:	~~12/16~~03/19
Division of Psychiatry Approval:	~~06/17~~03/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/17~~04/20
Administration Approval:	05/20
Professional Affairs Committee Approval:	~~09/17~~ n/a
Board of Directors Approval:	09/17

A. **PURPOSE:**
1. To define appropriate methods for admitting a patient to an inpatient psychiatric unit.

B. **POLICY:**
1. When a patient is in need of inpatient treatment, the program staff and attending physician will arrange the admission.

C. **PROCEDURE:**
1. Who may perform/responsible: Clinical and Nursing Staff
   a. The treatment team, to include the Clinical Coordinator, Operations Manager and Registered Nurse (RN) whenever possible, meets to triage the patient and determine the need for inpatient admission.
   b. The clinical staff contacts the attending psychiatrist to inform him/her of the current situation and the staff's assessment of the patient and recommendations for admission.
   c. If the attending psychiatrist concurs that admission is necessary, ~~s/he makes the recommendation as to whether a direct admission or Emergency Department (ED) admission must occur. If a direct admission is recommended, the attending psychiatrist, or designee contacts the on-call physician to make the recommendation and communicate information obtained in the clinical assessment. If an ED admission is recommended~~, the clinical staff contacts the psychiatric liaison ~~to inform them regarding the potential admission~~**to conduct handoff communication**. ~~Once the patient is medically cleared in the ED, they may be transferred to the crisis stabilization unit for evaluation and treatment or admitted to inpatient behavioral health unit.~~
   d. If the patient refuses hospitalization **psychiatric evaluation in the Emergency Department (ED)**, the attending program psychiatrist makes a determination as to whether ~~a hold is necessary.~~ **the Sheriff/PERT should be contacted to evaluate for involuntary hold.**
   e. The staff will be responsible for arranging for transport of the patient and obtaining consents from the patient/conservator, as needed. Depending on level of risk, a patient may ~~need to be accompanied by staff on program van or be transported via ambulance.~~**be transported by Tri-City Medical Center van or accompanied by Staff on the van if they are voluntarily agreeing to be evaluated for hospitalization. Patients who are high risk, danger to self or others should be transported via ambulance or the Sheriff. The staff will contact the local Sheriff/PERT to assist with involuntary hold 5150 evaluation. OPBHS Staff may not place patients on involuntary hold and must utilize local law enforcement for involuntary detention evaluation.**

f. Staff will use the Situation, Background, Assessment, Recommendation (SBAR) process to conduct hand off communication with the intake coordinator, psychiatric liaison, shift Supervisor, MD, police department, or ambulance.

g. The program staff will notify the patient's family or significant others of the transfer, in accordance with the patient's wishes. If appropriate, the patient's insurance reviewer is contacted and informed regarding the inpatient admission.

h. Patient information/records will be sent at the time of transfer. These records will include diagnosis, pertinent financial/administrative information, current medical findings, current medications and a brief summary of the course of treatment. Program nurse and clinical staff will ensure accuracy of medication reconciliation and hand off communication.

Tri-City Medical Center
Oceanside, California

DELETE: No Longer LPS Facility

Outpatient Behavioral Health Services

~~SUBJECT: Involuntary Patient Detention~~

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	~~12/16~~06/19
Division of Psychiatry Approval:	~~06/17~~03/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/17~~04/20
Administration Approval:	05/20
Professional Affairs Committee Approval:	~~08/17~~ n/a
Board of Directors Approval:	08/17

~~A. PURPOSE:~~

~~1. To protect the patient's health and safety when the patient is a danger to self, danger to others and/or gravely disabled.~~

~~B. POLICY:~~

~~1. When a patient displays behavior that indicates s/he is a danger to himself/herself or others, gravely disabled as a result of a mental disorder he/she may be placed on a 5150.~~

~~C. PROCEDURE~~

~~1. Who may perform/responsible: Outpatient Behavioral Health Services (OPBHS) clinical staff.~~
~~2. When a patient presents as a danger to self, danger to others or gravely disabled, the staff must follow OBHS policies (see Outpatient Behavioral Health: Suicide Assessment, Psychiatric Emergencies, and Destructive or Potentially Violent Behavior policies).~~
~~3. Staff has the legal obligation to contact authorized personnel for psychiatric evaluation of patient for involuntary detention per physician recommendation.~~
~~4. Those staff authorized to initiate a 5150 can complete the necessary paperwork with the attending physician's approval. See Patient Care Services: Hold 72 Hours, Evaluation and Treatment of the Involuntary Patient Policy.~~
~~5. Staff is to assist in patient disposition as requested by the authorized person(s). If the patient is uncooperative or the situation is particularly lethal, police assistance may be called for.~~

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

~~1. Outpatient Behavioral Health Policy: Suicide Assessment~~
~~2. Outpatient Behavioral Health Policy: Psychiatric Emergencies~~
~~3. Outpatient Behavioral Health Policy: Destructive or Potentially Violent Behavior~~
~~4. Patient Care Services Policy: Hold 72 Hours, Evaluation and Treatment of the Involuntary Patient~~

~~E. REFERENCE(S):~~

~~1. County of San Diego Health and Human Services Agency (2014). Training Packet for Involuntary Detainment Under Welfare and Institutions Code 5150.~~
~~2. Involuntary Treatment, Cal. S. 5150 – 5349.5, Chapter 2 (Cal. Stat. 1967).~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES~~UNIT~~

SUBJECT: Physician Progress Note

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 03/16

Department Approval ~~Date(s)~~:	**~~11/15~~11/19**
Division of Psychiatry Approval ~~Date(s)~~:	**~~01/16~~03/20**
~~Department of Medicine Chiefs Approval Date(s):~~	**~~02/16~~**
Pharmacy and Therapeutics Approval ~~Date(s)~~:	**n/a**
Medical Executive Committee Approval ~~Date(s)~~:	**~~02/16~~04/20**
Administration Approval:	**05/20**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~03/16~~ n/a**
Board of Directors Approval Date~~(s)~~:	**03/16**

A. **PURPOSE:**
1. To define expectations for Physician and Allied Health Professional's (AHP's) Progress Notes.

B. **POLICY:**
1. All patients are evaluated on a regular basis by the attending psychiatrist or AHP.

C. **PROCEDURES:**
1. Who May Perform / Responsible: Program psychiatrist
   a. Physicians and AHP's are expected to evaluate patients and complete a progress note at least monthly for all Outpatient Behavioral Health Service (OPBHS) patients.
   b. Physicians must see the patient periodically to oversee the care and ensure quality of services delivered in OPBHS.
   c. Physicians must review AHP's notes to ensure quality care provision.
   d. Open problems on the treatment plan should be addressed in the progress notes.
   e. The progress note is to include a mental status exam, treatment plan, and justification for continued treatment, interval history, medication changes and any changes in diagnosis.
   f. All progress notes are signed, dated and filed in the medical record.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: Psychiatric Emergencies

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	~~12/16~~**03/19**
Division of Psychiatry Approval:	~~06/17~~**03/20**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	~~07/17~~**04/20**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	~~08/17~~ **n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**
1. To define the appropriate methods of handling emergency psychiatric situations.

B. **POLICY:**
1. Psychiatric emergencies should be handled by the most qualified person(s) available. Patient and staff safety are of prime concern.

C. **PROCEDURE:**
1. Who may perform/responsible: Clinical and Nursing Staff.
2. For minor psychiatric problems (i.e., agitation, oppositional behavior and verbal abuse of others), attempts should be made to isolate the patient from others in the milieu, reduce stimulation (i.e., noise, traffic), and prevent any further escalation of the behavior. Depending on how receptive the patient is to staff intervention, he/she may ~~be permitted to~~ rejoin the group, ~~be instructed to~~ take a "time out" or be excused from the Outpatient Behavioral Health Services (OPBHS) for the remainder of the day. The Registered Nurse (RN) may contact the physician/Allied Health Professional (AHP) to evaluate the need for ~~a PRN~~ medication **adjustment.**~~.~~
3. There's a psychiatric emergency box that contains emergency medications, such as Cogentin, ~~and Haldol~~ **Benadryl, and Naloxone that can be utilized with physician order.**
4. For major psychiatric emergencies (e.g., suicide attempt or violence), the safety and welfare of the patient and the group are the primary concerns. Proceed by dialing 911, request the type(s) of assistance needed (e.g., ambulance, police), and remove all other patients from the area. In all cases, the patient's primary and attending psychiatrist (if not the same) are notified and consulted in a timely manner.
5. Physical restraint is not used as a clinical intervention. If a patient becomes violent, 911 must be called immediately.
6. For both major and minor psychiatric emergencies,~~;~~ the Clinical Coordinator, program RN, or designated clinical staff member must assess the need for inpatient hospitalization. This assessment must be made in consultation with the patient's attending psychiatrist. If the attending psychiatrist cannot be reached, the Program Medical Director should be notified and consulted. If the decision is made to ~~admit~~ **evaluate** the patient for inpatient hospitalization, the following procedures are followed:
   a. The Clinical Coordinator, RN or Therapist discusses the need for ~~inpatient hospitalization~~**Emergency Department evaluation/inpatient hospitalization** with the patient. The patient's family, residential care provider, case manager, and/or primary physician are also notified. If the patient agrees to voluntary admission, the staff makes

transportation arrangements and the patient is transported to the ~~inpatient unit~~ **Emergency Department**. Relevant information from the chart (psychiatric evaluation, assessments, treatment plan, medication list, etc.) will be sent to the ~~inpatient facility~~**Emergency Department** to ensure coordination of treatment.

~~b. If the physician recommends a direct admission to the Behavioral Health Unit (BHU), the physician or designated staff must contact the physician-on-call or the Psychiatric Liaison to make the recommendation and conduct hand-off communication~~

~~c.~~**b.** The Community Liaison Coordinator or Therapist maintains contact with ~~the inpatient treatment team during hospitalization,~~ **patient** to ensure continuity of care and a smooth transition back to the OPBHS after discharge from the inpatient unit.

~~d.~~**c.** When a patient ~~that~~ **who** is suicidal or homicidal, or gravely disabled, will not voluntarily ~~accept admission to the inpatient unit, the involuntary detention procedure may be initiated by a physician or 5150 certified clinical staff under the direction of a physician~~ **agree to go to the Emergency Department for an evaluation, the local police/Sheriff will be contacted.**

7. Psychiatric emergencies that occur after program hours will be directed to call the 911, ~~Tri-City Healthcare District (TCHD) in-patient unit~~ or a psychiatric Crisis hotline.
8. If the psychiatric emergency results in the patients independently leaving the program during normal treatment hours, the clinical staff notifies the primary and/or attending physician, patient's family, residential care provider, case manager and anyone else actively involved in the patient's care. Police should be notified, if appropriate, and in all cases when the patient may be a danger to self or others, or gravely disabled.
9. All interventions and the results of the interventions must be documented in the patient's medical record by the RN or clinician who managed the psychiatric emergency.

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

1. Behavioral Health Services Policy: Involuntary Hold Patients

E. **REFERENCE(S):**

1. Involuntary Treatment, Cal. S. 5150 – 5349.5, Chapter 2 (Cal. Stat. 1967).

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Solicitation of Patients / Referrals to Self**

ISSUE DATE: **NEW**
REVISION DATE(S):

Department Approval:	**03/19**
Division of Psychiatry Approval:	**03/20**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**04/20**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE**

1. To specify parameters with respect to the solicitation of patients or referrals to self.

B. **POLICY**

1. Who may perform/responsible: OPBHS Clinical Staff
2. Tri-City Medical Center employees ~~and contracted employees~~ will not refer patients, directly or indirectly, to their private practices.
3. Tri-City Medical Center employees ~~and contracted employees~~ will not, directly or indirectly, approach, solicit or suggest to any patient (or patient's representative) that the patient should or must see such employee on any basis outside the program(s) for additional care or therapy, with the exception of those patients who were seen in the therapist's private practice prior to the patient being admitted to the program. In such a case, referrals back to the therapist's private practice is acceptable, if deemed clinically appropriate.
4. If additional treatment is needed, as determined by the treatment team a list of at least **two to** three qualified ~~therapists~~ **therapists** will be given to the patient for the patient's selection.
5. An exception to the above is when a patient expresses an interest in ~~continuing to~~ **seeing the** program psychiatrist ~~after discharge from program~~. In that case, it would be acceptable for the patient to ~~continue to~~ be treated by the program psychiatrist in their private practice. **This would improve continuity of treatment and allow the patient more treatment options.**

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 3/08 **SUBJECT: Block Time**

REVISION DATE(S): 6/09, 11/09, 4/15, 11/15, 02/17

Department Approval:	~~10/16~~03/20
Operating Room Committee Approval:	~~10/16~~03/20
Department of Anesthesiology Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~01/17~~04/20
Administration Approval:	05/20
Professional Affairs Committee Approval:	~~02/17~~ n/a
Board of Directors Approval:	02/17

A. **PURPOSE:**

1. To outline the granting, review, use and revocation of block time. Block time scheduling will be provided in the operating room to regulate and ensure continuity of scheduling and to optimize the utilization of the operating room.

B. **DEFINITIONS:**

1. **Block Time:** Surgical time consistently reserved for a surgeon, surgeon group or specialty.
2. **Full Block:** Eight (8) hours of time.
3. **Half Block:** Four (4) hours of time.
4. **Release Time:** Specified lead time prior to the day of the block which is a cutoff date or time.
   a. If the block is not booked by this time, the time will become available for open booking.
   b. If the surgeon voluntarily releases the block prior to the specified release date, the time will not be included when the adjusted utilization is calculated.
   c. If the block is not released prior to the specified lead time, the unused time is included in the adjusted utilization.
5. **Utilization:** The amount of time used for surgical cases.
6. **Utilization calculation:** The amount of time used for surgical cases divided by the amount of time allocated to the block.
7. **Adjusted Utilization:** Utilization calculated with released time subtracted from the allocated time.
8. ~~**Unadjusted Utilization:** Utilization calculated with all released and unused time included in the allocated time.~~

C. **POLICY:**

1. Requested/Approval of Block Time:
   a. Surgeon, service or group may request time.
   b. Hospital administration may request time on behalf of a new surgeon or service.
   c. Block time will be granted based on actual/anticipated case volume.
   d. Requests will be approved by the OR Committee.
2. Release Time: Release time may vary among individual block and percentage released, depending upon utilization and type of service.
   a. For utilization of 85% or greater for a three-month period: 24 hour release (except in cases where 25% of the block time is released).
   b. For utilization of 70-84%: 72 hour release.

c. For utilization at or below 69%: 7 day release.
d. Robotic block times are released two (2) weeks in advance.
~~d.~~**e.** Released block time cannot be reclaimed once released ~~and~~ **if** other cases are scheduled **during the time**.
~~e.~~**f.** Released block time can be reclaimed if no cases are scheduled in the time.
~~f.~~**g.** If the block time is voluntarily released before the assigned release time, the released time does not count in the adjusted utilization calculation.
~~g.~~**h.** If the block time is not voluntarily released before the automatic release time, then unused time will be included in the adjusted utilization.
~~h.~~**i.** Adjustments to release times will be made quarterly (January, April, July, October) based on the prior quarter's utilization.

3. Maintenance of Block Time:
   a. Monthly block time utilization reports will be distributed to individual surgeons.
   b. Monthly block time utilization reports will be reviewed at OR Committee.
   c. Quarterly (January, April, July, and October) block utilization will be reviewed and the block time may be increased, reduced or revoked based on the prior six-month average.
   d. Block utilization must be at 60% adjusted or 50% unadjusted to retain block time.
   e. If utilization for the previous quarter falls below requirements, the surgeon/surgeon group/service will be notified of the deficiency.
   f. Periodic reviews of block time and surgeon on time arrival by the OR Committee may result in further adjustments to or reinstatement of block time.
   g. Generally, action is taken based on a rolling six-month average, NOT by per month average.

Tri-City Medical Center	Surgical Services
PROCEDURE:	**CELL SAVER SET-UP, USE AND MONITORING**
Purpose:	To outline the steps for cell saver set-up, use, and monitoring in surgery for recovery and reinfusion of the patient's own blood.
Supportive Data:	The cell saver device is an autotransfusion system for intraoperative processing of blood lost through surgery or trauma. Blood from the surgical field is anticoagulated, collected in a sterile collection reservoir, and processed in a continuous washing process to obtain washed packed red cells for reinfusion to the patient. During this process all plasmatic and non-erythrocytic cellular components of the collected blood, and thus activated coagulation factors, products of fibrinolysis, cell trauma, and anticoagulant, are removed.
Equipment:	• Haemonetics Cell Saver 5⁺ Machine • Cell Saver Collection Reservoir • Bowl and Harness Disposable Set (125mL) • Anticoagulant Suction Line • Yankauer Suction Tip • Transfer Packs with Viaflex Bags • Alcohol Swabs x3 • **0.9%** NaCl 1000mL Bag (Irrigation) • Heparin 30,000 Units • 5mL Syringe • Medication Added Label • **0.9%** NaCl 3000mL Bag (Wash) • 3mL Syringe with Needle • 18 gauge Needle • TUR Tubing Set • Fenwell Adapter

A. **INSTALLATION OF THE MACHINE DISPOSABLES:**

1. Power ON the Cell Saver 5⁺ by pressing the white ON/OFF button located on the right side of the lower cabinet. The machine will perform a self-test. Do NOT use the machine unless it passes the self-test.
2. Open reservoir, load reservoir into bracket and close step-down clamp.
3. Attach regulated vacuum source (wall suction) to yellow-capped port on reservoir. Keep suction in the ~~green~~ range **of** ~~(~~-150 to -200mmHg~~)~~.
4. Open the bowl and harness disposable set and place the bowl firmly into the centrifuge well with higher inlet port facing left.
5. Hang the waste bag on the three support pins located on the front of the machine.
   a. Ensure the drain port on the bottom of the waste bag is closed.
6. Lock support arm around bowl header.
   a. A click will be felt or heard.
   b. Ensure the bowl is level and spins freely.
7. Insert effluent tubing into line sensor.
8. Insert the tubing from the inlet port into the air detector.
9. Open the pump platen.
   a. Thread the pump tubing around the pump and place tubing manifold into its slots.
   b. Close the pump platen, manifold/valve door and latch.
10. Close the centrifuge and fluid deck covers.
11. Hang the reinfusion bag on the IV pole and close small clamps on pigtails.
    a. Ensure blue line tubing clamps are open and twist-lock connection is secure.
12. Connect the red line tubing to the bottom of the collection reservoir and open step-down clamp.
13. Hang wash solution (~~3000 ml~~**3L 0.9%** NaCl bag) on the IV pole.
14. Close both yellow line tubing clamps and spike ~~saline~~ **0.9% NaCl** bag(s).
15. Open yellow line clamp(s) on ~~saline~~ **0.9% NaCl** bag(s) to be used.
16. Once the disposable set is loaded properly, press START and the system will display CURRENT SETTINGS.

Department Review	Department of Anesthesiology	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
05/00, 04/01, 08/01, 12/05, 09/09, 08/10, 09/12, 06/15, 11/16; 02/20	n/a	12/16, 03/17, 02/20	05/17, 03/20	06/17, 04/20	05/20	07/17, n/a	07/17

a. While in CURRENT SETTINGS, the operator may press YES to restore default settings.
b. The display prompts the operator to press START to begin a procedure.

B. **COLLECTION SET-UP:**

1. Prepare the anticoagulant solution.
   a. Add 30,000 Units of Heparin into 1000mL bag of 0.9% ~~Sodium Chloride~~**NaCl**.
   b. Complete the Medication Added label and attach to the heparinized saline bag.
   c. Hang the heparinized saline bag on the IV pole located on the right of the machine.
2. Open the sterile suction line and pass it to the sterile field using aseptic technique.
3. Connect the suction tubing to the yellow port of the reservoir and to the regulated wall suction, and turn ON suction. Do NOT use Neptune as suction source for Cell Saver machine.
   a. Regulate suction to keep between -150 and -200mmHg.
   b. Vacuum levels greater than -200mmHg may cause hemolysis.
4. Receive suction line from the sterile field and attach to blue-capped port on collection reservoir.
5. Spike the heparinized ~~saline~~ **0.9% NaCl** bag.
6. Prime the collection reservoir with 200mL of heparinized ~~saline~~**0.9% NaCl**.
   a. Regulate the anticoagulant drip rate to approximately one drop per second.

C. **COLLECT FIRST OPTION:**

1. Use the collect first method if it is not clear that sufficient volume will be collected during a procedure to process for reinfusion.
2. Set up the machine for collect first:
   a. Load collection reservoir into bracket and close step-down clamp.
   b. Attach regulated vacuum source to yellow-capped port on reservoir.
   c. Receive sterile suction line(s) from the field and attach to blue-capped port(s) on reservoir.
   d. Prepare, hang and spike heparinized ~~saline~~ **0.9% NaCl** solution (as described in B.1)
   e. Prime reservoir with 200mL heparinized ~~saline~~ **0.9% NaCl** solution, then adjust drip rate of heparinized ~~saline~~ **0.9% NaCl** to 1 drop/second.
3. Load Cell Saver 5^{+} processing set if sufficient blood volume is collected.

D. **PROCESSING IN AUTOMATIC MODE:**

1. The FILL mode automatically begins when the preset reservoir level is reached.
   a. To begin processing prior to reaching this preset fluid level, press START.
   b. The Cell Saver 5^{+} automatically advances through the FILL, WASH, and EMPTY modes if enough salvaged blood and wash solution are available.
2. The machine automatically advances to the WASH mode when the RBC's reach the optics trip point, ¼ inch over the shoulder of the Latham bowl.
3. If there is an insufficient volume of blood collected for the RBC's to reach the trip point, the air detector senses air from the red line and the system enters the STANDBY mode.
   a. The machine automatically resumes the FILL mode when the "Resume At" Level has been reached.
4. In the WASH mode, the programmed minimum volume of wash solution is pumped into the bowl to dilute the supernatant contaminants with the RBC's.
5. The EMPTY mode stops the spinning of the centrifuge.
   a. The contents of the bowl are pumped through the blue line to the reinfusion bag.
6. The CONC mode is commonly used at the end of a procedure when no more blood loss is expected and there are not enough red blood cells to fill the bowl.
   a. In this mode, red cells in the reinfusion bag are pumped to the bowl.
7. The RETURN mode pumps the bowl contents to the reservoir.

E. **QUALITY CONTROL:**

1. Test Hematocrit on first bowl of processed blood prior to administration for Quality Control monitoring.

F. **EMERGENCY MODE:**

1. The EMERGENCY mode may be used when the reservoir is filling too fast due to rapid blood loss and it is necessary to process blood urgently for immediate transfusion.
2. The EMERGENCY mode will process blood solution continuously through the FILL, WASH, and EMPTY modes until no more RBC's remain in the reservoir.
   a. When the reservoir is empty, the Cell Saver 5+ will automatically return to Automatic mode.
   b. The operator may also choose to Concentrate or RETURN cells to reservoir while in the EMERGENCY mode.
3. Red cells may spill into the waste bag as a result of choosing the EMERGENCY option, due to the increased pump rate.
4. To enter EMERGENCY option:
   a. Press the MODE key twice within two seconds.
   b. Press the YES key within 5 seconds to confirm.
   c. If the YES key is not pressed within 5 seconds, or the NO key is pressed, the Cell Saver 5+ will revert back to the Automatic mode.
5. To exit EMERGENCY mode and return to Automatic mode, press the MODE key once.

G. **PARTIAL BOWL OPTION:**

1. Use partial bowl option to process a partial bowl of blood at the end of a procedure or whenever it is necessary to process blood before a full bowl has been collected.
2. To process a partial bowl:
   a. Press WASH to begin partial bowl wash.
   b. Double the programmed wash volume by pressing the YES key to automatically double the programmed wash volume for that wash cycle only.
   c. Blood processed in a partial bowl cycle may have a lower hematocrit than blood processed in a normal full bowl cycle.
3. To concentrate RBC's:
   a. If RBC's in reinfusion bag, press CONC to fill bowl.
   b. Wash with minimum wash volume.

H. **EMPTY THE BLUE LINE:**

1. At the completion of the procedure, approximately 40mL of RBC's remain in the blue line that should be emptied to the reinfusion bag.
2. Do not empty the blue line during the procedure or the bowl displacement air will be lost adversely affecting subsequent EMPTY modes.
3. To empty 40mL remaining in the blue tubing into the reinfusion bag:
   a. DONE AT END OF CASE ONLY for last bowl processed!
   b. Press START, then press EMPTY, and repeat (Press START then EMPTY) until the blue striped line is empty.
   c. Alternatively, when the EMPTY mode is complete and prior to entering STANDBY a message will flash for 10 seconds "Is Case Completed? Y/N". If the NO key is pressed or no action is taken within 10 seconds, the machine will enter STANDBY. If the YES key is pressed within 10 seconds, the following message will flash: "Empty Blue Line? Y/N". If the YES key is pressed, the machine will empty the line at 100mL/min and then enter STANDBY. If the NO key is pressed, the machine will enter STANDBY without emptying the line.

I. **EMPTY AND CHANGE THE WASTE BAG:**

1. When emptying/changing the waste bag, do not lose the displacement air from the system. If this occurs, the bowl may not empty properly.
2. Empty the waste bag by draining waste fluid into an empty container for discard or use an extra suction line to suction out the waste bag.
   a. DO NOT completely empty the waste bag. Unless the bowl is completely empty, keep fluid level in the waste bag ABOVE the drain port, to prevent loss of displaced air.
3. Change the waste bag at the end of the EMPTY mode, only when the machine is at rest to prevent the loss of displacement air.
   a. Prior to removing the full waste bag, press STOP to ensure that processing does not begin.
   b. When the new bag is installed press START to resume.

J. **DOCUMENTATION:**

1. Document the following information in the ~~Cell Saver segment of the Perioperative Nursing Record~~**patient's electronic health record (EHR)**:
   a. Cell Saver operator's name
   b. Cell Saver machine identification number
   c. Type and amount of anticoagulant used
   d. Volume collected in reservoir
   e. Volume returned to patient
   f. Wash volume
   g. Hematocrit of first processed unit (QC)
   h. Name of person reinfusing blood
   i. Comment section to document any complications and/or adverse reactions during the procedure

K. **BREAKDOWN AND CLEANING:**

1. Power the machine OFF.
2. Close all clamps on the disposable tubing.
3. Cap all open ports on the collection reservoir.
   a. Tubing stubs and caps included with the reservoir and processing kit may be used for closing open ports.
4. Remove the waste bag from support pins (may be emptied before removing).
5. Remove the bowl from the centrifuge well.
6. Remove the remaining tubing harness.
7. Remove the collection reservoir; keep tubing harness connected to reservoir outlet to avoid fluid spill.
8. Place the machine disposables in a biohazardous waste bag.
9. ~~Wipe the exterior of the machine with a cloth moistened with hospital-approved disinfectant~~**Clean machine per manufacturer's instructions for use (IFU).**
   a. **To prevent damage to the machine, D**do not spray or pour disinfectant solution **directly** on machine.

~~a.~~10. **Prepare machine for next use by replacing all disposables.**

~~L. MACHINE PREPARATION:~~

~~1. Prepare machine for next case or emergency use:~~
   ~~a. Ensure machine is clean.~~
   ~~b. Replace all disposables.~~
   ~~c. Restock supplies on bottom shelf of machine.~~

~~M.~~L. **REFERENCE(S):**

1. Haemonetics Cell Saver 5^{+} System Operator's Manual

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY
~~PERI-ANESTHESIA NURSING SERVICES~~

ISSUE DATE: 04/94 **SUBJECT: CPR IN ~~Surgery~~surgical Services**

REVISION DATE(S): 02/05; 07/09; ~~11/12~~; 01/13

Department Approval:	**02/20**
Operating Room Committee Approval:	**03/20**
Department of Anesthesiology Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**04/20**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/13**

A. **DEFINITION(S):**

1. Surgical ~~Suite~~**Services**: **Includes** Pre-~~e~~Operative Hold **(POH)**~~area~~, **Progressive Care Unit (PCU) POH,** ~~Operating Suits~~**Surgery, Endoscopy, and** Post Anesthesia Care Unit (PACU).

B. **POLICY:**

1. Code Blue resuscitation efforts will be implemented on any patient suffering cardiac and/or respiratory arrest in the surgical suite, **as appropriate to patient's code status.**
2. A ~~"Code/~~Crash Cart~~"~~ ~~will be maintained and ready for use at all times~~**is available for use at all times in Surgery, POH, PCU-POH, and PACU. Crash Carts in Surgical Services are maintained per Patient Care Services (PCS) Policy: Emergency Carts.**
3. Emergency cardiopulmonary resuscitation
   a. ~~Operating Rooms~~**Surgery:**
      ~~i. Will be handled internally when possible.~~
      ~~ii.~~i. The anesthesiologist will indicate when a patient is in a state of cardiac and/or respiratory arrest and will direct resuscitative efforts.
      ~~iii.~~ii. The surgeon, assistant or other personnel trained in BLS will initiate chest compressions per the anesthesiologist's direction.
      ~~iv.~~iii. The circulating nurse or designee will **call for additional help as needed (call the Supervisor/designee to recruit additional help STAT, or overhead page the need for additional help, as applicable),** ~~start the time elapsed clock and/or noth~~**enote** the time of the code **begins**, and assist the anesthesiologist as necessary.
      ~~v.~~iv. ~~Person (s)~~**Personnel** responding to the code will bring the crash cart **(including defibrillator)** ~~and defibrillator~~ to the room.
      ~~vi.~~v. The circulating nurse or another member of the nursing staff will be designated to record the events on the "Code Blue Record~~s~~" and ~~complete the electronic "Emergency Events" form in Corner Power Chart under Ad Hoc Charting~~**record details of the event in the patient's Electronic Health Record (EHR).**
      ~~vii.~~vi. ~~The s~~**Scrubbed personnel**~~technician /nurse~~ will maintain the sterile field and supplies as the situation warrants.
      ~~viii. Additional physicians/surgeons or other specialized personnel will be summoned upon the request of the anesthesiologist or surgeon.~~
      ~~ix.~~vii. Additional available ~~OR~~ staff members shall remain outside the room (but still within close proximity) to ~~run additional tasks~~**perform duties as assigned.**

~~x. Briefly document resuscitation efforts and outcomes under "Comments" area of Peri-Operative Nursing Record.~~

~~xi. Document under "Complications" section of Peri-operative Nursing Record.~~

~~xii.~~viii. A hospital-wide "Code-Blue" page may be initiated ~~after normal working hours, or~~ when necessary, **at the discretion of the anesthesiologist and circulating RN.**

b. POH:

i. Initiate a hospital-wide "Code Blue" page.

c. PCU-POH:

i. Initiate a hospital-wide "Code Blue" page.

~~b.~~d. PACU:

i. Initiate a hospital-wide "Code Blue" page.

~~i. A hospital-wide "Code-Blue" page will be initiated.~~

~~c. Pre-operative Hold area:~~

~~i. A hospital-wide "Code-Blue" page will be initiated.~~

~~d.~~e. Endoscopy (OR 12):

i. ~~A hospital-wide "Code-Blue" page will be initiated~~**Initiate a hospital-wide "Code Blue" page.**

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 10/11 **SUBJECT:** Hysteroscopy

REVISION DATE(S): ~~11/12~~01/13

Department Approval:	02/20
Operating Room Committee Approval:	03/20
Department of Anesthesiology Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	04/20
Administration Approval:	05/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/13

A. **PURPOSE:**

1. To outline fluid selection, fluid management parameters, and patient safety considerations in hysteroscopic procedures. ~~Hysteroscopic procedures are used to diagnose and treat a variety of intra-uterine abnormalities (i.e. menorrhagia, uterine polyps and fibroids). Both diagnostic and operative hysteroscopic procedures involve the use of distention fluid to adequately visualize the uterine cavity. The patient must be monitored for the dangers of fluid overload, resulting from irrigation fluids passing through the uterus and into the patient's tissue or blood system. This can occur in the case of overpressure, a lengthy operation, or perforation of the uterine cavity. Disruption of electrolyte balance may result. Hysteroscopy is contraindicated in patients who are pregnant, have known genital tract infections or known uterine cancer~~.

B. **DEFINITION(S):**

1. -Diagnostic hysteroscopy: Endoscopic visualization of the uterine cavity and tubal orifices to aid in the diagnosis of intra-uterine disease.
2. Operative hysteroscopy: Endoscopic visualization of the uterine cavity and tubal orifices and treatment of intrauterine disease.
3. -Fluid deficit: The amount of fluid retained through extravasation during a hysteroscopic procedure. The fluid deficit is the amount of distending fluid infused during the procedure minus the amount of fluid recovered either by manual measurement or by measurement by the hysteroscopy fluid management system.

C. **POLICY:**

1. **Antibiotic prophylaxis is not recommended for routine hysteroscopic procedures.**
2. ~~The hysteroscopy fluid pump with balancing~~ **A fluid management** system shall ~~only~~ be used for **all** hysteroscopies.~~, for the purpose of introducing fluid into the uterine cavity.~~
3. Fluid selection:
   a. ~~Non-electrolyte solution (i.e. Sorbitol) will be used for uterine distention during hysteroscopic procedures when monopolar instrumentation will be used.~~
      i. ~~Sorbitol can cause hyponatremia.~~
      ii. ~~At fluid deficit of 500mL, consider completing procedure.~~
      iii. ~~At fluid deficit of 1000mL, conclude the procedure immediately.~~
   b. ~~Normal Saline~~**0.9% Sodium Chloride** ~~will be used for uterine distention when bipolar instrumentation will be used~~**is the fluid media of choice for diagnostic hysteroscopy and in operative cases where mechanical, laser, or bipolar energy is used. Monopolar electrosurgery is contraindicated with 0.9% Sodium Chloride.**

~~i. Normal saline poses less risk of hyponatremia, but excessive deficit can cause pulmonary edema.~~

~~ii.~~i. At fluid deficit of 1500mL, consider completing the procedure.

~~iii.~~ii. At fluid deficit of 2500mL, conclude the procedure immediately.

~~3.~~4. Patients undergoing hysteroscopy procedure will be monitored for fluid deficit to prevent fluid overload.

a. **Monitor the amount of fluid dispensed and collected during the procedure.**

~~a.~~b. The ~~hysteroscopy p~~**fluid management** pump displays fluid inflow volume (the total volume that goes into the patient) and the fluid deficit (the volume that is missing from the scale).

~~b.~~c. The hysteroscopy pump automatically tracks fluid deficit throughout the case, measuring and updating the fluid deficit display every 30 seconds.

~~c.~~d. The "Deficit alert icon" on the pump alarms when the fluid deficit increases dramatically in a short time (greater than or equal to 300mL/minute).

~~d.~~e. The hysteroscopy pump is programmed with a deficit threshold of 500mL. When this fluid deficit is reached, the pump will sound an alarm and the deficit value will blink continuously.

~~e.~~f. After each additional 100mL over the selected threshold, three warning tones will sound and the deficit display will blink.

~~f.~~g. The circulating nurse shall monitor the fluid inflow volume and fluid deficit throughout the case and notify the surgeon and Anesthesiologist when the fluid deficit reaches 500mL, and every 100mL thereafter.

~~4.~~5. An air embolism can result from air contained in the tube set or connected instrument reaching the patient. To prevent air embolism:

a. **Properly prime the tubing and instrument before use, per manufacturer's instructions for use (IFU).**

~~a.~~b. ~~Ensure there is always fluid in the irrigation bags; d~~Do not allow **irrigation** bags to run dry.

~~b. Properly prime the tubing and instrument before use, per manufacturer's instructions.~~

~~5.~~6. ~~To prevent a balancing error on the automated hysteroscopy pump, ensure irrigation bags, tubing, cords, containers, or other components do not come in contact with the pump unit~~**Follow manufacturer's IFU for hysteroscopy pump set-up and operation.**

~~6.~~7. Monitor the patient **for physiologic changes, including core temperature, laboratory test results (e.g., electrolytes, coagulation studies) and potential fluid retention in the abdomen, face, and neck.**~~post-operatively for signs and symptoms of hyponatremia, including bradycardia, hypertension followed by hypotension, nausea, vomiting, headache, visual disturbances, agitation, confusion, and lethargy.~~

D. **DOCUMENTATIONS:**

1. Document the following in the Perioperative Record:

a. Type of irrigation fluid used

~~a.~~b. **Fluid deficit (in mL).**

E. **REFERENCE(S):**

1. **The Use of Hysteroscopy for the Diagnosis and Treatment of Intrauterine Pathology. ACOG Committee Opinion No. 800. American College of Obstetricians and Gynecologists. Obstet Gynecol 2020;135:e138-48.**

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

~~1. American College of Obstetricians and Gynecologists (ACOG) Technology Assessment in Obstetrics and Gynecology, Compendium of Selected Publications, Number 4. August, 2005.~~

~~2. AORN Perioperative Standards and Recommended Practices, 2011 Edition.~~

~~3. Rothrock, Jane. (2007) Alexander's Care of the Patient in Surgery, 13th Edition, Mosby, Co.~~

~~Richard Wolf Hystero Pump II Fluid Monitoring Manufacturer's Instruction Manual.~~

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 04/94 **SUBJECT: Intraoperative Deaths**

REVISION DATE(S): 02/05; 06/09; ~~11/12~~01/13

Department Approval:	**02/20**
Operating Room Committee Approval:	**03/20**
Department of Anesthesiology Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**04/20**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/13**

A. **PURPOSE:**
1. To outline nursing and physician responsibilities in the event of an intraoperative death.

B. **POLICY:**
1. NURSING RESPONSIBILITIES
   a. Notify **a member of the Surgical Services leadership team (i.e., Director, Assistant Director, or Supervisor) and** Nursing Administration **(i.e., Administrative Supervisor)** of ~~intraoperative~~ **patient** death~~s~~ **in the Operating Room (OR).**
   b. Document the death ~~as a surgical complication in the Intraoperative~~**in the patient's Electronic Health Record (EHR), including details of events preceding the death** ~~record with any associated comments~~.
   c. Obtain a post-mortem kit ~~from the case cart room supply Pyxis or from Sterile Processing Department (SPD);~~**and** ~~follow~~ **manufacturer's** instructions for **use (IFU).**~~proper usage.~~
   d. **Complete a Quality Review Report (QRR) via the RL system**~~Fill out an incident report~~.
   e. Notify the Coroner of all deaths occurring in the OR.
   f. If the Coroner accepts the case, leave all invasive devices ~~or~~**and** lines intact, including, **but not limited to,** intravenous/vascular catheters, bladder catheters, drains, and endotracheal tube.
   g. If necessary and under the approved direction of the Coroner, the body may be moved to an ~~more~~ appropriate location for holding or viewing.~~(i.e. another Operating Room or PACU).~~
   h. If the Coroner declines the case, the Surgeon determines the disposition of the body (i.e. autopsy, mortuary). Contact a Perioperative Aide ~~or Transporter~~ to ~~trasnsport~~**transport** the body to the morgue.
   i. The Coroner or Mortuary must sign for body's release, when occurring directly from the OR.
   j. Complete the ~~"~~Expiration Record~~"~~ in **the patient's EHR**~~Cerner Power Chart, located under Ad Hoc Charting. This form also contains separate forms for "Organ Donation" and "Release of Body and Belongings". (See attached screenshots for examples of forms.)~~
   ~~k. When completing the "Release of Body Belongings" form, click in the bubble under "Print Release of Deceased Report", and it will print upon completion and saving of the form. This form can also be accessed from Cerner Power Chart, under the Task menu, select Reports, and select the appropriate report for printing. (Example report attached to policy).~~
   k. After the Surgeon and Anesthesiologist have completed their documentation, send the **paper** chart to ~~Medical Records~~**the Administrative Supervisor.**

l. **Refer to Patient Care Services ~~Patient Expiration~~Release of Deceased Policy for additional details on patient expiration.**

2. ~~MEDICAL~~**PHYSICIAN** RESPONSIBILITIES
   a. ~~Attending p~~**The p**hysician pronounces the ~~deceased~~**death**.
   b. Physician may need to inform the Coroner of circumstances surrounding the death; if the Coroner ~~refuses~~**declines/releases** the case, the physician determines the disposition of the body (i.e. autopsy, mortuary).
   c. Physician informs the family/significant other(s) of patient's outcome.
   ~~c.~~**d. The physician shall communicate the patient's expiration to the admitting physician or other providers as appropriate.**

~~3. DEPARTMENT OF NURSING DEATH POLICIES~~
   ~~a. Refer to the Patient Care Services Manual for details on morgue transports, funeral home arrangements, autopsy, and Coroner's cases.~~

Tri-City Medical Center	Surgical Services	**DELETE**
PROCEDURE:	**ORGAN TISSUE PROCUREMENT**	**Add content to PCS Organ Donation, Including Tissue and Eyes**
Purpose:	To outline the steps for organ procurement	
Supportive Data:		
Equipment:		

A. **POLICY:**

1. LEGAL CONSENT/AUTHORIZATION FOR ORGAN DONOR/HARVESTING
   a. The Life Sharing Coordinator obtains legal consent and authorization for donation of organs/tissue.
   b. After the consent is obtained, the Life Sharing Coordinator will schedule the donation procedure with the OR Charge Nurse
   c. Life Sharing will coordinate between the OR and the harvest team as to what is being harvested by whom and the time of the harvest.
   d. The communication with the harvest team is the responsibility of the Life Sharing Coordinator.
2. COMMUNICATION WITH ORGAN PROCUREMENT ORGANIZATION
   a. The circulating nurse will review the chart with the Life Sharing Coordinator to ascertain that the following is on the chart:
      i. Consent form for donation
      ii. Legal requirement in California is two (2) physician notes on the chart indicating Brain Death. Life Sharing prefers that at least one note be from a neurologist or neurosurgeon.
      iii. Notification of the Medical Examiner/Coroner on Medical Examiner cases. Note: The following deaths would fall under the jurisdiction of the Medical Examiner:
         1) When operative or perioperative death is not readily explainable on the basis of current or prior disease
         2) In the event of any surgical misadventure
         3) Any death due directly or indirectly to an accident, trauma, or poisoning
         4) Deaths of violent nature whether homicide, suicide, or accident
         5) Deaths under suspicious circumstances
         6) Sudden death not caused by recognizable diseases
         7) All DOA's not under a physician's care
3. ASSESSMENT
   a. Review chart for:
      i. Two physicians' notations pronouncing the patient brain dead and the date and time at which they pronounced the patient brain dead.
      ii. Consent for organ and tissue donation which may be signed by spouse, and adult son or daughter, either parent or legal guardian.
      iii. History and physical
      iv. EKG
      v. X-ray reports
      vi. Laboratory results
      vii. Drug Allergies
      viii. Durable Power of Attorney, if any
   b. Assess for impaired skin and tissue integrity.
   c. Assess all IVs, IV medication, invasive lines, catheters and tubes as to location patency and fluid amounts.
4. SURGICAL INTERVENTION

   NOTE: A transplant coordinator from the Organ and Tissue Acquisition Center will be on site to handle all the logistics of the procurement.

Department Revised	Operating Room Committee	Department of Anesthesiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
02/05; 06/09; 11/12	03/20	n/a	n/a	04/20			01/13

a. Transport patient to the operating room with all lines, tubes, and catheters secure and intact after transplant teams arrive.
b. Position patient on the operating table.
c. Apply safety strap across thighs.
d. Place EKG leads on patient.
e. Place blood pressure cuff on arm and check for proper function.
f. Place pulse oximeter to finger and check for proper function.
g. Apply two grounding pads – one on each buttock.
h. Prep patient with appropriate prep solution from chin to groin.
i. Provide 15 liters of iced saline available in the room at the start of surgery.
j. Provide a separate back table with instrumentation for each organ to be acquired.
k. Provide a sterile table with towels on which organs can be examined and flushed once they are removed from the patient.
l. Provide a shroud for handling the body at the end of the case.

5. NURSING RESPONSIBILITIES
   a. Follow procedure for organ harvesting

B. **DOCUMENTATION**

1. Document in patient's electronic record
   a. The recorded time for completion of surgery will be when the organ donation is completed (Incision Closed) and OR surgical staff is no longer required.
   b. The circulator will document procedure as appropriate on the Intraoperative Record, including preoperative diagnosis: "Brain Death" or "Cardiac Death"; Postoperative diagnosis: "Brain Death" or "Cardiac Death" and Procedure: "Organ and Tissue Acquisition." In addition, the circulator will also document supplies needing to be charged and/or replenished.
   c. The circulating nurse will also complete the electronic Power Form listed under Ad Hoc Forms: "Expiration Record." Although there are three (3) screens to complete, the record will print out only a single (1) page with all required information.
   d. The circulating nurse will complete all operative records as with any other surgical procedure:
      i. Pre-op diagnosis: Brain Death or Cardiac Death
      ii. Operation: Cadaver organ recovery
      iii. Post-op diagnosis: Brain Death or Cardiac Death
      iv. All personnel involved
      v. Surgical times
      vi. Assessment sheet
      vii. Supply charges

C. **POST-OPERATIVE CARE:**

1. Clean the donor of all secretions, fluids, and prep solutions.
2. Coroner will determine if all lines are to be removed.
3. Place body in shroud and transfer to the morgue.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 06/00 **SUBJECT:** Perioperative Documentation

REVISION DATE(S): 02/02; 02/06; 11/12; 08/15

Department Approval:	03/20
Operating Room Committee Approval:	03/20
Department of Anesthesiology Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	04/20
Administration Approval:	05/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/15

A. **PURPOSE:**

~~1. To describe the nursing responsibilities in the Operating Room in completing the intraoperative record accurately and completely.~~

~~2.~~1. To establish guidelines for intraoperative nursing documentation. ~~It is the responsibility of the circulating registered nurse (RN) to initiate and complete the charting before the patient leaves the OR suite.~~

B. **POLICY:**

1. As part of the patient's legal health record, the perioperative patient healthcare record should reflect the plan of care, including patient assessment findings, nursing interventions performed, and patient outcomes.
2. The electronic health record (EHR) should reflect continuous reassessment and evaluation of the perioperative nursing care and the patient's response to implemented nursing interventions.
3. The components of clinical documentation shall include, but not be limited to the following elements, as applicable to each case:
   a. Assessments
   b. Clinical problems
   c. Communications with other health care professionals regarding the patient
   d. Communication with and education of the patient, patient's family members, and the patient's designated support person (as applicable)
   e. Medication records
   f. Order acknowledgement, implementation and management
   g. Patient care interventions
   h. Patient clinical parameters
   i. Patient responses and outcomes, including changes in the patient's status
   j. Plans of care that reflect the social and cultural framework of the patient
4. Perioperative nursing documentation should correspond with established guidelines and practices for perioperative nursing care, health care accreditation organization requirements, Tri-City Medical policies and procedures, and local, state, and federal regulatory requirements.
5. The names, roles, and credentials of all individuals participating in the patient's care, as well as observers in the procedure, must be recorded in the patient health care record.

6. **Applicable segments of the perioperative record shall be completed in the EHR for each procedure, including, but not limited to:**
   a. **Pre-Operative Checklist (including documentation of the Pre-Procedure Verification process)**
   b. **Case times**
   c. **Case attendees**
   d. **Skin assessment**
   e. **Patient positioning**
   f. **Procedural verification for all procedures performed in the case (i.e., Time Out)**
   g. **Fire risk assessment**
   h. **General case data, including location of the procedure, patient ASA score, wound classification, and pre-operative and post-operative diagnosis**
   i. **Surgical procedure(s) and anesthesia type(s)**
   j. **Skin preparation and hair removal**
   k. **Counts, including outcomes of counts and follow-up actions for incorrect counts**
   l. **Patient care devices**
   m. **Laser information and laser safety measures**
   n. **Cautery used, including settings, lot number and expiration date of return electrode, and skin assessment before and after return electrode placement**
   o. **Tourniquet, including settings and skin assessment before and after tourniquet use**
   p. **Catheters, drains and tubes**
   q. **Medications administered on the sterile field**
   r. **Irrigation fluids**
   s. **Cell Saver (i.e., blood salvage system) information, including machine identification number, anticoagulant used, volume collected in the reservoir and volume returned to the patient, wash volume, hematocrit (QC) of the first processed bowl, and name of personnel reinfusing blood**
   t. **All surgical specimens and cultures sent**
   u. **Implants and prosthetics, including all identifiers as applicable**
   v. **Dressings**
   w. **OR departure information**
   x. **Charges for supplies used during the procedure (i.e., Pick List)**
7. Tissue implants shall be documented in the Carefusion Tissue and Implant Module (TIM) system, using the Carefusion TIM application icon located on each computer desktop in Surgery. Refer to Carefusion Pyxis Tissue and Implant Module User Guide for complete guidelines.

C. **REFERENCES:**

~~B.~~1. **AORN, Inc. (2020). *Guidelines for Perioperative Practice*. Denver.**

1. Click on the SNSurgiNet icon (unless the application is already open, in which case, click on icon at bottom of screen). The SurgiNet Documentation Manager screen will appear.

The first time you use SNSurgiNet, you will be prompted to select a Surgical Area. Each subsequent time you enter the application; the most recent Surgical Area used will default in. (Note: If you need to change surgical areas, click on the location tab at the top of the screen.) A "Case Selection" window then appears and shows all of the procedures that are scheduled for that day. To view other dates, refer below.

Changing the date:

To change the date one day at a time, click the small double button to the immediate right of the date field. The top button is to move forward and the bottom button moves back in time.

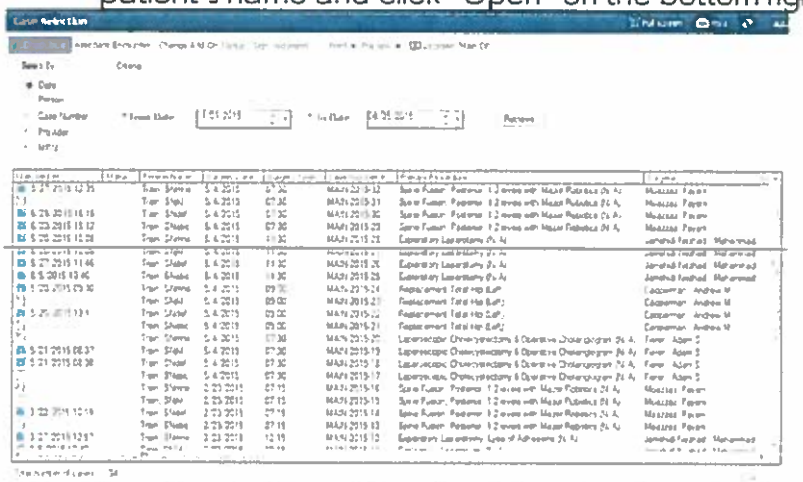
b. To change to a distant date, click the upside down triangle to view the calendar. From there, click the correct date or use the "<" or ">" change the months. NOTE: The upper "<" and ">" change the year and the lower change the month. Make sure that you have the correct year.

c. Now click RETRIEVE and a list of patients will appear.

i. The patients are listed in alphabetical order.

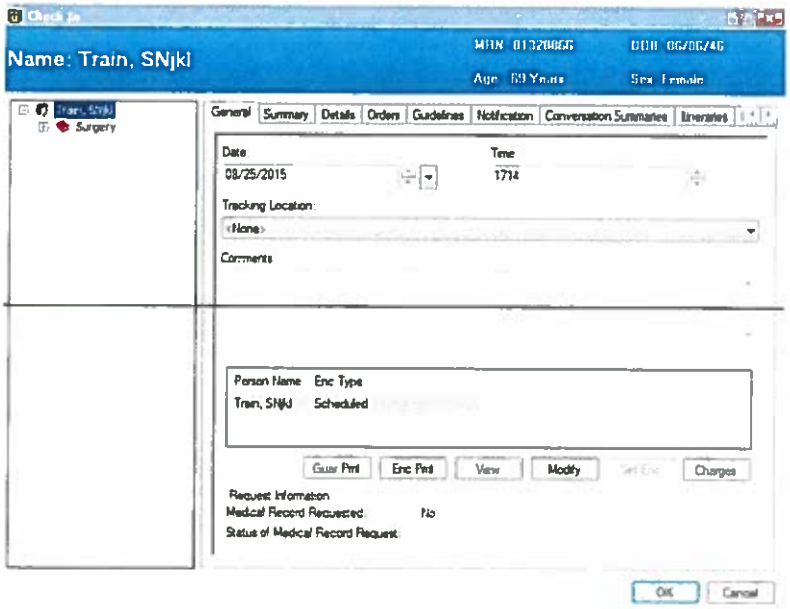
ii. You can change the sorting of the case list by clicking on the appropriate column heading. Multiple clicks will change whether the sort is in ascending or descending order.

iii. When you locate the correct patient, either double click or highlight the patient's name and click "Open" on the bottom right of the screen.



4. If the patient has already been "Checked In" to SurgiNet, the Documentation screen will display. If the patient has not been "Checked In" (which is the process of associating a patient with a financial number), the next screen that appears will vary, depending on which scheduling application was used. The primary method is through Scheduling Appointment Book, rarely should Surgical Case Manager be used.

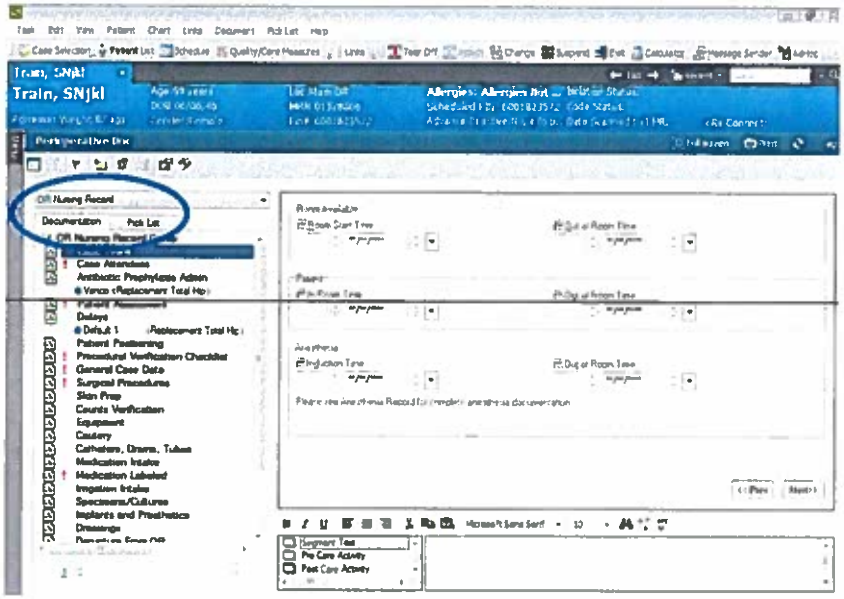
a. If the patient was booked though Sched Appt Book, a "Check In" box appears.



~~b. Make sure you are on the "General" tab.~~
~~c. Verify that you have the correct patient.~~
~~d. Click the SET ENC (set encounter) button towards the bottom right of the screen.~~
~~e. When the "Encounter Selection" box appears, click to highlight and choose the correct patient encounter. (Compare the FIN number with the one on the chart to verify that you have chosen the correct encounter. If the chart is not available, check the arrival date and encounter type.)~~
~~f. NOTE: It is very important that you choose the correct encounter at this point. If you choose the wrong encounter, the patient's bill will not be correct.~~
~~g. Click OK.~~
~~h. The "Check In" screen reappears. Click OK.~~

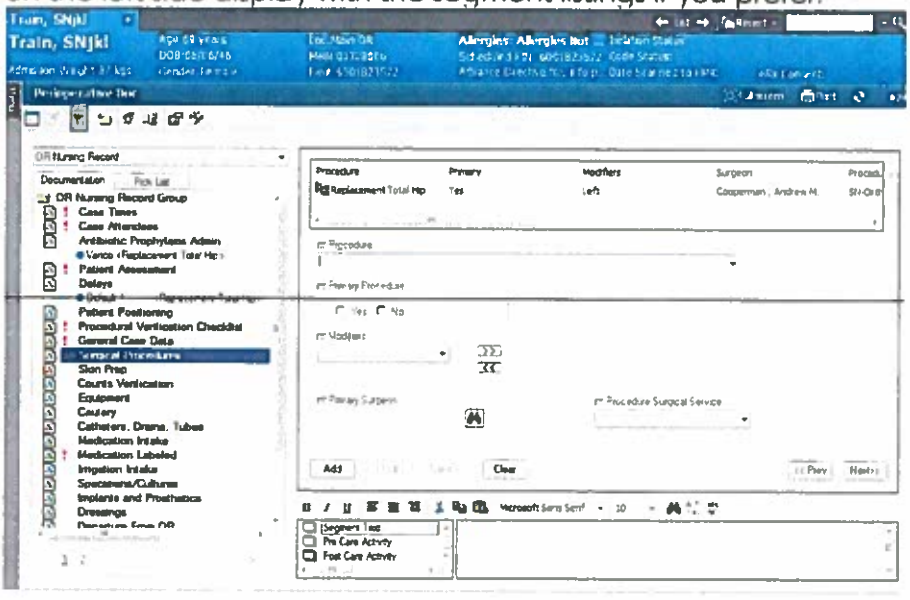
~~5. If the patient was scheduled thoguht Surg Case Mgr, an "Associate Encounter" box will appear.~~
~~a. Confirm that the admit date, encounter type, and FIN number are correct and click ACCEPT.~~
~~b. If it is not the correct patient encounter, click RE-SELECT. An "Encounter Search" window will appear.~~
~~c. Click and highlight the correct FIN number/encounter and then click OK.~~
~~d. Open case by double clicking on patient's name in Case Selection Window.~~
~~e. A documentation selection window will open giving you the choice to open the "OR Nursing Record", "PRE-OP Hold Time", or "PACU Times". Select "OR Nursing Record" and click "OK".~~
~~f. Note: Click on "Task" at the top left corner of the screen and choose "Document Type Prompt". This setting will prompt you for a document type prior to starting the case.~~

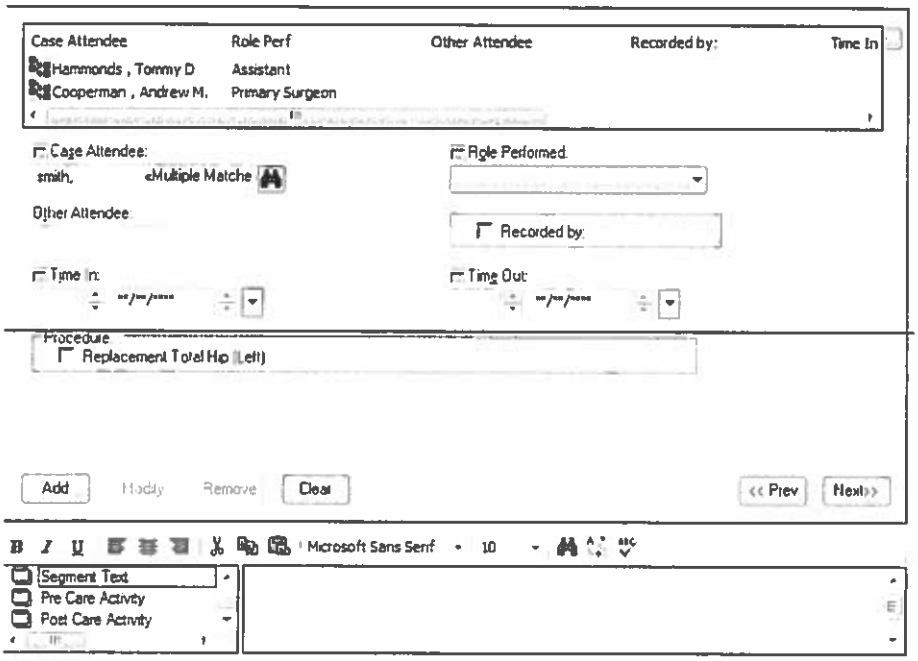
~~6. Your patient's name and basic information will display in the patient banner highlighted in yellow. Immediately under the "Perioperative Doc" tab are two additional tabs: "Documentation" and "Pick List".~~



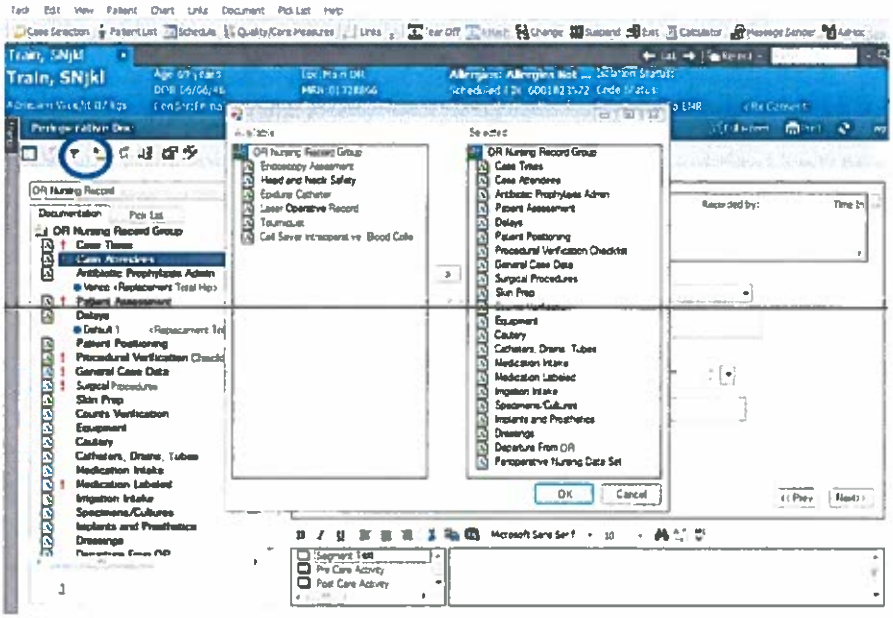
a. ~~The "Documentation" tab lists all of the segments assigned to that record. Documents can be customized for different surgeons and procedures, so you may not always see the same segments listed. Additional available segments can be viewed by clicking on the "Add Segment" icon (explained further below).~~
b. ~~Those segments that have a green checkmark in the left margin have already been opened and may be complete.~~
c. ~~The unopened segments will have a red exclamation point and the lettering will be in bold print.~~
d. ~~Under the segment list is a set of numbers that indicate the quantity of screens for the segment being viewed. The yellow colored-in number indicates which page is displayed.~~
e. ~~On the bottom right is a long blank white box. This is a segment comment field, which should only be utilized if no other comment field is present. These comment fields will print out on the record but cannot be reported upon.~~

7. ~~To move from one page to the next or to another segment, click on <<PREV or NEXT>> on the bottom right of the screen. You can also move from one segment to another by clicking on the left side display with the segment listings if you prefer.~~



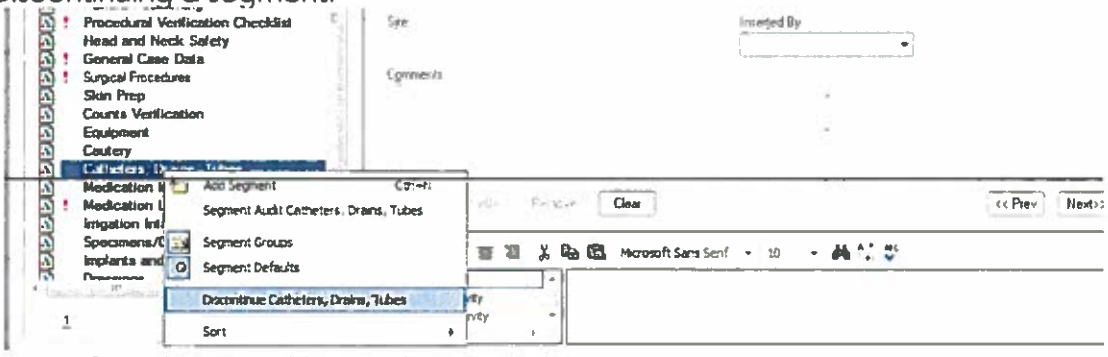


8. Each segment consists of fields. Types of fields include:
   a. Check box: click small box to select entry. A check mark will appear.
   b. Drop down box: click on small arrow to view options, then highlight and click to select correct entry.
   c. Multiple entries: click on small downward arrow as described above. When the correct option is selected, click on double right arrow to move the entry to response box. Repeat to select additional responses. To remove entry from response box, highlight and click on double left arrow.
   d. Free text: type in value using letters, numbers, or both.
   e. Numeric: type in value using only numbers.
   f. Date/Time: type in date (T=today) and time (N=now), or click on prompt to enter current date/time. Can adjust, as needed using up or down arrows.
   g. Provider field (Staff): begin typing the last name of the staff person. The computer will try to complete it for you. If there are multiple matches, click on the binoculars icon, highlight the correct choice, and click OK.
9. To move from one field to the next, click in the desired field. The TAB key will advance the cursor to the next field for you, within the current page selected.
10. Some segments contain List Boxes. A list box is used for repeating forms where you can add more than one entry into that segment (e.g., multiple procedures).
   a. Completing a List Box:
i. When all fields of a segment are filled in, click on the ADD button toward the bottom of the screen. This will transfer your entries into the list box.
   b. Modifying a List Box entry after it's been added:
      i. Click to highlight the entry in the top list box.
      ii. Change the appropriate field(s).
iii. Click MODIFY on the bottom of the segment screen and the new information will transfer up to the appropriate line in the list box.
c. Deleting a List Box entry after it's been added:
   i. Click to highlight the unwanted entry in the list box on the top of the screen.
   ii. Click REMOVE on the bottom of the segment screen.
   iii. Click YES when asked if you want to delete the current entry, and the unwanted entry.
11. Adding an additional segment:



a. Click the icon on the top center of the screen that looks like a file with a start behind it (shown above with the blue circle). An "Add Segment" window will appear (see above).
b. The list on the left contains segments that have not been used for this patient. The list on the right contains segments that have already been opened for this patient's record.
c. On the "Available" list, click and highlight/choose the appropriate segment. Then click the > button and the segment will move to the "Selected" list. Click OK.
d. Back on the SurgiNet Document Manager screen, the "Documentation" tab list on the far left side of the screen will now show the new segment in bold print. It will not have a check mark in front of it.
e. Click and highlight/choose the new segment then complete the documentation.

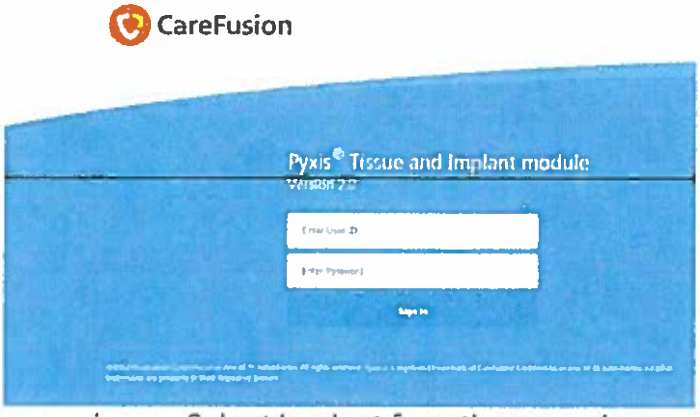
12. Discontinuing a segment:



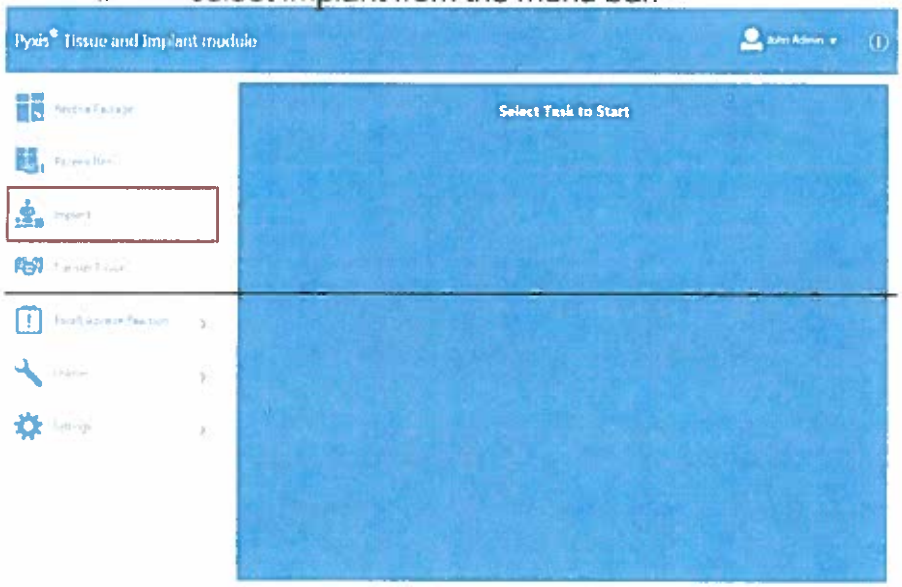
a. If you have nothing to document in a segment, discontinue it.
b. Highlight segment on the display list, right click and click "Discontinue".
c. If you are prompted to give a reason, select "Could not be performed", "None" or "See Comments", then click OK. Enter a comment in the segment comment field if necessary.
d. Some segments are required and cannot be discontinued. These must be completed for finalization of the document.
e. Note: If you need to activate a discontinued segment, highlight it, right click, and click "Activate".

13. Implant Documentation:

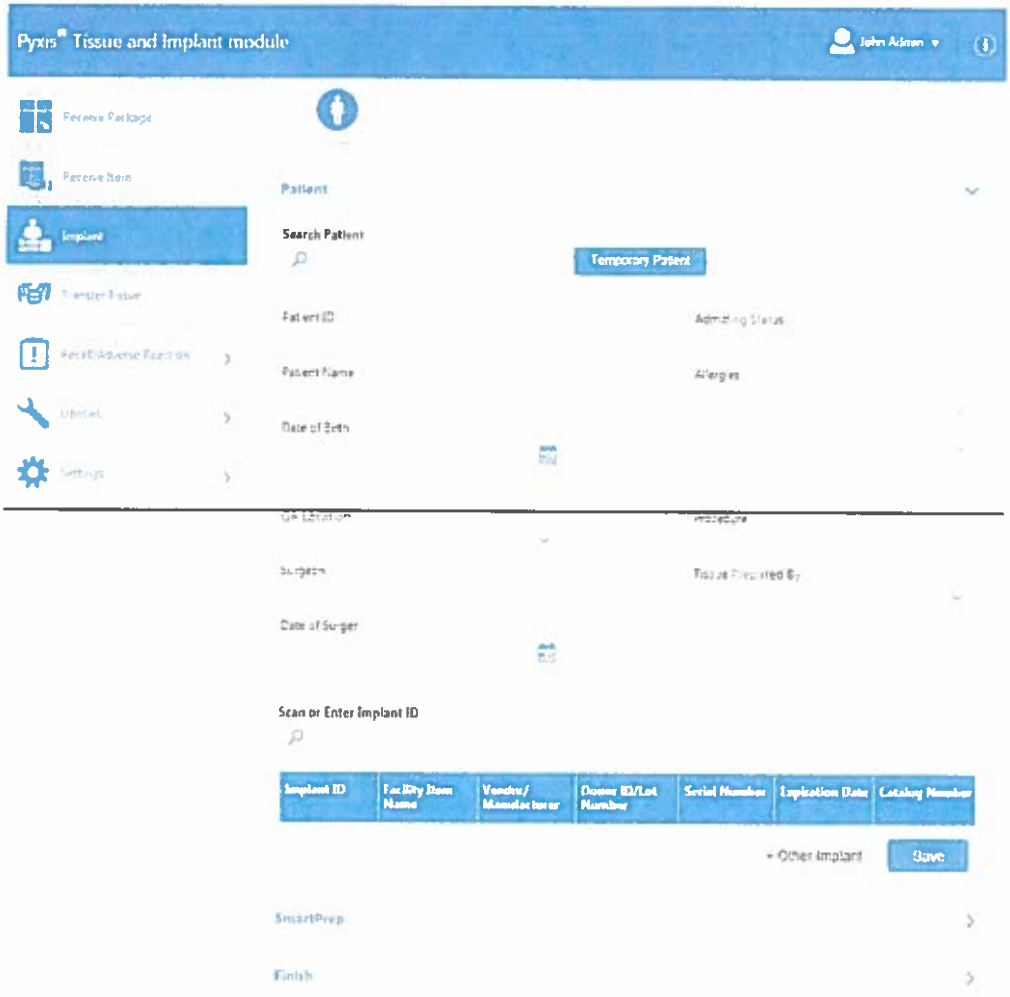
a. Tissue implants shall be documented in the Carefusion Tissue Implant Module (TIMS) system, using the Carefusion application icon located on each computer desktop in the OR. Refer to Carefusion Pyxis Tissue and Implant Module v2.0 User Guide for complete TIMS guidelines.



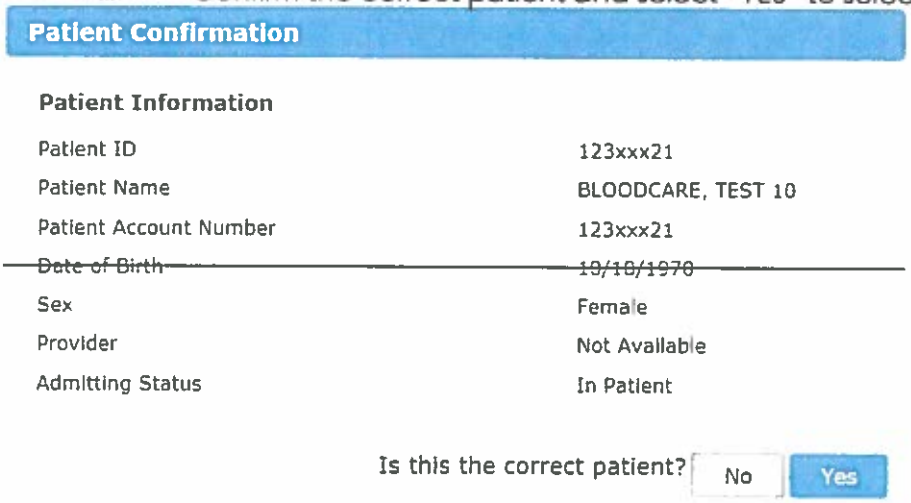
i. Select Implant from the menu bar.



ii. Search for the patient (using the patient name or FIN).

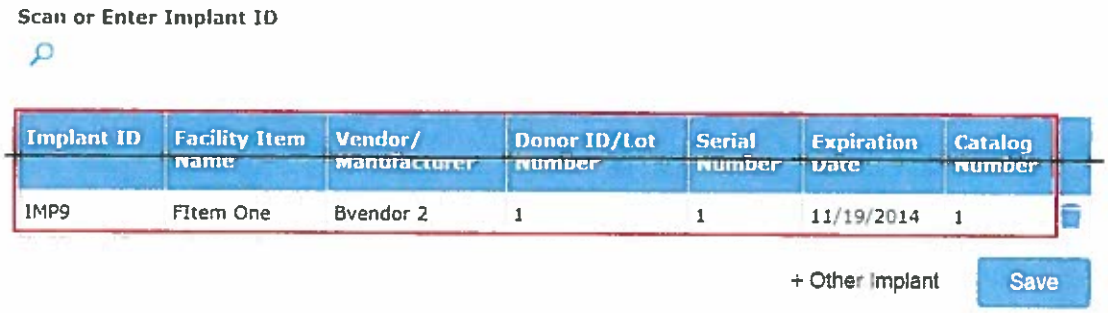


~~iii. Confirm the correct patient and select "YES" to select the patient.~~

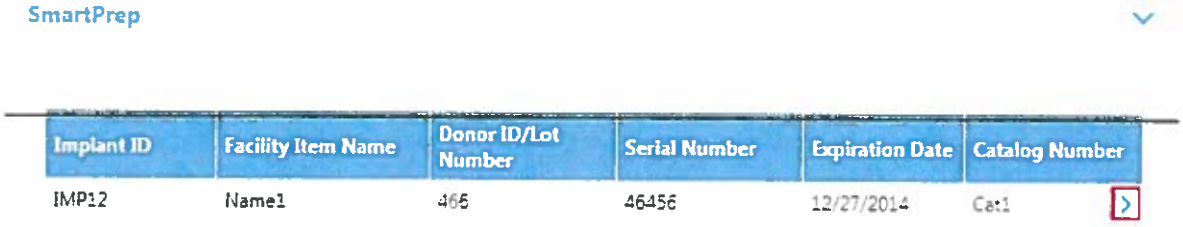


~~iv. Enter the following information into the record:~~
~~a) OR location~~
~~b) Procedure~~
~~c) Surgeon's name~~
~~d) Tissue Prepared by (scrubbed personnel's name)~~
~~e) Date of Surgery~~

v. Implants which have been removed under the patient's name from the OR tissue pyxis or the lab tissue bank should appear in the implant list. Press the trash can to delete the implants from the list. Press "SAVE" to continue with documentation and progress to the implant preparation steps.

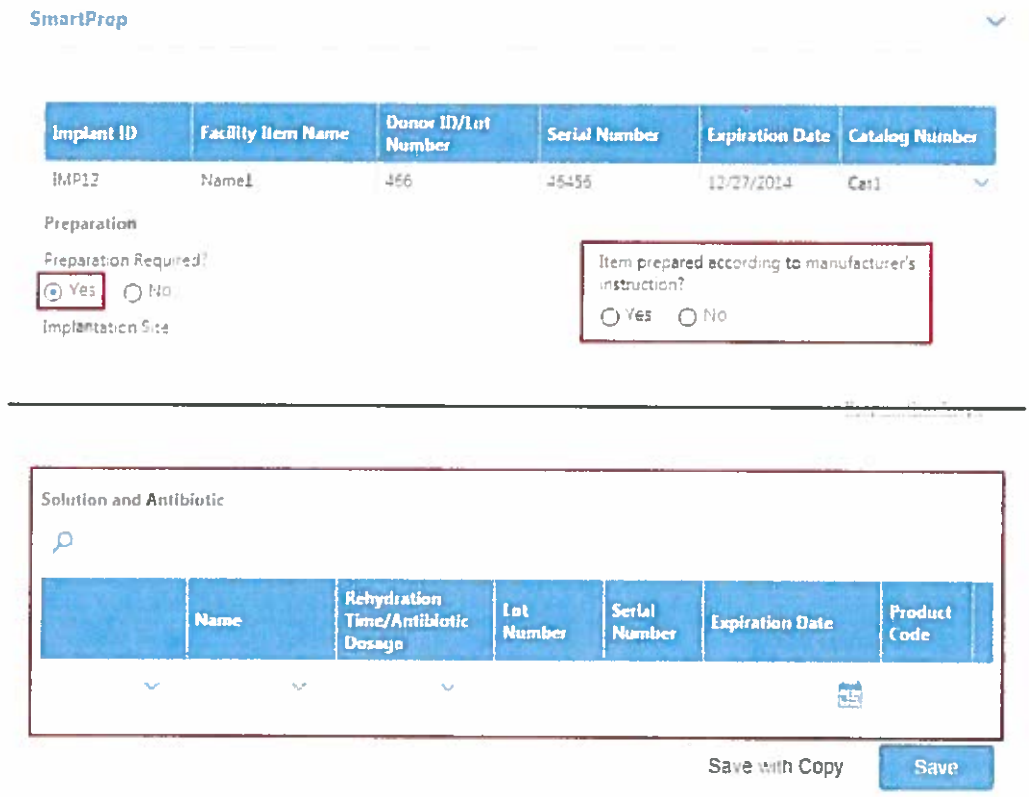


vi. Press the arrow to proceed with preparation steps documentation for each implant.

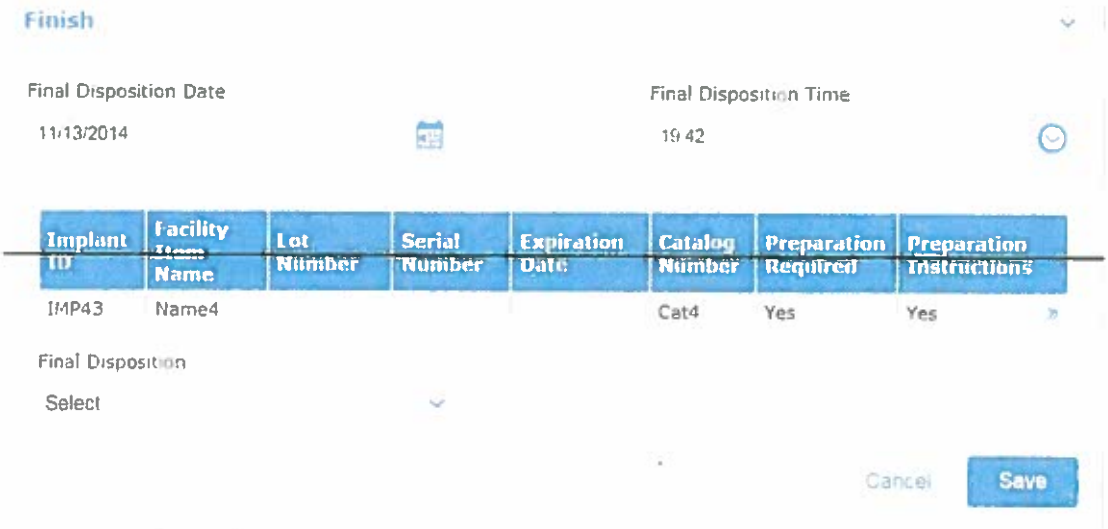


vii. If preparation is required for the implant, select "YES" for preparation required. If the implant was prepared according to manufacturer's instructions, select "YES" and document the implant site. If the implant was prepared in a method other than manufacturer's recommendations, select "NO" and enter the preparation deviation comments.

viii. Enter the solution(s)/medication(s) used to prepare the implant, including, as applicable, the name, rehydration time, antibiotic dosage, lot number, serial number and expiration date. Select SAVE when preparation information is complete. SAVE WITH COPY may be used to copy preparation information to other implant entries.



ix. ~~Document the final disposition of each implant (either Implanted or Discarded). If the implant was discarded, enter a reason. Select SAVE to finalize the entry.~~



x. ~~Email the Tissue Usage Info Card by selecting the EMAIL option and press SAVE. If a warning is received that the e-mail address is not known or is not valid, type the following e-mail address in the e-mail field: TissueImplantReceive@tcmc.com.~~

xi. A print preview of the final Tissue Usage Information Card will appear on the screen. Print the card and place a TIMS barcode label sticker and patient ID label on the printout. Place the labeled paper on the patient's paper chart.

CareFusion

Tissue Usage Information Card

Implant Id:	IMP211
Purchase Order Number:	11
Name of Facility:	
Address 1:	
Address 2:	
City State Zip:	
Facility Item Name:	FAN1
Lot Number:	1
Serial Number:	1
Manufacturer Catalog Number:	09801
Tissue Status:	Implanted
Vendor Name:	vendor1name
Vendor Mailing Address:	vendor1address City: vendor1city State: GA Zip Code: 12345
Vendor Fax Number	
Patient ID:	123xxx30
Date of Surgery:	11/12/2014
Patient Name:	TEST 11 BLOODCARE
Implant Surgeon:	12
Date of Birth:	11/11/1957
Implantation Site:	12
Procedure Type:	12
The reason if implant discarded:	N/A

Signature:

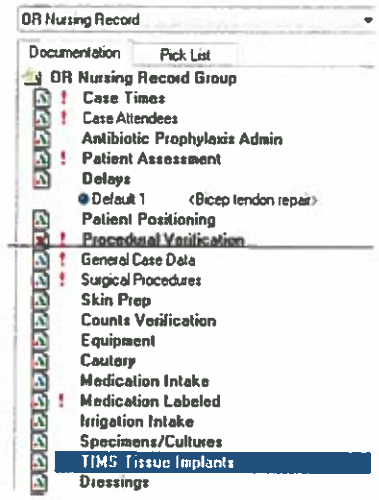
Date:

Name:

Title:

Page 1 of 1

b. Note TIMS implants in the Surginet record by activating the TIMS Tissue Implants field.



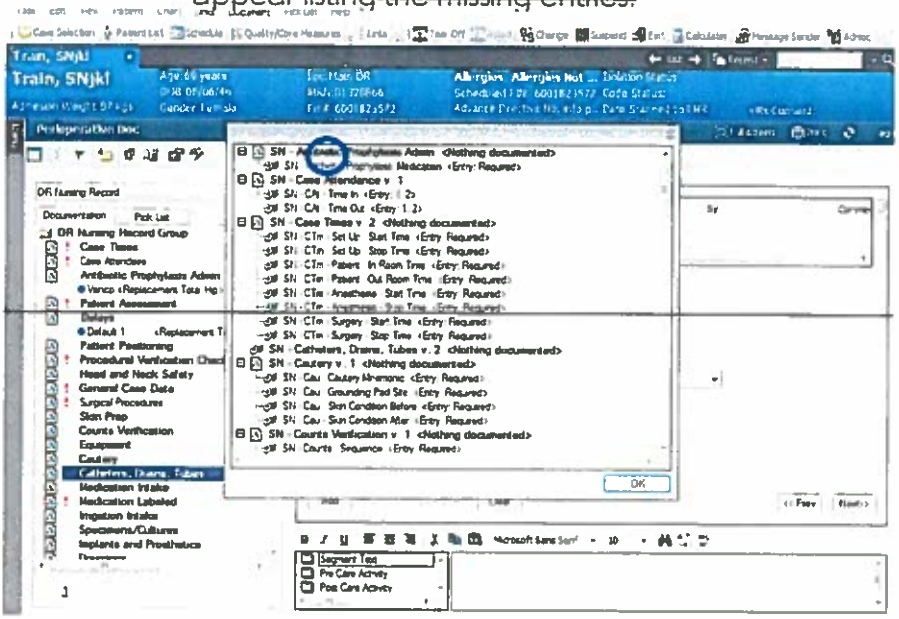
i. The Surginet documentation field consists of a single entry:

Finalizing the SurgiNet Record

a. Click the green flag icon on the toolbar at the top of the screen.

b. If all listed segments and required fields have been completed, a "Document Verified" message will appear. Click YES to finalize the document.

c. If all segments/fields have not been completed, a "Document Deficits" screen will appear listing the missing entries.



i. You can access each segment in one of two ways. Keep the Documentation Deficit window open and double click on each entry, complete the appropriate fields, and click OK, in the segment. Repeat for each segment requiring documentation. Or close the Documentation window by clicking OK and address each segment from the segment listing on the left side of the screen.

ii. Discontinue segments as needed, this can only be accomplished from the segment list the the deficit window.

iii. When all segments are completed and/or discontinued, click the green flag again to attempt finalization.

iv. The system will do another deficit check and then display a message that there are no deficits. Click OK to finalize the case. You will then be prompted to print the

document, click NO. We are not currently printing out documents to place on the record.

v. Before closing out the document you must complete the charge component.

C. CHARGES FROM PICK LIST

1. Initial View Options Setup:

a. While the OR Nursing Record is opened under your current patient, select "Pick List" tab. Right mouse click, select "Options" from the menu, the display options window will open.

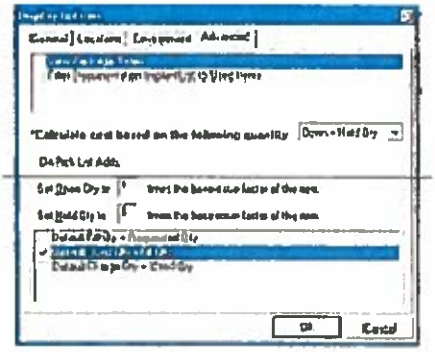
b. Under the General tab, make sure only the following boxes have check marks in them, and are arranged in this order: Item Image, Description, Duplicate Indicator, Open Qty, Hold Qty, Fill Qty, Used Qty, and Wasted Qty. To deselect an entry, click on the check mark. It will disappear. To move an entry up or down, highlight it, and then use the arrows on the right to reposition it appropriately.

c. Click on the Advanced tab. Make sure the following are set up as shown:

i. Set Open Qty to 1 times the base issue factor of the item

ii. Check the box for Default Used Qty = Fill Qty

d. Click OK



2. Anatomy of the Pick List

a. The case number appears at the top of the Pick List. Below it are the item classes, in the same order as on the pref card. Note that when the case number is highlighted, all pick list items are listed alphabetically, regardless of class. When an item class is highlighted, only the items in that class are listed. You can also click on any column heading to sort by that column.

b. Note these as the column headers listed on the picklist:

i. Open – These are the items that are pulled for the case that will be opened prior to case starting. (this is reference information)

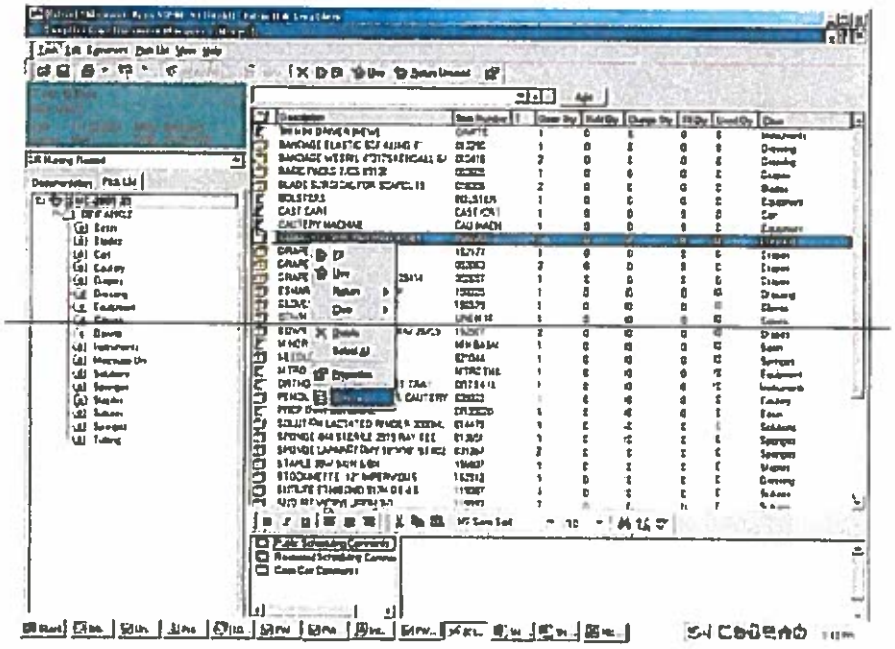
ii. Hold – These items are pulled for the case, but are not opened. (this is reference information)

iii. Fill – The fill qty is the initial sum of the Open and Hold Qty's. When using the items, the Fill Qty must be equal to the sum of the Used and Wasted Qty's. Therefore, it is required that you enter a "Fill Qty" to any additional item prior to placing a "Used

Qty". When the Used/Wasted total is greater than the fill, the system will prompt whether to add another item to the Fill Qty, answer "Yes".

iv. Used – This is the qty that was actually used. This qty will default from the Open Qty.

v. Wasted – This is the qty of any wasted item. When entering a qty, the system will prompt you for a reason.



3. Edit Pick List Items

a. You should always "Fill" and "Use" the case pick list before modifying the "Used" quantities. Follow these steps to "Fill" and "Use" the case pick list:

i. Right click on the case number (Example: MAIN 2009-7165) on the left side of the screen.

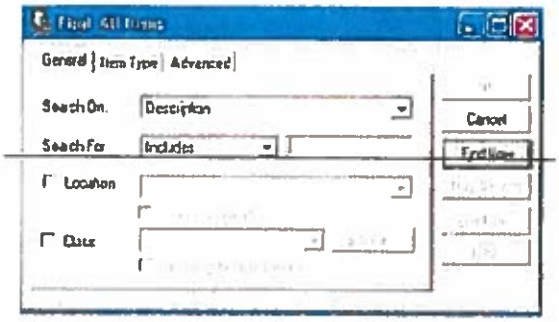
ii. Click on the "Fill" icon

iii. Right click again on the case number and choose "Use".

b. Chart by exception to modify item "Used" quantities for the case.

4. Add items not on Pick List

a. Click on Ellipses (looks like three dots) to the left of the Add button. The "Final All Items" window will appear.



i. Search On: Should be set to "Description". Search For: Should be set to "Includes", not "Begins with". Make sure there is no check in the box next to Location. This will prevent an accurate search from being completed.

ii. In the field to the right of Search For and Includes, type the name (partial or complete) of the item or catalog number, click Find Now. Too much information entered may be too restrictive, partial names of catalog numbers works best.

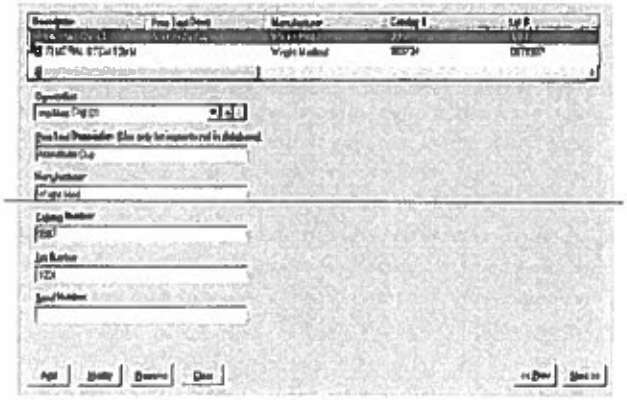
iii. If unable to locate item, click New Search, and type a different description.

iv. When the item is found, highlight item, and double click. The item will be moved to the Pick List.
v. Continue pulling in additional items.
vi. When finished, click OK.
vii. Confirm that all items have been moved to the Pick List, and edit quantities prn.
viii. If you delete an item, highlight it, right click, and click, delete.
ix. If you are unable to find all items, note the missing items on the Pref Card.

5. Add Implants

a. SurgiNet does not pull implants from the documentation into the Pick List. Unless the implant is already listed in the Pick List under Implants, complete the following steps for each implant documented. Note that the process for implants found in the database is the same as for miscellaneous implants.

b. Click on Documentation tab and go to the Implant Segment. Highlight the top row in the list box, and note that the information moves to the fields below.

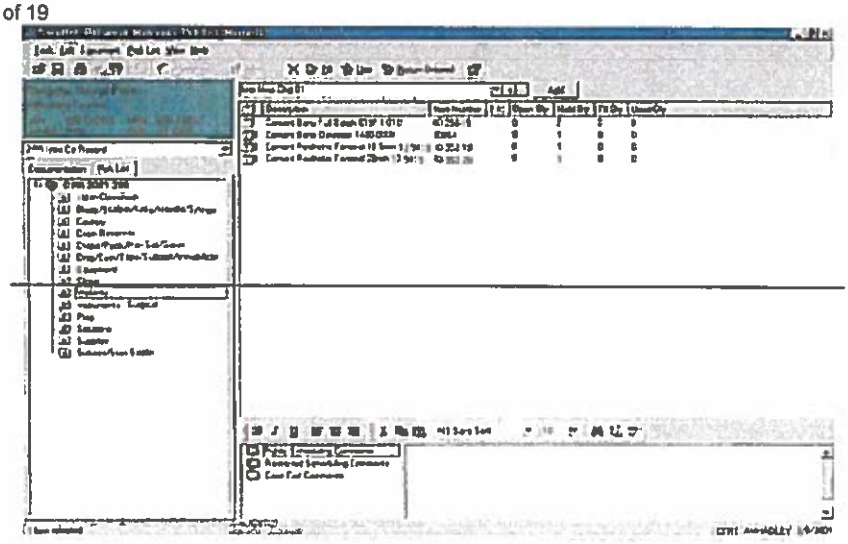


i. Click in the Description field to highlight entry.
ii. Right click, and click Copy.
iii. Click on Pick List tab.
iv. Click on Implant class.
v. Right click in blank field at top of screen, and click Paste and the click Enter.
vi. Click Add, and confirm that item appears in Pick List. Edit Used quantity prn.
vii. Repeat process for each implant.

6. SurgiNet Charges

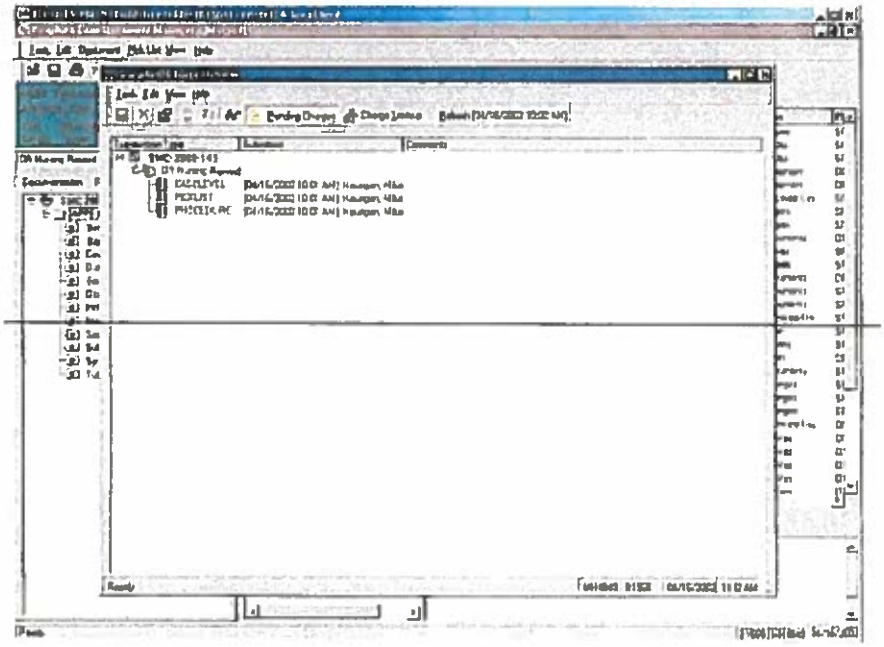
a. Room time, procedure, and anesthesia time charges are sent to a SurgiNet charging queue automatically when you finalize the document.

b. Item charges are sent to a SurgiNet charging queue automatically when you save the pick list.



7. Entering PACU Charges
   a. Select PACU Record.
   b. Click on the Documentation Tab and Enter PACU Times.
   c. Next click on the Pick List Tab
   d. Follow the same procedures as in Intra Op charges.
8. SN Charge Viewer to confirm/correct charges
   a. Go to snchargereview.exe
   b. There is an ops job that run daily to send charges to charge services.

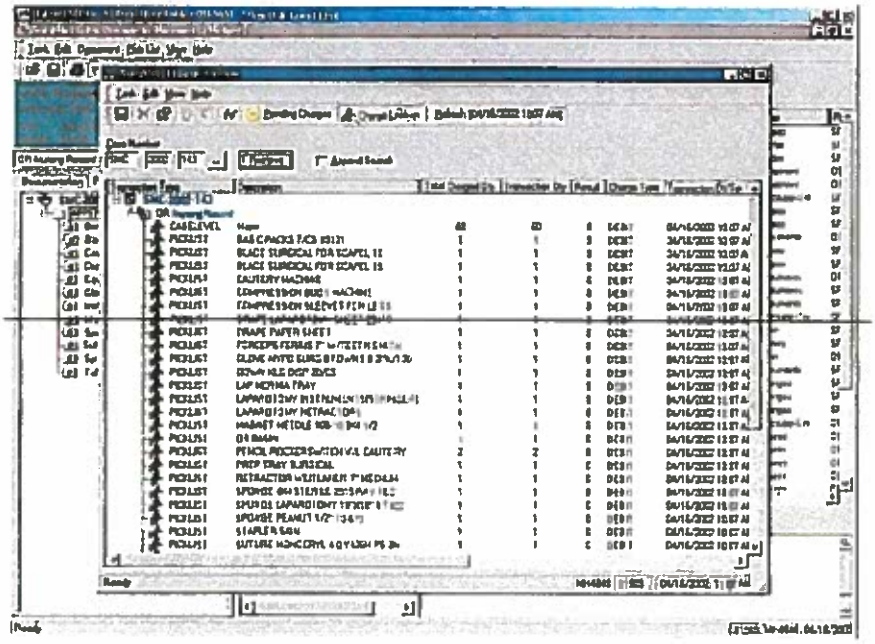
c. If you would like to manually send charges, click on Task > Run charge job. Choose the document type that you would like to send charges for and click run.



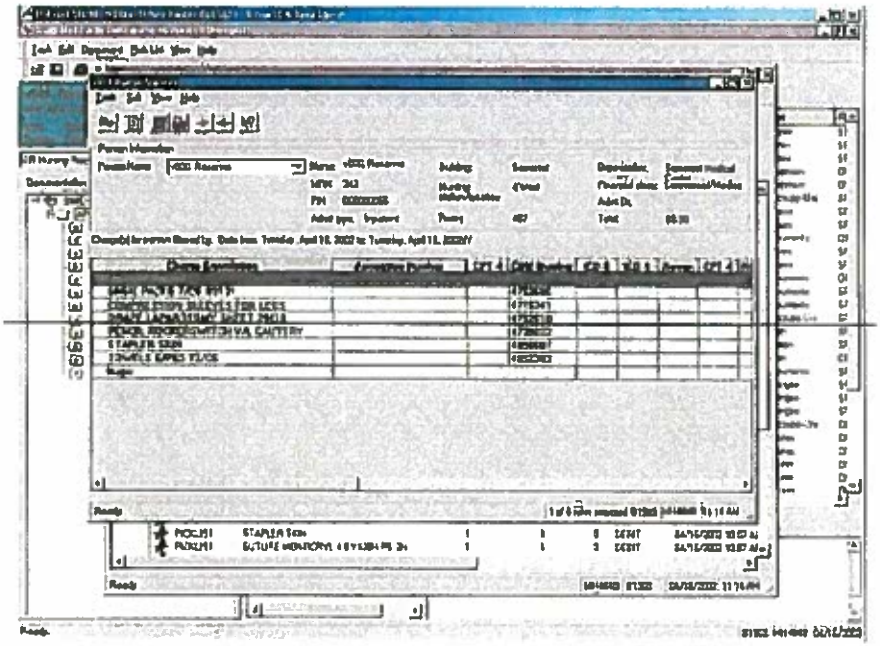
d. If you click refresh on the tool bar, the case will disappear from the pending charges screen.

e. Click on the charge lookup icon on the tool bar to see details of what was sent to charge services.

f. When the charge lookup screen displays, enter the case number of the case that you would like to see.



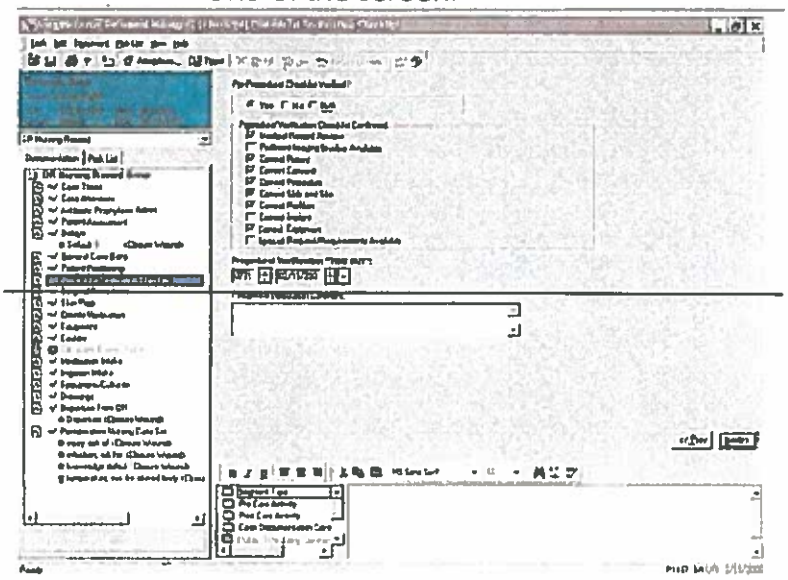
g. This is what was sent to Charge Services from SurgiNet.
h. To check what was posted in Charge Services, click on the eye-glasses icon on the tool bar. This launches CSChargeReview.exe.
i. Search for patient and add filters to view charges in CSChargeReview.exe.



9. SurgiNet Corrected/Late Entries:
a. Changes to the Operative Record are to be made as needed to maintain accuracy.
b. Go to segment of record to be corrected or updated.
c. Make indicated changes or additions to record
i. Modify existing entry or
ii. Add missed information/data
d. In General Comments Section (located at bottom of each page state "Corrected or Updated or Late or Revised Entry."
e. Beneath the words "Corrected or Updated or Late or Revised Entry" make the required change/modification/or new data entry.

f. Modify/Save (as indicated) and re-Finalize record to add new data.
g. Print out new record and sign
h. Close record
i. take updated record to Medical Records (retrieve patient chart if still in hospital)
i. add updated record to the chart
ii. DO NOT remove the existing record.
10. FINALIZING A RECORD IS FOR FINANCE CHARGES ONLY AND IS NOT AN ELECTRONIC SIGNATURE.

D. DOCUMENTING THE PROCEDURAL "TIME OUT"
1. Under the heading Pre-Procedural Checklist, check "Yes", "No" or "N/A"
2. Place a check mark in each box of the verification process.
3. Enter the actual "Time" in the space labeled "Procedural Verification "Time Out"
4. List the members of the surgical team involved in the "Time Out" process.
5. Advance to next screen by pushing "Tab", or click on the "Next" button in the lower right hand of the screen.



REFERENCE:

1. Cerner Surgi Net Self Study Module on TCMC Intranet under Education "Cerner Virtual University," 2003.
2. Cerner Surgi Net Training Manual, Hard Copy, 2003
3. Cerner Surgi Net Documentation Guide, Hard Copy, 2003

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 04/94 **SUBJECT:** Positioning the Surgical Patient

REVISION DATE(S): 01/96; 01/97; 04/97; 02/00; 03/03; 01/06; 09/07; 06/09; ~~11/12~~01/13

Department Approval:	02/20
Operating Room Committee Approval:	03/30
Department of Anesthesiology Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	04/20
Administration Approval:	05/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/13

A. **PURPOSE:**

1. To provide guidelines for positioning the patient ~~during~~ **undergoing operative or other procedures in the perioperative area.** ~~surgical intervention and to promote the safety and well-being of a patient while providing optimum exposure and access to the operative site, sustaining body alignment, circulatory and respiratory function, providing access to the patient for administration of intravenous fluids, drugs and anesthetic agents, preventing compromise to the neuromuscular and integumentary systems, and providing as much comfort to the patient as possible. Improper positioning of the patient can result in neural damage, which can be painful and result in temporary or permanent disability.~~
2. **The goals of patient positioning include:**
   - a. **Providing exposure of the surgical site**
   - b. **Maintaining the patient's comfort and privacy**
   - c. **Providing access to intravenous (IV) lines and monitoring equipment**
   - d. **Allowing for optimal ventilation by maintaining a patent airway and avoiding constriction or pressure on the chest or abdomen**
   - e. **Maintaining circulation and protecting muscles, nerves, bony prominences, joints, skin, and vital organs from injury**
   - f. **Observing and protecting fingers, toes and genitals**
   - ~~1.~~g. **Stabilizing the patient to prevent unintended shifting or movement**

B. **POLICY:**

1. **Provide care that respects the dignity and privacy of each patient during patient positioning.**
2. **Implement measures to provide privacy during patient positioning.**
   - a. **Keep windows covered (as applicable) and doors closed in patient care areas**
   - b. **Limit traffic in the procedure room**
   - c. **Expose only the areas of the patient's body necessary to provide care or access**
3. **Conduct a preoperative patient assessment to identify patients at risk for positioning injury, develop a plan of care, and implement interventions to prevent injury.**
4. **Perform a preoperative assessment of factors related to the procedure that includes:**
   - a. **Type of procedure**
   - b. **Estimated length of the procedure**
   - c. **Ability of the patient to tolerate the anticipated position**
   - d. **Amount of surgical exposure required**

e. Ability of the anesthesia professional to access the patient
f. Desired procedural position, potential change of position, and positioning devices required
g. Critical devices (e.g., catheters, drains)
h. Jewelry or body piercings
i. Braided hair, hair accessories, or hair extensions
j. Superficial implants (e.g., dermal) or implanted critical devices (e.g., pacemaker)
k. Prosthesis (e.g., prosthetic limb) or corrective devices

5. Perform a preoperative assessment of the patient's risk for pressure injury. The patient is considered high risk for pressure injury development in surgery if any of the following criteria are met:
   a. Surgical procedure duration greater than three (3) hours
   b. 70 years of age or greater
   c. Smoker
   d. Diabetes
   e. Vascular disease
   f. Vascular surgery
   g. Malnourished
   h. Morbidly obese
6. Implement protective measures to bony prominences if the patient meets one or more of the high risk criteria for pressure injury development in surgery.
   a. Offload pressure points (e.g., float heels of the bed by placing pillows beneath the legs).
   b. Place prophylactic dressings to bony prominences or other areas subjected to pressure, friction and shear (specific to each position).
7. Remove patient's jewelry, body piercings, hair accessories, or other items that may pose a risk for positioning injury before the patient is transferred to or positioned on the operating room bed.
8. Do not position the patient directly on critical or superficial implanted devices, to the extent possible.
9. Use OR beds, bed attachments, positioning equipment, positioning devices, and support surfaces according to manufacturer's instructions for use (IFU).
   a. Verify cleanliness, surface integrity, and correct function of positioning equipment, devices, and support surfaces before use.
   b. Remove soiled, damaged, or defective surfaces, devices, and equipment from service and have them cleaned, repaired, or replaced.
   c. Ensure all beds/gurneys and operative tables are locked before transferring the patient from one surface to another.
10. Ensure adequate number of personnel, devices, and equipment are available during patient positioning activities to promote patient and personnel safety.
11. At least one surgical team member should attend to the patient on the OR bed at all times.
12. Coordinate positioning of the patient with team members by verifying all team members are ready for positioning to occur and implementing a countdown to begin positioning.
13. When the patient has critical devices (i.e., catheters, drains, tubes) communicate about the presence of the critical device and take measures to secure the devices during and after positioning.
14. Position patients on surfaces that reduce the potential for pressure injury and ensure surfaces are smooth and wrinkle-free.
   a. Avoid positioning patients on multiple layers of blankets, sheets, or other materials.
   b. Avoid positioning patients on warming blankets.

~~1. The patient's position shall provide access to the surgical site as well as the patient's airway, intravenous lines and monitoring devices.~~

~~2. Pre-operative assessment for positioning needs shall include the following considerations:~~
~~a. Physical limitations~~
~~b. Height and weight~~

~~c. Nutritional status~~
~~d. Skin condition~~
~~e. Pre-existing conditions~~
~~f. Length and type of procedure~~
~~g. Physician preference~~

15. **Implement safe positioning practices, including, but not limited to:**
    a. ~~The perioperative nurse shall a~~Assess and maintain the patient's **physiologic** ~~body~~ alignment, **including head and neck in a neutral position without extreme lateral rotation,** ~~and tissue integrity~~ during all phases of the procedure.
    b. **The anesthesiologist shall protect the patient's eyes when the patient is under general anesthesia.**
    c. **Do not allow the patient's neck to be hyperextended for long periods of time.**
    d. **Prevent the patient's body from contacting metal portions of the OR bed and other hard surfaces.**
    e. **Prevent the patient's extremities from unintentionally dropping or hanging below the level of the OR bed.**
    f. **Monitor the location of the patient's hands, fingers, feet, toes, and genitals during positioning activities, including changes in configuration of the OR bed.**
    g. **Apply safety restraints and monitoring devices (e.g., blood pressure cuffs, pulse oximetry sensors) in a manner that safely secures the patient and allows the accessory device to function effectively without nerve, tissue or circulatory compromise.**
        i. **Verify placement, tightness, and security of safety restraints after positioning or repositioning activities.**
    h. **Monitor the patient's position after positioning activities and during the procedure, and take corrective actions as indicated.**
        i. **Scrubbed personnel shall not lean against the patient.**
    i. **Repositioning interventions may be implemented during the procedure as necessary.**

~~3.~~

~~a. Bony prominences shall be appropriately padded~~
~~b. Skin folds shall be protected from trapped moisture~~
~~c. During hypotensive, hypothermia and prolonged procedures, care shall be taken to prevent injury due to resulting decreases in tissue perfusion.~~
~~d. After positioning the patient, the nurse will reassess the patient's body alignment and tissue integrity. The assessment shall include, but not be limited to, the following systems:~~
~~i. Respiratory~~
~~ii. Circulatory~~
~~iii. Musculoskeletal~~
~~iv. Neurological~~
~~v. Integumentary~~
~~e. A minimum of four people is recommended to lift an unconscious adult patient as sliding or pulling the patient across the bed may cause sheering.~~
~~i. Assistive devices shall be used to transfer the patient from one surface to another, such as a roller board and draw sheet, air mat, etc.~~
~~f. Care shall be taken not to dislodge any tubes, catheters or cannulas when moving and positioning the patient.~~
~~g. Positioning shall be achieved without prolonged or unnecessary exposure of the patient, in order to maintain body temperature and preserve patient dignity.~~
~~h. Communication between the entire surgical team is necessary to prevent post-operative complications.~~
~~i. Ensure all beds/gurneys and operative tables are locked before transferring the patient from one surface to another.~~
~~j. The patient's arms shall always be secured during the procedure~~
~~i. Pad the arms when appropriate~~

ii. Arms may be secured to arm boards or tucked

k. Reassess the patient's position intraoperative, to areas that are accessible without interfering with the surgical procedure.

l.j. Assess the patient's skin immediately post-operatively and document any interventions.

4. Anesthesia and operative time shall be kept to a minimum:

a. Positioning devices shall be readily available, clean, free of sharp edges, and in good working order.

b. Personnel shall demonstrate competency in selection and use of positioning devices which shall include, but not be limited to:

i. Operative bed or specialty table/frame
ii. Stirrups/banana boots
iii. Arm supports
iv. Kidney rests
v. Headrests
vi. Orthopedic positioning devices (i.e. for shoulders, hips, knees, etc.)
vii. Neuro/Spine positioning devices (i.e. Mayfield headrest, Andrews frame, Jackson table, Wilson frame, etc.)
viii. Padding and securing devices

C. **PROCEDURE:**

1. For specific instructions on positioning the surgical patient and use of specialty frames, tables and positioning equipment, see Mosby's **refer to Elsevier Online Skills** Online Nursing Skills: Perioperative Skills on the Tri-City Medical Center intranet , as well as manufacturer's Equipment User Manuals located in the Surgery department equipment manual library in the Case Cart Room **and equipment manufacturer's IFU**.

2. Specific positioning considerations:

a. SUPINE

i. Prepare bed with sheet, pillow, draw sheet and arm boards x2 prior to patient transfer
ii. Arm boards are positioned in a less than 90 degree angle to decrease stress to the brachial plexus, and are padded to prevent ulnar injury.
iii. Pad tucked arms, position with thumbs up and secure with a draw sheet.
iv. Apply safety strap 2' above the patient's knees.

b. LITHOTOMY

i. Prepare the OR bed for lithotomy position (turn the table or adjust table pieces, if necessary). Place stirrups at an even level to prevent joint and nerve damage.
ii. After patient is anesthetized, position the patient's hips over the lower break of the table.
iii. Carefully lift legs together slowly and using proper range of motion, to allow the body to compensate for the increase venous return. Secure legs in stirrups or banana boots.
iv. Pad patient's legs appropriately to avoid pressure on the leg from the stirrup devices.
v. At the end of the case, lower patient's legs from the stirrup simultaneously and slowly, and re-apply safety strap to 2" above the knees.

c. PRONE

i. If using chest rolls, position the chest roll should extend from the patient's axilla to iliac crest to promote adequate ventilation.
ii. Use adequate padding with pillows beneath legs to prevent pressure points on the knees and feet.
iii. If placing arms on arm boards, position arm boards to extend upward, using careful movement to prevent hyper-rotation of the shoulder.
iv. Always keep a gurney or bed outside the OR door to easily turn patient supine in the event of an emergency.

d. LATERAL

~~i. Position patient onto side with kidney area over the table break, and secure with lateral positioners as indicated.~~
~~ii. Flex the lower leg and keep the upper leg straight; apply pillows between the legs and beneath the lower leg.~~
~~iii. Position the arms on an arm board: Apply padding beneath the lower arm, pillows, between the arms and secure.~~
~~iv. Place an axillary roll when indicated.~~
~~v. Ensure adequate padding of all bony prominences and secure patient using safety straps and/or tape.~~

D. **DOCUMENTATION**:

1. Document **the following information**~~patient's position, personnel who positioned patient, and equipment used for positioning, in the Surgient Record~~ **in the patient's electronic health record (EHR)**~~.~~**:**
   - **a. Pre-operative skin assessment and reassessment(s) as necessary for changes in skin integrity**
   - **b. Patient's position, including position of the patient's arms and legs and any repositioning activities**
   - **c. Personnel participating in positioning the patient**
   - **d. Type and location of positioning equipment or devices**
   - **e. Type and location of safety restraints**
   - **f. Type and location of any additional padding provided**
   - ~~1.~~**g. Actions taken to prevent patient injury, especially any actions taken in response to findings from pre-operative assessment and location(s) of dressing(s) applied for pressure injury prevention**

~~2. Document patient's skin condition pre-positioning in the assessment form. Document any problems post-positioning.~~

E. **REFERENCES**:

1. **AORN, Inc. (2020). *Guidelines for Perioperative Practice.* Denver.**
~~3. AORN Standards and Recommended Practices, 2012 Edition~~
~~4. Mosby's Online Nursing Skills: Perioperative Skills; TCMC Intranet~~

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

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

REVISION DATE(S): 09/99, 04/01, 01/02, 06/03, 02/05, 02/08, 06/09, 11/10, 10/12, 12/12, 01/13, 03/14, 02/17, 08/19

Surgical Services Department Approval:	~~02/19~~02/20
Department of Anesthesiology Approval:	n/a
Operating Room Committee Approval:	~~04/19~~03/20
Pharmacy &Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~06/19~~04/20
Administration Approval:	~~07/19~~05/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/19

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

B. **DEFINITIONS:**
1. Add-On Cases: Additions to the surgery schedule after the "final schedule" has been published. The "final schedule" is published by 4:00pm ~~PM~~ for the next day.
2. Elective Case: Surgery can be scheduled at the time best suited for the surgeon and the patient.
3. Urgent Case: Surgical intervention is needed within 4-6 hours of presentation. Urgent procedures are placed in an available time on the OR schedule.
4. Emergent Case: Surgical intervention is needed within one hour of presentation and may require that another scheduled or add-on case is bumped.
5. Emergency: Surgical intervention is needed immediately upon presentation to preserve life or limb. Emergency procedures are performed in the first available operating room and may require that another scheduled or add-on case is bumped.

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

3. Expected available surgery rooms Monday-Thursday (may fluctuate based on staffing, surgical volume and surgical acuity):
   a. **0715-1700**~~0730-1500~~ hours: -8 rooms
   b. **1700**~~1500~~-1900 hours: ~~-45~~ rooms
   c. 1900-2100 hours: -3 rooms
   d. 2100-2300 hours: -2 rooms
4. Expected available surgery rooms on Friday (may fluctuate based on staffing, surgical volume and surgical acuity):
   a. **0715-1700**~~0730-1500~~ hours: -7 rooms
   b. **1700**~~1500~~-1900 hours: -4 rooms
   c. 1900-2100 hours: 3 rooms
   d. 2100-2300 hours: 2 rooms
5. Elective cases shall be scheduled by the surgery scheduling office between the hours of 0800 and 1630, Monday through Friday, at 760-940-7382. After **1430**~~1400~~, cases scheduled for the following day are scheduled by staff at the Surgery desk (760-940-5400).
   a. Elective cases are performed Monday through Friday from 0715 (0815 on Thursday) to 2300 hours. Elective cases should not extend beyond 2300.
6. Start Times:
   a. The Start time of a procedure (time on the OR schedule) is the time the patient is expected to be in the OR. Start time of first cases are tracked and report to the OR committee monthly.
   b. The start time of elective or add-on case requested for 1600 or later cannot be guaranteed. In those instances, the surgeon's preferred start time will be noted, and the surgeon will be given one hour's notice of expected start time. If the surgeon cannot start at the expected time, the next surgeon to start will be offered the time.
7. Delays:
   a. Surgeons who notify the OR they will be late for their scheduled start time must provide an expected time of arrival. Delays of more than 30 minutes, or delays that will impact another surgeon's schedule will cause the first surgeon to be bumped back to the next available start time.
   b. Surgeons who are not in ~~house~~ **the hospital** 30 minutes past the scheduled time of surgery and are unable to be contacted will be bumped back to the next available start time once they either arrive at the hospital or contact the OR.
8. Cases are scheduled on a consecutive, first-come first-served basis, or in a surgeon's block time.
9. Procedures may be scheduled by the surgeon or the surgeon's office staff only.
10. The process for scheduling an elective case is as follows:
    a. The surgeon's office calls the TCMC Surgery Scheduling department to reserve a case time.
    b. The surgeon's office completes a written "TCMC Surgery Scheduling Patient Information" booking form and faxes to the TCMC Surgery department fax server (Fax # 760-940-7138) within 48 hours of the telephone reservation.
       i. Upon receiving the written booking form, the TCMC Surgery Scheduler will schedule the case, obtain a financial account number (FIN#) and book a Pre-Operative Education appointment.
       ii. The TCMC Surgery Scheduler will write the FIN# and the date and time of the Pre-Operative Education appointment on the "TCMC Surgery Scheduling Patient Information" booking form, and will fax the form back to the surgeon's office as confirmation.
    c. The surgeon's office enters electronic orders or faxes written orders to the TCMC Surgery Scheduling department fax server at least one week prior to surgery date. Electronic orders will also be accepted.
       i. If the case is scheduled less than one week prior to the date of surgery, written or electronic orders are required by the next business day.

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

D. **PRE-OPERATIVE EDUCATION APPOINTMENT SCHEDULING GUIDELINES:**
1. Patients may be scheduled for a telephone vs. in-person Pre-Operative Education appointment.
2. Those patients who qualify for a telephone Pre-Operative Education appointment include:
    a. Debilitated patients
    b. Nursing home patients
    c. Requests from physician's office if HMO is doing blood work and the patient has a transportation problem
    d. Patients who are rescheduled for surgery and have already attended a Pre-Operative Education appointment

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

F. **WEEKEND/HOLIDAY CASES:**
~~1. Saturday, Sunday and three recognized Monday Holidays (President's Day, Memorial Day and Labor Day) have two rooms available for Add-on and Urgent cases 0730-1530. After 4 PM only one room is available. In addition, one room is available for emergency cases only.~~
~~a. The heart room counts as one of the available rooms.~~
1. **For Saturday and Sunday 0730-1500, 2 rooms are available for Add-on cases and 1 room is available for emergency cases or a heart. For 1500-0730, 1 room is available for Add-on cases and 1 room is available for emergency cases or a heart.**

2. **Memorial Day, Labor Day, July 4th, Thanksgiving, Christmas, and New Year's Day have one urgent and one emergent room only. No elective surgeries are scheduled on these holidays.**
3. **President's Day will be treated like a regular weekend day.**

~~2. The remaining holidays (July 4, Thanksgiving, Christmas, New Year's Day) have one urgent room and one emergent room only. No elective surgeries are scheduled on these holidays.~~

~~3.~~4. Weekend~~/~~ **and** holiday cases are **not to be** scheduled ~~no~~ more than 24 hours prior to the day of surgery.

~~4.~~5. Add-on cases are started in order of scheduling, providing the surgeon is available and the patient is ready for surgery.

~~5.~~6. If the first scheduled add-on case cannot be performed in the first available time, the next case's surgeon will be contacted and offered to start at the available time. Upon availability of the next time to start an add-on case, the surgeon for the first case will again be contact and offered the time.

a. The first available time is 0730. If a physician requests a specific time, e.g., 0900 to start a case, then another physician is available to start at 0730, the physician requesting the 0900 start time will be contacted to move up to 0730, or will start after the preceding case is finished.

7. For 0730 cases, the patient must be ready for transfer to the Operating ~~Suite~~**Room** by 0645, otherwise, the next scheduled case may replace the delayed case.
8. When the first Saturday/Sunday room is booked for three hours or more, the second room is opened. The surgeon following the 0730 slot in the first room will be offered the 0730 slot in the newly available room.

~~6. Surgeons are allowed to schedule no more than ONE elective procedure, no greater than three hours, per weekend. Scheduling questions for weekend electives are decided by the 1st call Anesthesiologist.~~

9. Robotic ~~C~~cases ~~(Mazor or daVinci)~~ are not **to be** scheduled on holidays. **However, R**robotic cases may be scheduled on weekends if **the** appropriately trained staff **members** are scheduled and **the** necessary vendor representatives are available.

~~7.~~10. **Requests may be approved on an individual basis by the OR Nursing Director/Assistant Director/designee and Operating Room Medical Director.**

G. **ENDOSCOPY:**

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

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 11/09

SUBJECT: Surgical Patients with ~~Aicd~~ ~~Implant~~implanted Electronic Devices

REVISION DATE(S): ~~11/12~~01/13

Department Approval:	02/20
Operating Room Committee Approval:	03/20
Department of Anesthesiology Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	04/20
Administration Approval:	05/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/13

A. **PURPOSE:**

1. To outline the necessary steps in caring for a surgical patient with an ~~AICD implant~~**implanted electronic device (IED).**

B. **POLICY:**

1. **Take precautions when the patient has any IED (e.g., gastric or cardiac pacemaker, implantable cardioverter defibrillator, cochlear implant, deep brain, vagal nerve, sacral nerve, phrenic nerve, spinal cord or bone stimulator).**
   a. **Electromagnetic interference (EMI) caused by energy-generating devices used during surgery can cause complications for the IED.**
   b. **Ensure surgeon and anesthesiologist are aware of patient's IED prior to surgery.**
2. **The team managing the implanted device should be consulted before surgery and as needed (e.g., implanting surgeon and/or device manufacturer).**
3. **Determine interventions to be performed for a patient with an existing IED based on the following information that may be obtained from patient assessment, patient caregivers, the device identification card carried by the patient, and the medical record:**
   a. **Type of implanted device**
   b. **Patient's level of dependence**
   c. **Location of the device and leads (e.g., within or outside the path between the active and dispersive electrodes)**
   d. **Device manufacturer and model**
   e. **Clinical indication for the device**
   f. **Battery life**
   g. **Device settings**
   h. **Lead placement**
4. **For cardiac devices, the following information is also needed:**
   a. **Date of last device interrogation or monitoring**
   b. **Lead polarity (i.e., unipolar or bipolar)**
   c. **Need for device programming**
   d. **Response of the device to a magnet**
   e. **Presence of an alert status on the generator or on the lead**
   f. **The last pacing threshold**
5. **Perform the following interventions for a patient with an existing cardiac implanted electronic device (CIED):**

a. Reprogram the device by magnet or having equipment reprogrammed by a qualified person, if so advised by the team managing the CIED.
b. Place the dispersive electrode as close as possible to the surgical site, verifying the IED is not in the current pathway between the active and dispersive electrode.
c. Use electrocautery, bipolar forceps, or other alternative technology (e.g., ultrasonic technology).
d. Place the active electrode cord away from the pulse generator.
e. Use a five-lead ECG system.
f. Use a beat-to-beat indicator (e.g., arterial line, pulse oximeter).
g. Have temporary pacing equipment and an external defibrillator readily available.
h. Keep a magnet immediately available if the pacemaker will respond to a magnet and one is not used for reprogramming.
i. Use continuous cardiac monitoring whenever the pacemaker is deactivated.

6. Perform the following interventions for a patient with an existing non-cardiac IED:
   a. Use alternative technology (e.g., electrocautery, bipolar forceps, ultrasonic technology) instead of monopolar electrosurgery when possible.
   b. Activate the electrosurgical unit for the shortest amount of time possible.
   c. Place the grounding pad as far as possible from the device's generator and leads.
   d. Verify the implanted device and leads are not between the active electrode and the dispersive electrode.
   e. Turn off the IED if it is safe to do so.
7. Take precautions for a patient with an existing cochlear implant:
   a. Do not use electrosurgical devices within 2-3cm of the implant package and electrodes.
   b. Remove all external components.
8. Take precautions for patients who have deep brain stimulators, sacral nerve stimulators, spinal cord stimulators, vagal nerve stimulators, or gastric pacemakers, including turning off the device if so advised by the implant management team and if it is safe to do so.
9. Tri-City Medical Center employees may not deactivate or reactivate a patient's IED.
10. Document IED in the patient's electronic health record (EHR), including all assessments, consultations, interventions and outcomes regarding the IED pre-, intra-, and post-operatively.
11. Provide education to patients and their caregivers on the effects of electrosurgery on IED's.
12. Notify post-operative RN of IED status during hand-off report.

~~1. AICD implant information to be obtained from patient (AICD patient ID card or emergency bracelet/necklace):~~
~~a. Type~~
~~b. Model number~~
~~c.a. Manufacturer~~
~~2. Surgeon and anesthesiologist are to be notified pre-operatively of presence of AICD.~~
~~a. AICD company representative is to be called to deactivate the AICD if requested by surgeon/anesthesiologist.~~
~~3. The AICD must be deactivated prior to any procedure above the waistline where the use of electrocautery is possible.~~
~~a. The Company representative or surgeon/anesthesiologist must deactivate the AICD.~~
~~b. Hospital employees may not deactivate an AICD.~~
~~c. It is at the discretion of the operating surgeon and anesthesiologist to decide whether or not to turn off the AICD for procedures below the waistline.~~
~~4. If AICD is to be turned off for a procedure, defibrillator pads should be placed on patient and connected to defibrillator intraoperatively.~~
~~a. Patient is to remain connected to defibrillator from time AICD is deactivated until it is reactivated.~~
~~5. Intraoperatively, the electrosurgical grounding pad is to be placed as far from the AICD implant as possible.~~

~~a. Electrocautery pad is not to be placed directly over AICD generator.~~
~~b. Electrocautery on or near the lead tip may cause burning of the lead-tissue interface.~~
~~c. The electrical current may unintentionally deactivate the AICD, or inappropriately shock the patient.~~

~~6. Electrocautery is to be set to the lowest possible clinically effective setting.~~
~~a. If the AICD generator is continually inhibited by frequent bursts of electrocautery, a magnet may be placed on the generator.~~
~~b. Placement of the magnet will, depending on the manufacturer and/or model, deactivate the device, if held in position for greater that 80 seconds, or suspend delivery of shock therapy until the magnet is removed.~~
~~c. The surgeon is to be alerted of the possible interference of electrocautery activation with CPI AICD.~~
~~d. The company representative should be consulted for specifics of magnet interaction.~~

~~7. The AICD must be reactivated following the procedure.~~
~~a. The company representative or surgeon/anesthesiologist must reactivate the AICD.~~
~~b. Hospital employees may not reactivate an AICD.~~

~~8. Deactivation and reactivation of the AICD is to be documented in the OR record.~~

~~9. The patient is to be transported to PACU/ICU with transport monitor and/or external defibrillator, and report given to PACU/ICU registered nurse on AICD status.~~

C. **REFERENCES:**

1. AORN, Inc. (2020). *Guidelines for Perioperative Practice.* Denver.
~~1.~~

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 06/15

SUBJECT: Surgical Supply Stocking, Rotation and Outdate

REVISION DATE(S): 09/18

Surgical Services Department Approval:	~~01/18~~02/20
Operating Room Committee Approval:	~~07/18~~03/20
Department of Anesthesiology Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~09/18~~05/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	09/18

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

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

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

Tri-City Medical Center
Oceanside, California

DELETE
Policy is no longer necessary.

SURGICAL SERVICES POLICY & PROCEDURE M

ISSUE DATE: 03/13

SUBJECT: TCMC EMPLOYEES AND INDEPENDENT CONTRACTOR WORK

REVISION DATE(S):

Department Approval:	**03/20**
Operating Room Committee Approval:	**03/20**
Department of Anesthesiology Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**04/20**
Administration Approval:	
Professional Affairs Committee Approval:	
Board of Directors Approval:	**03/13**

~~A. POLICY~~

~~1. TCMC employees who are credentialed through Medical Staff as a Physician Assistant (PA)/Nurse Practitioner (NP)/Registered Nurse First Assist (RNFA) may assist in surgery as an independent contractor/physician employee with the following understanding:~~

~~a. The work as an independent practitioner/physician employee may not interfere or conflict with the employee's regularly scheduled shift. Interfering with a regularly scheduled shift includes:~~

~~i. Early release from the shift to engage in independent practitioner/physician employee work~~

~~ii. Failure to start or be available to scheduled shifts or on call shifts~~

~~iii. Performing duties normally performed by a PA/NP/RNFA while on duty as a TCMC employee (unless the TCMC employee role is as a PA/NP/RNFA)~~

~~iv. Clocking in and out at will during a regularly scheduled shift or on call shift or perform duties as an independent contractor/physician employee.~~

~~b. TCMC reserves the right to limit the direction and receiving of patient care orders from a relative (TCMC Administrative Policy #8610-406). This policy does not apply when the TCMC employee is working as an independent contractor or physician employee.~~

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 04/94 **SUBJECT: Visitors in the Operating Room (OR)**

REVISION DATE(S): 02/05, 06/09, 10/12, 04/15, ~~09/16~~07/17

Department Approval:	**~~03/17~~02/20**
Department of Anesthesiology Approval:	**n/a**
Operating Room Committee Approval:	**~~03/17~~03/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~06/17~~04/20**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**~~07/17~~ n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**

1. To assure ~~that~~ the patient~~,~~ **and healthcare team** ~~Health Care Team, and Perioperative Services~~ are notified and/or given permission for a **medical or** non-medical ~~person to observe~~**observer in** a surgical procedure.

B. **DEFINITION(S):**

1. Non-Medical observer: those who have no clinical or scientific affiliation with Tri-City Medical Center (TCMC), the surgical procedure, or the medical and scientific equipment being used.
2. Medical observer: those who have no clinical or scientific affiliation with TCMC, the surgical procedure, or the medical and scientific equipment being used, however, do have a current valid license in a patient care field, such as a Medical Doctor (MD), Registered Nurse (RN), ~~and~~**or** Physical Therapist (PT).
3. Exemptions from this policy: Medical and Nursing personnel and students and related health care workers who are affiliated with TCMC.

C. **POLICY:**

1. The request for an observer must be communicated to the ~~Perioperative~~ Director **of Surgical Services/designee** prior to the day of surgery by the sponsoring physician.
2. Medical and Non-Medical observers have a maximum of five (5) observation opportunities during a 30 calendar day period.
3. Non-Medical observers:
   a. Must be at least 18 years of age.
   b. The surgeon, anesthesiologist, Charge Nurse, and the patient must consent that the named person be allowed to observe the procedure(s).
   c. The Operating Room must be notified prior to surgery that the named person has permission to observe a specific procedure(s).
   d. A Consent for Observer in Surgical Procedures form shall be completed and in the patient's chart prior to the patient coming to the Operating Room.
   e. Family members and/or significant others of the patient may not observe surgical procedures.
   f. Limit of one observer per room will be allowed to provide for patient confidentiality, to maintain the sterile field, and to control traffic in the Operating Room. Special exceptions will be evaluated on an individual basis.

g. Observers are not allowed to enter the operating room before the patient is fully positioned, prepped and draped for surgery. Special exceptions will be evaluated on an individual basis.

h. Observers are not allowed to touch the patient, "scrub in" or participate in the care of the patient.

4. Medical Personnel:

a. Medical personnel who wish to observe must have approval of the surgeon, anesthesiologist, and the Director of ~~Surgery (or Assistant Nurse Manager/Charge Nurse)~~**Surgical Services/designee**.

D. **PROCEDURE**:

1. Observers shall report to the Operating Room desk at specified time and state their name, title, and purpose. A name tag will be provided to identify the observer and must be worn at all times.
2. Observers shall don surgical attire in the appropriate Surgery locker room, in accordance with Patient Care Service Policy: Surgical Attire.
3. All valuables shall be ~~placed~~ **secured** in the assigned locker.~~ and other valuables may be taken to the OR Desk for safekeeping.~~

~~a. Note: Valuables shall not be left in the Locker Room unless in a locked locker.~~

4. A staff member shall escort the observer to the appropriate room and instruct them in the appropriate use of the mask.
5. A staff member shall introduce the observer to the room personnel and explain appropriate conversation etiquette.
6. The observer shall stand/sit out of the traffic pattern until the circulator can assist in moving him/her to the point of observation.
7. Observers shall ask questions as needed during an appropriate time.
8. Observers shall ask the circulator for assistance if the need arises to move about the room.
9. While moving around the room, proper aseptic technique must be maintained by keeping at least a minimum of 12" distance between non-sterile personnel and any sterile item or person.
10. Observers shall report directly to the ~~Main~~ **OR** Desk when leaving the assigned room.
11. Observers shall not enter or exit any operating room without an escort.

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

1. Administrative Policy: 203 Business Visitor Visitation Requirements

Tri-City Medical Center	Women and Newborn Services (WNS)
PROCEDURE:	**INSTRUMENT CLEANING PROCESS AND TRANSPORT TO STERILE PROCESSING DEPARTMENT (SPD) -**
Purpose:	To outline the procedure and individuals responsible for the initial instrument cleaning process and transport to SPD. Instrument decontamination, final cleaning and sterilization occur in SPD and not at the unit level. Once sterilized, instrument packs and instrument trays are picked up in SPD for unit use.
Equipment:	1. An identified enclosed case cart to transport dirty instruments to SPD 2. An identified case cart to transport sterilized instrument packs and trays from SPD to the unit. 3. Appropriate sized containers and/or basins, with lids to transport dirty instruments to SPD. 4. Appropriate enzymatic cleaning product **(Pre-Klenz Enzymatic Gel)** 5. Protective personal equipment

A. **PROCEDURE:**

1. All instruments from the Women and Newborn Services (WNS) unit will be initially cleaned on the unit but then transported to SPD for further decontamination, packaging, and sterilization **per Sterile Processing Procedure: Decontamination.**~~,~~
   ~~2.~~**a.** WNS staff shall adhere to standard universal precautions, to include eye protection as indicated.

~~3.~~**2.** WNS staff is responsible for the initial instrument cleaning process which includes transferring the instruments to the biohazard room for initial cleaning, as soon as possible after use, and coating the instruments generously with an approved enzymatic gel or spray while in a basin or container that can be securely covered.
   a. For grossly contaminated instruments, the staff shall remove tissue, clots, and/or gross blood, with gauze or rinse lightly with water before applying the enzymatic product.

~~4.~~**3.** The containers with the dirty instruments will be placed into a case cart, located in the biohazard room in the Labor and Delivery (L&D) Operating Room spaces and transported to SPD in an enclosed case cart, with a biohazard label on the outside, for eventual processing at least once a shift, at a minimum.
   a. If dirty instrument sets become more than four in number, efforts shall be made by the L&D staff to transport the case cart to SPD immediately, so the instrument kits/ trays are cleaned, processed, sterilized, and returned in a timely manner.

~~5.~~**4.** The L&D Techs/ staff will pick up clean/sterilized, packaged instruments and trays from SPD at least once a shift, or more often if needed, and transport the sterile gear back to the unit in a "clean" case cart

~~6.~~**5.** The sterilized trays and instrument packs will be stored in a clean supply room until utilized for patient care.

~~7.~~**6.** The SPD manager shall be notified ~~offer~~ any problems encountered related to the instrument cleaning, packaging, and/or sterilization process by calling 760-908-3367. .

B. **REFERENCES:**

1. AORN (201~~5~~**20**). Guidelines for Perioperative Practice, 201~~5~~**20** Edition, Denver, CO.
2. ACOG & AAP (201~~2~~**7**). Guidelines for Perinatal Care, ~~7~~**8**th Edition, Washington DC.

Department Review	Department of OB/GYN	Department of Pediatrics	Pharmacy ~~and~~ & Therapeutics Committee	Infection Control Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
01/16; 02/20	n/a	n/a	n/a	03/16, 04/20	n/a	05/20	04/16, n/a	04/16

Tri-City Health Care District
Oceanside, California

WOUND CARE CENTER
HYPERBARIC CLINIC

ISSUE DATE: 06/07 **SUBJECT: Medical Equipment Maintenance**

REVISION DATE(S): 12/10

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/10**

A. **PURPOSE**

1. Due to the potential for injury that medical equipment poses, an effective preventive maintenance and equipment management program must be in place and strictly observed. All patient care equipment used by the clinic will be maintained in good working order and inspected and repaired according to hospital policy.

B. **POLICY**

1. The Biomedical Department will conduct routine inspection and preventive maintenance (PM) on the Center's medical equipment on a regularly scheduled basis, according to hospital policy.
2. Staff will be trained in the proper and safe use of all medical equipment.8=7
3. Incidents involving medical equipment will be reported according to hospital policy.
4. The clinic manager is responsible for the implementation of the program and the continued observance and monitoring of safe use of equipment.

C. **PROCEDURE**

1. Prior to use, all electrical devices will be inspected and approved by the Biomed Department.
2. Staff members will be trained in the proper use of electrical (or mechanical) devices prior to use.
3. Staff members are required to pull malfunctioning equipment out of use and to notify the appropriate person (biomedical engineer, clinic manager, etc.) for repair.
4. The manufacturer's operating instructions will be followed when operating medical equipment.
5. Annually, or more frequently as indicated, equipment will be inspected per PM schedule.

Tri-City Health Care District
Oceanside, California

WOUND CARE CENTER
HYPERBARIC CLINIC

ISSUE DATE: 06/07 **SUBJECT: Patient Advocacy**

REVISION DATE(S): 12/10

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/10**

A. **PURPOSE**

1. Consistent with the hospital policies related to vital patient advocacy issues, wound/ ostomy care and hyperbaric medicine recognizes that every patient has rights related to personal information and healthcare. Although not all-inclusive, patients seeking medical attention at the clinic can expect the following:
   a. Know and understand their rights as they relate to receiving care/services at the Center (Patient Rights policy).
   b. The right to know about and understand their disease condition and be informed of specific treatment options that are available to them (Informed Consent policy).
   c. The right to be included in their healthcare decision (Advance Directive policy)
   d. The right to be treated with respect and dignity (Patient Rights)
   e. The right to expect resolution to complaints/problems (Patient Complaint policy)
   f. The right to be protected from neglect or abuse (Mandatory Reporting of Victims of Assault, Domestic Battery & Suspected Abuse policy)
   g. The right to a safe environment when seeking healthcare at the Center, an environment where measures have been instituted to minimize or eliminate the risk for injury (Falls Prevention policy)
   h. The right to privacy and confidentiality whenever their medical information is being discussed or managed and maintained (Release of Records, Medical Records, Photography HIPAA)

B. **POLICY**

1. Informed Consent: Coincident with the hospital's mission and values and state statutory regulation, the Center performs certain diagnostic or therapeutic procedures only after informed consent has been given by the patient or his/her representative (Consent for Treatment form). It is the responsibility of the clinic physician to fully inform the patient of the risks and benefits of the recommended treatment as well as any other options available to them and to obtain the patient's consent. This may be supplemented with printed material or video information. In addition, clinical staff will advocate for the patient and assist with the process by ensuring that this step has been taken and researching and/or providing additional information at the patient's request. In addition to the clinic consent for treatment, other forms will be used per hospital policy, e.g. Consent for HIV Testing, Authorization for Release of Records, etc.
2. Patient Rights: All patients will be informed of his/her rights and responsibilities upon initial presentation to the Center. These rights are posted in the patient care areas and are written in

English & Spanish. All clinic staff will be informed of these rights during the hospital orientation program.

3. Advance Directive: The Center recognizes that every patient has the right to participate in his or her own healthcare decisions. They have the right of self-determination regarding health-related issues, including the right to refuse medical treatment. It is the policy of the hospital to honor a patient's wishes as it relates to healthcare decisions, including the designation of another person to direct the course of medical treatment upon his/her incapacitation. Patients (or their surrogate) presenting to the clinic for the first time will be asked if they have an Advance Directive. If the patient is not aware of Advance Directives, a copy of the Advance Directive Fact Sheet will be provided to the patient or surrogate.
4. Patient Complaints: Every patient can expect a good-faith effort to resolve problems and an opportunity to express concerns and unmet needs. Attempts will be made to address concerns/complaints at the clinic level first. If not resolved to the satisfaction of the patient/family, the issues will be forwarded per hospital policy to the designated Administrative representative within 72 hours of receipt.
5. Reporting Suspected Neglect or Abuse: Every patient presenting to the Center for medical evaluation/treatment will be assessed for signs of abuse/neglect. All clinical staff is trained to identify signs of neglect/abuse. Any patient whom the staff suspects abuse or neglect will be reported, per hospital policy. Social Services Department will be notified for assistance and guidance with the proper reporting process.
6. Falls Prevention: All patients are assessed for risk of falls during the initial assessment process when admitted to the clinic program. Prevention measures are instituted immediately to prevent injury and may include:
   a. Assisting patient on and off treatment chair/table
   b. Never leaving a confused or incompetent patient unattended in an exam room
   c. Guiding the patient while ambulating
   d. Keeping the bed in lowest position until the exam/treatment time
   e. Bedrails in UP position at all times except during treatment
   f. Placing personal items such as purses, bags, etc. close to patient
   g. When identified, the risk for falls will be noted on the front cover sheet of the chart in the section labeled PRECAUTIONS.
7. Medical Record/Release of Information: To protect the confidentiality of the patient's medical information and safeguard it against loss, destruction, tampering, and unauthorized access, use or release, the clinic will follow all the requirements of the health information management system established by the hospital. All medical records will be maintained in a locked area of the clinic until the time of patient discharge. Within 30 days of discharge, the patient medical record will be given to Medical Records of off-site storage for storage and safekeeping. On a daily basis, the records of active patients will be readily accessible to authorized personnel for use in patient care and secured at the end of each business day. The patient's written permission or that of his/her legally qualified representative (Release of Records form) must be obtained prior to releasing medical records information of any kind to any person, institution, agency not directly related to the care of the patient. However, medical records may be removed from the clinic's/hospital's jurisdiction in accordance with court order, subpoena or statute.

Tri-City Health Care District
Oceanside, California

WOUND CARE CENER
HYPERBARIC CLINICA

ISSUE DATE: 06/07 **SUBJECT: Patient Charges**

REVISION DATE(S): 12/10

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/10**

A. **PURPOSE**

1. Patient charges and payment processes must be delineated to:
   a. Provide guidelines for the clinic staff entering patient charges
   b. Clarify the appropriate charges for services rendered in the outpatient setting.
   c. Avoid overcharging the patient and/or the third-party payer
   d. Provide consistency in billing practices
   e. Prevent inadvertent fraudulent billing
   f. Outline the appropriate billing processes for the Center

B. **POLICY**

1. The patient's insurance will be verified just prior to or at the time of the first appointment.
2. Insurance authorizations will be obtained prior to all appointments, where applicable.
3. All charges for services will be accurately recorded and processed, per the hospital Business Office.
4. All appropriate staff will be trained in the charging procedure.
5. A "superbill" format containing standard clinic procedures and charge/payment codes will be utilized for accurate billing purposes.
6. Managed-care patients will be billed according to the prevailing contact/agreement following managed-care charging/payment protocols.
7. Cash-paying patients will be billed according to hospital-approved fee schedule.

C. **PROCEDURE**

1. Clinical personnel will be trained in accurate charging for services rendered.
2. The physicians will check the appropriate charges on the "superbill" at the end of each patient visit.
3. Notification of cash-paying patients will be made to the Business Office to avoid duplication of billing and/or collection notice.
4. "Superbill" forms will be complete by the end of each business day and forwarded to the Office Coordinator for processing.
5. The Office Coordinator will validate the daily "superbills" generated each day for accuracy against the list of patients treated a the Center and submit copies to the appropriate departments.
6. The Office Coordinator reviews the posted revenue for accuracy the following business day.
7. For the managed-care patients:
   a. Charges are entered per clinic procedure

b. The Business Office is made aware of the managed-care patient and bills the Third-Party Administrator (TPA) for patient visit/procedure
c. The TPA bills the managed-care group
d. Upon receipt of payment, the TPA disburses funds to the hospital for facility expense.

Tri-City Health Care District
Oceanside, California

WOUND CARE CENTER
HYPERBARIC CLINIC

ISSUE DATE: 06/07

SUBJECT: Patient Photography

REVISION DATE(S): 12/10

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/10**

A. **PURPOSE**

1. Photography is an important aspect of care in the Center's setting. The photography program is tailored to:
   a. Document the presence of wounds or other pertinent medical conditions
   b. Show the progress of the healing process or response to care
   c. Use for educational and marketing purposes
   d. Assess the quality of service provided at the Center

B. **POLICY**

1. Patients will consent to photography before any pictures will be taken.
2. All patients presenting to the clinic with open wounds or other pertinent medical conditions will have photographs taken on initial visit and periodically to demonstrate progress (or non-progress) and/or with any significant changes.
3. Photography of other events/conditions will occur with patient's permission as ordered by physician or at the discretion of the clinical staff.
4. Photographs will be maintained as with all confidential medical information.
5. Photographs will be released only with patient's consent.

C. **PROCEDURE**

1. During the initial visit, the patient will be asked to sign the Consent for Photography form.
2. A member of the clinical staff will witness the patient signature.
3. If an interpreter is used, the interpreter will sign as well.
4. Refusal to give consent for photography will be honored by the clinic staff, and no photographs will be taken. The clinical staff will note this on the consent form and on the front of the chart in section "OTHER".
5. Pictures will be taken using various forms of photography such as digital, Polaroid or 35mm.
6. Picture will be labeled with date, patient initials, medical record number and wound number and/or site of wound/condition.
7. Whenever a photograph is taken it will be noted in the Progress Notes in the section called Wound Assessment.
8. Staff members will be trained in the proper use of the cameras and in technique for good quality pictures.

Tri-City Health Care District
Oceanside, California

WOUND CARE CENTER
HYPERBARIC CLINIC

ISSUE DATE: 06/07 **SUBJECT: Patient Reception**

REVISION DATE(S): 12/10

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/10**

A. **PURPOSE**

1. It is essential that the image we project is one that is consistent with the philosophy and mission of the hospital. First impressions set the tone for subsequent visits. Factors that may adversely affect a patient's perception are:
   a. Lack of respect when dealing with patients
   b. Long waiting periods prior to being seen by physician
   c. Not providing adequate or providing inaccurate instructions/information.
   d. Not including patient's support team (e.g., family, friend, caregiver) in the plan of care.
2. A negative impression may dissuade the patient from returning to the clinic or discourage compliance/cooperation with the plan of care. This document delineates the guidelines necessary to meet the clinic's customer service goals.

B. **POLICY**

1. All patients seen at the Center can expect:
   a. To be treated with respect and dignity according to the values of the hospital
   b. A supportive, compassionate staff
   c. A therapeutic environment
2. All patients will be greeted professionally and with compassion.

C. **PROCEDURE**

1. During the patient's first visit, the patient will be instructed about the initial process and oriented to the reception area (TV, reading materials, restroom, writing surfaces, etc.)
2. Patients will be asked to complete information forms and sign consent forms (except consent for treatment) prior to the first evaluation/exam.
3. Patients will be given assistance as needed with registration, e.g., Spanish interpretation.
4. Every effort will be made to make the patient comfortable in the waiting area. If indicated, the clinical staff will be asked to assist with comfort measures.
5. Priority will be given to the day's clinic patients to minimize waiting periods. Interruptions for telephone calls by the clinical staff will be reserved for urgent needs only in order to facilitate the clinical flow.
6. Patients will be addressed respectfully and according to their expressed wishes.
7. The patient will be informed about:
   a. The purpose of the program
   b. The plan of care
   c. The communication procedures

8. The clinic physician will clearly define his/her recommendations for the treatment plan and include members of the patient's support team
9. Staff members will introduce themselves to the patient and explain all procedures prior to implementing them.
10. After-care instructions will always be provided in written form ("Patient Instruction" form) after each visit.
11. All patient complaints will be addressed per hospital policy.

Tri-City Health Care District
Oceanside, California

WOUND CARE CENTER
HYPERBARIC CLINIC

ISSUE DATE: 06/07 **SUBJECT: Patient Survey Process**

REVISION DATE(S): 12/10

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/10**

A. **PURPOSE**

1. The quality or effectiveness of any program is reflected in the satisfaction experienced by the client receiving service in and out of a program setting. The Center's survey process is designed to recapitulate the patient experience at the Center. Results of the survey are reviewed by qualified person(s), and opportunities to improve services are identified and corrective actions implemented.

B. **POLICY**

1. All patients receiving care at the Center will be asked to complete a satisfaction survey after discharge.
2. Survey results will be reviewed and tabulated by qualified person(s), per hospital procedure, and reported to pertinent hospital committee(s) and the medical staff of the Center.
3. Opportunities for improvement will be identified.
4. Corrective action will be implemented, evaluated, and reported as appropriate.
5. Patients may also express concerns anytime during their treatment period and expect resolution whenever possible.

C. **PROCEDURE**

1. After discharge, each patient will be handed or sent a survey and asked to complete and return before they leave or in a self-addressed envelope to the hospital.
2. The surveys will be tabulated using an approved method.
3. The results will be reviewed by the Center manager, the office coordinator, and the physician quality advocate, as well as the Center staff.
4. Opportunities for improvement will be identified by the tam.
5. Corrective actions will be implemented.
6. Ongoing monitoring will be conducted to measure the effectiveness of actions.
7. The findings will be reported to pertinent hospital committee(s) (i.e., Performance Improvement) and persons.
8. The Center staff will participate in the improvement process. The results of the surveys will be discussed at the monthly meetings.

Tri-City Health Care District
Oceanside, California

WOUND CARE CENTER
HYPERBARIC CLINIC

ISSUE DATE: 06/07

SUBJECT: Patient Visual Auditory Privacy

REVISION DATE(S): 12/10

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/10**

A. **PURPOSE**

1. This policy defines the measures taken by the Center to preserve and maintain the patient's right to privacy.

B. **POLICY**

1. Every effort will be made to maintain the patient's visual and auditory privacy while being treated at the Center.
2. Immediate action, to the extent possible, will be taken when a breach of privacy is identified.
3. Employees found violating the privacy policy will be counseled and an appropriate inservice provided, if appropriate.

C. **PROCEDURE**

1. Interview/counsel patients out of hearing and visual range of other patients and visitors. A private room or exam room is appropriate.
2. Do not speak above the patient's hearing level.
3. Seek patient's permission to allow students, manufacturer's representatives, or any other appropriate observers to be present in the exam room.
4. Do not call out patient information, including name, orders or treatment plan, etc. across distances within the clinic to communicate with other members of the healthcare team.
5. Provide privacy when any part of the patient's body is exposed; or if patient is disrobing by closing privacy curtain and using a sheet to cover the patient if appropriate.
6. Keep exam room door closed at all times while the patient occupies the room, unless contraindicated or at the patient's request.
7. Be sure that windows are covered appropriately to provide adequate privacy.
8. Maintain patient confidentiality with the medical record as well as all verbal and written communications.

Tri-City Health Care District
Oceanside, California

WOUND CARE CLINIC
HYPERBARIC CLINIC

ISSUE DATE: 06/07 **SUBJECT: Program Description**

REVISION DATE(S): 12/10

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/10**

A. **PURPOSE**

1. The clinic is a comprehensive advanced therapy/treatment program that addresses specific medical needs of the community. The purpose of this document is to:
   a. Describe the program
   b. Establish the mission of the program
   c. Delineate the scope of services
   d. Define the roles, responsibilities and qualifications of the medical and clinical staff
2. Mission Statement: Consistent with the mission of Tri-City Medical Center, the wound care clinic will serve the needs of this community as it relates to the treatment of chronic wounds, ostomy care and hyperbaric medicine.

B. **POLICY**

1. The primary goal of the clinic is to provide vital services to the population at risk, which includes patients of multiple and differing socioeconomic and cultural backgrounds. These are patients with diabetes, renal failure, peripheral vascular disease, hypertension, and many other chronic illnesses and their sequelae.
2. Access to care for all patients including those with limited funding and transportation will be served by multiple specialists while still allowing the patients to maintain their primary care physician/patient relationship.
3. These services shall be marketed to our immediate community, insurance plans, workers' compensation programs and the State (Medi-Cal).
4. Consideration of other sources of income, i.e. clinical research programs, grants and partnering with other institutions will be further evaluated and utilized when beneficial to Tri-City Medical Center for its community.

C. **ACCOUNTABILITY/REPORTING STRUCTURE**

1. The program is a hospital-based service, licensed as an outpatient program. The program is accountable to hospital administration through a reporting relationship to the Senior Director of Patient Care Services and Chief Operating Officer/Chief Nurse Executive.

D. **SCOPE OF SERVICES**

1. The service model chosen by the hospital relates directly to medical information obtained from various sources, including:

a. CDC statistics
b. ADA
c. Hospital DRGs
d. DHS

2. The goals of the clinic are accomplished through the services it provides, including:
   a. Management/healing of chronic wounds, including:
      a) Vascular assessment
      b) Nutritional assessment
      c) Infection control
      d) Edema control
      e) Offloading methods and devices
      f) Surgical intervention, as indicated
   b. Hyperbaric Oxygen Therapy as adjunctive therapy for the treatment of difficult-to-treat wounds
   c. Diabetic self-management and education program collaborating with the patient's primary care physician to include:
      a) Diabetic education
      b) Nutritional instruction
      c) Disease self-management
      d) Referral to sub-specialists for prevention of complication
   d. d. Ostomy care:
3. Pre-operative education and site marking
4. Post-operative education, appliance needs, and lifestyle adaptation

E. **QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT PROGRAM**

1. The quality management program, consistent with that of the hospital, is designed to measure outcomes and related processes of care and to seek ways to improve the quality of services provided at the clinic. The key elements of the program are:
   a. Collect meaningful data
   b. Select measurable indicators
   c. Use a valid method of data collection, management and storage
   d. Analysis of the data by a qualified person
   e. Reporting to pertinent hospital committees
   f. Corrective actions designed to improve the quality of services
2. Data sources: The primary source of information is the clinic database. The patient medical record, laboratory, radiology reports and the hospital computer information systems are utilized, where appropriate, following HIPAA guidelines. Data is collected by the program director/clinical manager and/or the clinic staff, as appropriate. Data may be concurrent or retrospective dependent on availability of data.
3. Benchmarking: The clinic results are compared to national and/or system-wide benchmarks, when available, or the clinic's own historical data. Unmet goals are perceived as opportunities for improvement. Corrective actions are relevant to improving the services rendered.
4. Reporting: The data results are reported to the pertinent hospital committees/ teams as mandated by the hospital's governing bodies and may include:
   a. The hospital Safety/Environment of Care Committee
   b. The hospital Quality Committee
   c. The Medical Executive Committee
   d. The Hospital Board of Directors

F. **STAFF QUALIFICATIONS, EDUCATION, AND TRAINING**

1. Medical Staff

a. Medical Director: The program is directed by a qualified medical staff member who is a clinician who may be trained in 1 or more of the following disciplines, has the responsibility to educate and train the medical staff, and works closely with the program director/clinical manager to recommend and to order the educational activities of the clinic staff. Moreover, the Medical Director provides direction and oversight for the overall medical services.
   a) Plastic and reconstructive surgery
   b) Vascular surgery
   c) Orthopedic surgery
   d) Internal medicine
   e) Infectious disease
   f) Nephrology
   g) Endocrinology
   h) Dermatology
   i) Podiatry
   j) Interventional radiology
   k) Emergency medicine

b. Medical Staff Members: Relevant continuing education is required to maintain their status as medical practitioners in this specialized program (see "Credentialing Criteria for Outpatient Wound Care"). A qualified practitioner is selected based on:
   a) Proven skills in a relevant discipline
   b) Medical or specialty experience
   c) Established reputation in the medical community
   d) Hospital staff privileges
   e) Ability to perform the requirements of the service to be rendered
   f) Interest in an interdisciplinary approach and collaboration in the care of chronic diseases

2. For physicians involved with hyperbaric oxygen therapy, see "Credentialing Criteria for Hyperbaric Medicine".
   a. Clinic Staff Members
      a) Clinical Manager: The clinic is staffed with a full-time qualified Clinical Manger whose qualifications include:
         (a) Education and training (RN)
         (b) Previous managerial experience OR the ability to demonstrate the necessary skills to perform the managerial duties
         (c) Proven skills in collaborating with the medical staff, Administration, and outside agencies that govern the standards of medical care
         (d) Ability to communicate effectively with the medical and clinic staff, Administration, other departments of the hospital, and patients and their families
         (e) Ability to develop and/or coordinate educational programs for clinic staff and patients
         (f) Knowledge and skills in developing and implementing policies, procedures and new programs

b. Clinic Staff: The type and number of staff members are selected based on qualifications, experience and clinic needs. Clinic needs are determined by the number of active patients in the program, the type and the acuity of patients, the type of service required by the patients, and the overall requirements of the clinic. Members of the staff may include:
   a) Office Coordinator
   b) Registered Nurses, WOCNs, Physical Therapists
   c) Licensed Vocational Nurses
   d) Medical Assistants
   e) Receptionist
   f) Clerical support staff
   g) Certified Diabetes Educators
   h) HBOT Safety Manager
   i) HBO Technologists

c. Each position is defined in the Job Description Manual. Overall competency of clinic staff is based on:
   a) Education, training, licensing and certification, as required
   b) Years of experience
   c) Ability to demonstrate the necessary skills to perform the defined duties as defined and assessed on performance appraisal
   d) Ability to communicate effectively with the medical staff and patients and their families

G. **STAFF DEVELOPMENT**

1. In collaboration with the Medical Director, the staff education and training schedule is developed on a monthly and as-needed basis. It is comprised of all the elements necessary to affect a quality program. The topics include, but are not limited to:
   a. Department orientation for new staff members
   b. Diabetes
   c. Negative pressure wound therapy
   d. Use of chemotherapy as an adjunct to wound healing
   e. Vascular assessment
   f. Soft tissue infections/osteomyelitis
   g. Plastic and reconstructive surgery
   h. Off-loading wounds
   i. Wound healing strategies
   j. Hyperbaric oxygen therapy
   k. Edema control
   l. Science of wound healing
   m. Ostomy care
2. Educational programs are also defined by the clinical staff through need assessment discussed at the monthly staff meetings.

H. **PRODUCT SELECTION**

i) As much as possible, the products used in the clinic are selected in conjunction with the hospital's product selection process. The clinical staff actively participates in the selection process and bases its decisions on effectiveness of the products. Attention is given to cost, but benefit to the patient is the primary consideration.

Tri-City Health Care District
Oceanside, California

WOUND CARE CENTER
HYPERBARIC CLINIC

ISSUE DATE: 06/07 SUBJECT: **SUBJECT:Registration**

REVISION DATE(S): 12/10

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/10**

A. **PURPOSE**

1. Hospital or clinic registration can be a daunting and tedious task for someone whose health may be less than optimal. Every effort will be made to simplify and expedite this process. This document outlines the registration process at the Center.

B. **POLICY**

1. The registration procedure will be simplified to the extent possible to minimize the stress related to initial visit procedures.
2. Every patient will be assisted, as appropriate, in completing the registration information.
3. The clerical staff will follow the hospital's procedures for data collection and electronic data entry.

C. **PROCEDURE**

1. At the conclusion of the patient's first inquiry and when an appointment has been scheduled, the patient or representative will be asked to bring with them the following information:
   a. Current medication list
   b. Physician referral letter, if applicable
   c. Primary physician information
   d. Insurance card(s)/information
   e. Copy of relevant diagnostic tests
   f. A resident or qualified representative of long-term or extended-care facilities will be required to complete and return pertinent information 24 hours prior to the first visit. The facility is responsible for ensuring that the appropriate consents are signed by authorized person(s) and returned with the patient at the time of the appointment. If the patient/resident cannot speak or act for himself, he/she must be accompanied by a representative (preferably a family member) who is knowledgeable about the medical history.
      i. The Center reserves the right to cancel the appointment, if all required documentation is not available at the time of the first visit.
      ii. A family member or facility representative must always accompany patients/residents who are not oriented to person, time, or place.
2. All patients will be admitted to the Center according to hospital policy. The following forms must be signed preceding any exam/treatment:
   a. Hospital's "Conditions of Agreement"
   b. Insurance and billing information

c. Consent for Treatment (after the clinic physician has informed the patient about the plan of care).

3. The office coordinator or designee will:
   a. Ensure that verification of the insurance information/coverage is complete prior to the first visit.
   b. Obtain any necessary prior authorizations from the third-party payer.
      i. Only services authorized may be provided
   c. Copy insurance card(s) for distribution as follows:
      i. The medical record
      ii. Admitting Department
      iii. Financial folders
      iv. Physician
   d. Notify the patient and primary care physician if verification indicates that the patient has no coverage or poor coverage, and discuss payment options.
   e. In the event that an individual payment plan must be constructed, the hospital's business office will advise and develop a payment plan with the patient or representative responsible for the payment.

Tri-City Health Care District
Oceanside, California

WOUND CARE CENTER
HYPERBARIC CLINIC

ISSUE DATE: 06/07 **SUBJECT: Scheduling**

REVISION DATE(S): 12/10

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/10**

A. **PURPOSE**

1. Establishing scheduling procedures is important for several reasons:
   a. Provides for orderly, efficient approach to patient visits
   b. Minimizes patient waiting periods
   c. Allows for adequate time for evaluation/treatment
   d. Defines a uniform approach to scheduling for staff members
   e. Assigns responsibilities to avoid duplication of effort

B. **POLICY**

1. Patients will be scheduled appropriately, allowing adequate time between visits to prevent prolonged waiting time for all patients.
2. Patients will receive written follow-up visit appointments at the end of each visit along with their home instructions.
3. As time permits, patients will be called 1-2 days prior to the scheduled visit to confirm the appointment.
4. Patients missing scheduled appointments will be called as time permits on the same or following day to ascertain the cause of the missed appointment and reschedule the patient whenever possible.

C. **PROCEDURE**

1. Schedule Order
   a. Patients will be instructed to check in with the receptionist upon their arrival.
   b. Patients will be seen in the order of their appointment time and not by their arrival time.
   c. The receptionist or front office support is responsible for maintaining the scheduling order for the clinic session. Working with and through the receptionist, the clinical staff may overrule the order of the schedule if deemed medically prudent.
   d. If the clinic session is running behind, the clinic staff will notify the reception/office personnel who, in turn, will inform the waiting patients and provide them with the option to reschedule their appointment.
2. Scheduling the New Patient
   a. The new patient will be scheduled with the appropriate clinic physician.
   b. The new patient will be schedule in an open time slot that allows adequate time for comprehensive medical evaluation and workup.
3. Follow-up Appointments
   a. The attending nurse (case manager)/PT will write the timeframe of the next visit ordered by the physician on the home instruction sheet and forward to the receptionist.

b. The patient will be given a copy of the written home care instructions by the receptionist, which will include the follow-up appointment date and time.

4. Missed Appointments
   a. When a patient has not arrived for his/her scheduled appointment, the clinic staff will attempt to contact the patient by telephone the same or following day (as time permits).
      i. A new appointment will be scheduled, as appropriate
   b. If the patient is able to arrive the same day before the clinic physician leaves, the patient may be scheduled in at the end of the clinic session.
   c. If the patient cannot or does not want to return, the receptionist will relay the information to the nurse case manager/PT for follow-up, as appropriate.
   d. For non-compliant patients, the clinician will record any information related to the scheduled appointment(s) in the medical record, documenting the attempts to contact the patient.
   e. The missed appointment will be recorded in the patient record on the physician order sheet and will include the reason, if ascertained.
5. Unscheduled Appointments
   a. Patients referred to the Center for a same-day visit may be accepted as time permits and if the clinic physician in session accepts the patient.
      i. The patient and the referring physician will be informed that the patient will be added to the schedule at the end of the session, or as time permits.
      ii. The clinic physician, nurse case manager/PT, or the clinic manager may overrule this policy if deemed medically prudent to see the patient sooner than at the end of the session.
6. Canceled Appointments
   a. The clinic physician will review the missed appointment list and may give instructions in addition to rescheduling the patient.
   b. The support staff will attempt to reschedule the appointment at the time of cancellation, if appropriate.
7. Patient Discontinues the Program
   a. Tracking will be done weekly by the data coordinator, who will generate a report from the database that identifies patients who have not returned for follow-up care within the last 4 to 6 weeks.
   b. The report will be given to the clinic manager for distribution and follow-up.
   c. The Center staff will make a good-faith attempt to reschedule the patients listed.
   d. Communication efforts will be documented in the medical record by the clinical staff.
   e. After a good-faith effort has been made to contact and reschedule the patient, a letter will be sent to the patient referring them back to their primary care physician for follow-up care.

Tri-City Health Care District
Oceanside, California

WOUND CARE CENTER
HYPERBARIC CLINIC

ISSUE DATE: 06/07 **SUBJECT: Staff Development**

REVISION DATE(S): 12/10

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/10**

A. **PURPOSE**

1. Learning is essential to personal growth and development. The hospital recognizes that staff education enhances the quality of patient care and improves staff motivation. Other benefits include:
   a. Improved competency
   b. Increased compliance with hospital policies, state, local and federal regulations/statutes
   c. Reduction of risks associated with patient/visitor and staff safety
   d. Understanding, better awareness, and compliance with standards of practice

B. **POLICY**

1. The clinic manager, in collaboration with the medical and clinic staff, will develop education calendars.
2. An educational needs assessment will be conducted at the monthly staff meetings.
3. Staff meetings will be held monthly and may include staff development topics.
4. The clinic manager is responsible for developing, implementing, and revising the staff development program.
5. All staff members will be given a thorough hospital and unit-specific orientation during the placement period.
6. Ongoing inservice education will be conducted on a monthly basis and more frequently as needed.
7. Attendance at hospital and outside educational program is encouraged.
8. The staff is encouraged to independently pursue educational opportunities to enhance their professional growth.
9. Monthly staff meetings/staff development activities may include, but are not limited to, the following:
   a. Job-related training
   b. Safety-related issues
   c. Infection control
   d. Introduction to new policies, procedures, techniques, and products
   e. Medical topics such as diabetes, vascular disease, infectious disease, wound healing, hyperbaric medicine
   f. Operational changes
   g. Pain assessment
   h. Patient advocacy issues
   i. Continuum of care
   j. Required annual training

10. Minutes of the staff meetings will be recorded and will include personnel in attendance, issues discussed, and action plans for identified problems. Associates not in attendance are required to read the minutes.
11. As much as possible, the programs/meetings will be held when most or all staff is scheduled.
12. Other miscellaneous information not included in the staff meetings, such as general hospital memos, will be included in the department communication book that is maintained by the support staff.

Tri-City Health Care District
Oceanside, California

WOUND CARE CENTER
HYPERBARIC CLINIC

ISSUE DATE: 06/07 **SUBJECT: Staffing Plan**

REVISION DATE(S): 12/10

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/10**

A. **PURPOSE**

1. Appropriate and adequate staffing is vital to the success of the multi-service outpatient clinic. A well-planned approach must be taken to accomplish this goal, and several factors for a good staffing plan must be considered. They are:
   a. Acuity of the patients treated
   b. Level of expertise/competency of the staff
   c. Time allotted for each visit
   d. Available resources (human, financial, and otherwise)
   e. Continuous planning and assessment (daily, weekly, monthly and yearly)
   f. Frequent review and evaluation to seek opportunities to enhance the system to benefit patient car and for good stewardship of financial resources that impact clinic operations.

B. **POLICY**

1. Acuity Classification: The Acuity Classification policy has been developed to provide for and validate adequate/appropriate resources for the plan of care for each patient who presents to the Center for treatment and to support the requirements for the continuum of care activities.
2. Staffing: In general, the type and number of staff members are selected based on qualifications, experience and clinic needs. Clinic needs are determined daily and weekly by the number of scheduled patients, the type and acuity of patients, and the type of service required by the patients. Members of the staff may include:
   a. RN Clinical Manager is empowered to run the day-to-day operations of the clinic. The manager also participates in the decision-making processes related to the selection of the clinic model and the services provided. He/she is accountable for ensuring that the clinic is adequately staffed and makes certain that patient visits are appropriate and timely.
   b. Office Coordinator has the overall responsibility for coordinating the activities of the clerical area and performs the administrative functions of the front office operations.
   c. Registered Nurse/PT develops the plan of care for each patient using the nursing process. The RN/PT leads and accepts responsibility for the multifaceted team to direct and evaluate the plan of care and takes the initiative to make necessary adjustments to enhance the quality of care provided and improve outcomes. The RN/PT takes the lead in the coordination in the continuum of care.
   d. Licensed Vocational Nurse, under the supervision of the clinical manager and the direction of the RN/PT, performs duties using the nursing process to provide and maintain individualized quality patient care and participates in the coordination in the continuum of care.

e. Medical Assistant (MA), under the supervision of the clinical manager and the direction of the RN/LVN/PT, performs tasks as assigned. The MA assists other members of the healthcare team while providing direct patient care. As a patient advocate, the MA reports observations and patient responses to care to the RN/PT/MD and assists with maintaining patient privacy/ confidentiality and reports patient complaints of pain to the RN/PT/MD.

f. Receptionist requires the coordination of the clinical, clerical and general secretarial/office duties, as well as realistic patient scheduling. As the first person the patient encounters by phone and with each visit, the receptionist must demonstrate excellent interpersonal skills.

g. Other staff members may include a nurse practitioner/physician assistant, CWOCN, enterostomal nurse, and additional clerical support staff. Competency of clinic staff is based upon:
   i. Education and training
   ii. Years of experience
   iii. Ability to demonstrate the necessary skills to perform the defined duties
   iv. Ability to communicate effectively with the medical staff and patients and their families.

3. Financial Resource Allotment for Staffing: Budget preparation for staffing the clinic is performed annually by the clinical manager with the assistance and approval of the administrative team. Budget requirement is determined by utilizing previous years' financial history and financial performance, as well as anticipated staffing needs for planned additional services, as justified by the clinical manager. Periodic adjustments to accommodate changes may be made at the discretion of the clinic manager and with the direction/approval of the administrative team.

4. Patient Scheduling: Allowing adequate time for each patient visit is necessary for patient satisfaction, convenience, and care needs and is an essential component of an efficient and smooth-running clinic. To determine the time required for/between each visit, the following general rules apply:
   a. Increased time is allowed for a new patient visit or for complex cases
   b. Less time is required for follow-up and/or less-complex cases
   c. For more specific information on patient classification, refer to the Acuity Classification policy.

5. Assignments: Assignments are planned by the clinical manager on a weekly basis and are based upon the number of patients scheduled, assessment of clinical needs of the patient, the complexity of the patient's condition, and the clinical care requirements. Staffing levels may be adjusted to correspond with the anticipated care requirements. In addition, the clinic manager reviews the changes in the daily clinic schedule and makes necessary adjustments to staffing levels.

6. Evaluation of Staffing Plan: The staffing plan is periodically reviewed and evaluated by the clinic manager. Opportunities for improvement/enhancement are identified, and changes are made consistent with the needs of the patients and the staff members.

Tri-City Health Care District
Oceanside, California

WOUND CARE CENTER
HYPERBARIC CLINIC

ISSUE DATE: 06/07

SUBJECT: Telephone Management

REVISION DATE(S): 12/10

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/10**

A. **PURPOSE**

1. Effective management of telephone operations is key to the success of the program. The important aspects of telephone management include:
   a. Etiquette
   b. Intake/information management skills
   c. Adequate coverage
   d. Telephone triage

B. **POLICY**

1. To promote excellence and competence in managing telephone communications:
   a. The telephone communications methods will be defined and systematic.
   b. All personnel will be trained in proper telephone etiquette and telephone information management.
   c. A designated person(s) will have full responsibility to coordinate and maintain the telephone communication program.
   d. The clinic manager will be responsible for oversight and implementation of the program.
   e. As a key customer relations/service tool, the telephone will reflect the mission and philosophy of the program:
      i. All patients will be treated with respect and dignity when communicating by phone.
      ii. All telephone messages will receive timely responses.
      iii. Telephone calls will be routed appropriately.
   f. Adequate telephone coverage will be provided during normal business hours.
   g. Provisions will be made for after-hour communication.

C. **PROCEDURE**

1. During business hours, the phone will be answered in a timely manner.
2. For after-business hours, a telephone recording system will be utilized to answer calls, and messages will be picked up promptly the following business day. The greeting/recording will contain instructions for emergency situations and provide the medical director's phone number for professional consultation.
3. Messages will be answered promptly.
4. Those responding to telephone calls will speak clearly and distinctly.
5. The general rules are:
   a. Answer the phone in a timely manner (3 rings or less is preferable)

b. Answer the phone in a pleasant and professional manner.
c. Identify yourself and the name of the clinic.
d. Route the call to the appropriate person, i.e., physician, nurse/PT, etc. if medically related
e. Take a message when the recipient is unavailable at the time of call and will include:
    i. The name of the caller
    ii. The purpose of the call
    iii. The telephone number where they can be reached
    iv. The best time to return the call
    v. If appropriate, ask if you can assist them

6. To decrease the interruptions to the clinic session:
    a. Determine the priority or urgency of the call
    b. Explain the reason the intended recipient may not be able to answer at this time, i.e., "The doctor is with a patient at this time."
    c. Take a message, as indicated in "e." above
7. To minimize the caller's waiting time, route the calls as soon as feasible and ensure they are received.
8. For inquires about the services of the clinic:
    a. Succinctly explain the services of the clinic
    b. Determine the purpose of the inquiry
    c. Schedule an appointment, if appropriate, with the proper physician/service (clinical staff to assist with triage).
    d. Request demographic data per Intake form:
        i. Provide directions to the clinic
        ii. Instruct patient to bring medication list, insurance information/card, as well as other pertinent medical information/diagnostic tests, referral documents, etc.
        iii. Instruct patient to arrive 30 minutes early for first visit to complete necessary information forms.
9. As time permits, call all scheduled patients 1-2 days prior to their appointment to confirm date and time.
10. When a patient misses their appointment, attempt to reach the patient by phone to ascertain the cause, and reschedule the appointment.
11. Significant patient-related calls will be documented in the patient record by the clinical staff.

Tri-City Health Care District
Oceanside, California

WOUND CARE CENTER
HYPERBARIC CLINIC

ISSUE DATE: 06/07 **SUBJECT: Transportation**

REVISION DATE(S): 12/10

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/10**

A. **PURPOSE**

1. The treatment plan may be adversely affected because of unreliable or lack of consistent transportation. This policy identifies the various resources available to meet the transportation needs of the patient.

B. **POLICY**

1. Any patient seeking medical attention at the Center will be assessed for adequacy of transportation.
2. Patients with transportation requirements will be identified during the admission process and anytime while in the treatment program.
3. Reasonable effort will be made to assist patients with transportation requirements.

C. **PROCEDURE**

1. During the patient telephone inquiry prior to admission, patients will be queried about their mode of transportation.
2. On admission day, patients will be asked how they will be transported for each visit.
3. While in the treatment program, patients who do not present for their scheduled visit will be queried about transportation.
4. The Center will assist patients identified with transportation needs by the following means:
   a. Use of the hospital van service, if patient lives within the service area
   b. Access transportation through the city or county programs
   c. Access transportation trough the patient's managed care group, HMO, etc., if appropriate.
   d. Investigate the possibility of having family member/friend/church member committing to transport the patient
   e. Contact the Social Services Department for assistance

D. After exhausting the above recommendations, hospital Administration will be contacted, and the patient will be evaluated; approval/disapproval for financial assistance for transportation will be obtained.

Tri-City Health Care District
Oceanside, California

WOUND CARE CENTER
HYPERBARIC CLINIC

ISSUE DATE: 06/07 **SUBJECT: Wound Measurement**

REVISION DATE(S): 12/10

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/10**

A. **PURPOSE**

1. Appropriate and consistent wound measuring is necessary to accurately assess wound healing. This document describes the appropriate procedure for obtaining wound measurements at the Center.

B. **POLICY**

1. To the extent possible, clinic staff members will utilize a consistent wound measurement procedure delineated in this policy.
2. It is the responsibility of the clinical manager to ensure that clinic staff members are competent in the approved wound measurement method and follow the prescribed procedures.
3. Photographs are taken of all new wounds, when measurable wounds are present:
   a. A measurable wound is defined as one that measures greater than 0.5cm x 0.5cm x 1cm at the time of initial assessment. If clinically significant, smaller wounds are documented. Stage I (non-blanchable erythema) wounds typically are not considered a measurable open wound in the wound care program. Stage I wounds may be documented in the narrative portion of the clinician's notes.
4. Each wound will receive a number at the initial visit and when a new wound develops (the order of the numbering is not specified for the initial measurements).
5. For multiple wounds at one site, a photograph of the entire area will be taken and numbering will be done on the photo, as well as the progress notes, for reference at subsequent visits.
6. Wounds that have been debrided with an associated charge for service and/or receive dressings or treatment orders must be numbered, measured at all clinic visits, and followed to outcome.

C. PROCEDURE

1. Materials:
   a. Disposable measuring tape
   b. Exam gloves
   c. Sterile cotton-tipped applicator
   d. Progress notes
2. Procedure:
   a. Apply exam gloves
   b. Remove dressing
   c. Measure the wounds in centimeters or as instructed by hospital, using disposable measuring tape and cotton-tipped applicator to probe wounds as indicated. Probing is

performed using the cotton-tipped end (using the wooden end can be harmful to the tissue and may leave wood fragments in the wound).

i. NOTE: Post-debridement measurements may be documented when debridement significantly alters the wound size.

d. Measure the longest axis of the wound to document length.

e. Measure perpendicular to the long axis of the wound to document width.

f. Using the cotton-tipped applicator, cotton-side down, measure the deepest part of the wound by placing the first applicator perpendicular to the wound bed and the other applicator at a 90° angle to the first applicator at the wound margin/skin surface interface for the depth. Use tape measure to measure from the tip of applicator to where the applicators intersect (90° angle).

D.

E.

F.

G.

H.

I.

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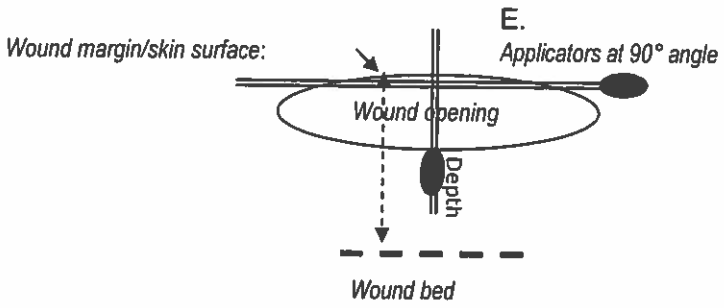
K.

L.

M.



i. Note: For data entry purposes, the minimum depth as at least 0.1cm (not zero) until the wound is healed.

b. Undermining/tunneling: probe with a cotton-tipped applicator to determine the extent of the undermining, tunneling, sinus tracts or folds. If there are multiple areas of undermining, etc., record the longest measurement obtained. If there is no undermining, etc., record zero for the entry. Document the position of the undermining, etc. using clock positions, e.g., 3 o'clock (the patient's head being 12 o'clock), as a reference for subsequent visits.

c. When the wound is healed, all measurements are zero.

d. Record all measurements in the designated areas in the Progress Notes.

e. If a wound converts to 2 or more wounds or 2 or more wounds convert to 1, close out the wound by using a "C", assign the next available number(s) and take a new photograph.

f. Using the numbering and location of the wounds from the previous visit, measure all active wounds at each clinic visit.

g. Measurements do not have to be taken for clinic visits scheduled for other purposes, unless ordered by physician or a significant amount of time has lapsed between visits to warrant a full assessment. The RN/case manager and/or the clinic physician will make the decision.

Tri-City Health Care District
Oceanside, California

WOUND CARE CENTER
HYPERBARIC CLINIC

ISSUE DATE: 06/07

SUBJECT: Wound Staging

REVISION DATE(S): 12/10

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/10**

A. **PURPOSE**

1. Baseline staging/grading of wounds is necessary to:
   a. Provide a consistent method for classifying wounds
   b. Establish the degree of severity of all wounds
   c. Define/clarify interventions
   d. Assist in developing individualized treatment plans
2. This policy defines the procedure for staging/grading all wounds.

B. **POLICY**

1. All wounds will have appropriate assessment to include staging or grading, as appropriate.
2. Wounds are evaluated using the Pressure Ulcer Staging System, as described in the Agency for Health Care Policy and Research (AHCPR) Guidelines.
3. Diabetic foot ulcers will be graded using the Wagner Ulcer Classification System when hyperbaric oxygen therapy may be a consideration.

C. **PROCEDURE**

1. Staging
   a. Qualified clinical staff will stage the wounds.
   b. At the time of initial wound assessment, a stage is determined according to the table below. Note: The stage remains the same throughout the course of treatment unless:
      i. The initial stage is found to be in error - and/or
      ii. The level of tissue involvement increases during the course of treatment
   c. If the staging is changed, it is recorded in the progress notes in the designated area.
   d. The clinic physician will sign concurrence in the designated area of the progress notes. The clinical staff, as directed by the clinic physician, will make any adjustments to the wound description.

Staging System

STAGE	DESCRIPTION
I	Non-blanchable erythema of intact skin; the heralding lesion of skin ulceration.
II	Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater.
III	Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.
IV	Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures (for example, tendon or joint capsule). Note: Undermining and sinus tracts may also be associated with Stage IV pressure ulcers.
Note: When eschar is present, accurate staging of the ulcer is not possible until eschar has sloughed or the wound has been debrided.	

Source: AHCPR

GRADING

5. The *Wagner Ulcer Classification System* will be utilized for diabetic wounds of the lower extremities, when hyperbaric oxygen therapy (HBOT) is being considered.

Wagner Ulcer Classification System

GRADE	DESCRIPTION
1	Superficial diabetic ulcer
2	Ulcer extension • Involves ligament, tendon, joint capsule or fascia • No abscess or osteomyelitis
3	Deep ulcer with abscess or osteomyelitis
4	Gangrene to portion of forefoot
5	Extensive gangrene of foot

Reference: Wagner (1987) Orthopedic 10:163-72

Tri-City Health Care District
Oceanside, California

WOUND CARE CENTER
HYPERBARIC CLINIC

ISSUE DATE: 06/07

SUBJECT: Patient Changing Area

REVISION DATE(S): 12/10

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/10**

A. **PURPOSE**

1. To establish guidelines for keeping patients' personal belongings and for providing privacy for patient changing clothing for HBOT.

B. **POLICY**

1. Patients undergoing hyperbaric therapy will be required to dress in 100% cotton prior to entering the hyperbaric chamber (NFPA 99 Hyperbaric Facilities Guidelines).
2. An enclosed private area will be provided for each patient for changing into the required garments.
3. A locker or locked area will be provided for each patient undergoing HBOT.

C. **PROCEDURE**

1. When a patient enters the unit, the following steps will be taken to ensure they comply with the requires for approved clothing in the hyperbaric oxygen chamber and keep their valuables or personal belongings in a safe area.
   a. Patients will be provided with 100% cotton gown/scrubs by the hyperbaric staff
   b. Patients will dress/undress in the designated area.
   c. Patients shall be given a key for their lockers to ensure that their belongings are kept safe.
   d. The key is not allowed in the hyperbaric chamber, per NFPA 99. Patients may leave their keys outside the chamber within plain sight while undergoing therapy.
   e. After hyperbaric therapy, the patient shall remove their cotton gown/scrubs and place them in the provided covered soiled linen hamper.
   f. Locker keys will be turned in to the hyperbaric staff prior to the patient's departure from the Center.

COMPREHENSIVE PHARMACY SERVICES

Eravacycline (XERAVA™)

Formulary Considerations:
Most intra-abdominal infections resulting from perforations of the gastrointestinal tract or its appendages are polymicrobial. Enteric Gram-negative bacilli, Gram-positive cocci, and anaerobic microorganisms are the predominant pathogens.[1,2] Antimicrobial therapy is generally considered an adjunct to the use of appropriate source control in the treatment of intra-abdominal infections [Physical measures to eradicate focus of infection, prevent on-going contamination and ultimately to restore optimal anatomy and function]. However, in patients in whom source control is deferred, antimicrobial therapy plays a more definitive role. Please refer to additional recommendations from the CPS Clinical Team for specific considerations for minimizing the induction of resistance and maximizing cost-effectiveness in patients with cIAI of mild-moderate as well as those with high severity. (Key Pharmacy Points for the Adult Patient with Complicated Intra-Abdominal Infection.)

Eravacycline met non-inferiority criteria for complicated intra-abdominal infections and was FDA approved for this indication. Due to its expanded antimicrobial coverage, including *Acinetobacter* and various mechanisms of resistance that cause CREs (i.e. *Klebsiella pneumoniae* carbapenemases [KPCs], metallobetalactamases (MBLs), etc), it can be a useful agent in infections that have no other antimicrobial options or where antimicrobial options can cause more patient harm than benefit (i.e. colistin, polymyxin B). Therefore, although eravacycline has only been approved for complicated intra-abdominal infection, its pharmacokinetic properties are similar to that of other antibiotics in its class and we can be certain it can be useful to treat multi-drug resistance organism causing infections in other areas.

As part of antimicrobial stewardship conservation efforts, it is recommended that this antibiotic be restricted for infectious diseases (ID) use only. ID will ensure the judicious and appropriate use of eravacycline so that it will continue to be effective against future MDROs. Susceptibility testing will need to be ordered through microlab since the isolate will need to be tested at an outside reference laboratory.

Cost Impact:

Antimicrobial	Standard dose	Cost
Eravacycline (Xerava)	1mg/kg q12h	Assuming 100kg patient: $49/50mg vial = $196/day
Ceftazidime-avibactam (Avycaz)	2.5g q8h	Assuming normal CrCl: $333.52/2.5g vial = $1000.56/day

Recommendations
☐ Eravacycline should be added to inpatient formulary restricted to ID

Drug Class: Tetracycline[3]

FDA Approval: August 27, 2018[4]

Manufacturer: Tetraphase Pharmaceuticals, Inc.[2]

How Supplied: Injectable, 50 mg/10 mL (reconstituted; 63.5 mg eravacycline dihydrochloride) single dose vial[2]

Product Information Link: XERAVA Label (PDF) [2]

Indications: Complicated intra-abdominal infections in patients 18 years of age and older[2], due to *Escherichia coli, Klebsiella pneumoniae, Citrobacter freundii, Enterobacter cloacae, Klebsiella oxytoca, Enterococcus faecalis, Enterococcus faecium, Staphylococcus aureus, Streptococcus anginosus group, Clostridium perfringens, Bacteroides species, and Parabacteroides distasonis.*[1]

Background:
Eravacycline is a fully synthetic fluorocycline, a newer generation tetracycline bacteriostatic antibacterial agent which is structurally similar to tigecycline.[5] Its mechanism of action is primarily via the disruption of protein synthesis by binding to the bacterial 30S ribosomal subunit; consequently, preventing the incorporation of amino acids into peptides.[1]

Tetracyclines were discovered from actinomycetes soil bacteria and were first reported in the scientific literature in 1948.[6] Pfizer and Wyeth scientists enabled semisynthetic tetracycline agents to market.[4] Tetraphase Pharmaceuticals was founded specifically to commercialize the tetracycline technology platform.[4] The C7 and C9 substitutions in the eravacycline molecule are theorized to impart activity against tetracycline-specific resistance.[1]

Pharmacokinetics:
Eravacycline pharmacokinetics were evaluated in healthy adult volunteers receiving 1 mg/kg up to 3 mg/kg, administered over 60 minutes, every 12 hours for 10 days.[1] Eravacycline is highly protein bound (79-90%) and is primarily metabolized via CYP3A4 enzymes and flavin-containing monooxygenase proteins (FMO) mediated oxidation.[1] The pharmacokinetics are described in Table 1.

Table 1. Eravacycline pharmacokinetics[1]

Parameter	Mean value
Cmax (ng/mL) day 1	2125
Cmax (ng/mL) day 10	1825
AUC_{0-12} (ng × h/mL) day 1	4305
AUC_{0-12} (ng × h/mL) day 10	6309
t½ (h)	20
Vss (L)	321

AUC: Area under the curve; Cmax: Maximum concentration; $t_{1/2}$: Half-life; Vss: Steady-state volume of distribution

Mechanisms of resistance:
Efflux pumps and ribosomal protection proteins are the primary mechanisms responsible for resistance to tetracyclines and are present in both Gram-positive and Gram-negative bacteria.[7] Some species of Gram-negative bacteria also demonstrate innate resistance to tetracyclines due to specific lipopolysaccharide components in their outer membranes, drug degradation and rRNA mutations.[4] Unfortunately, the widespread use of tetracyclines in human and veterinary medicine led to the development of bacterial resistance leading to decreased utility for indications such as intestinal, respiratory, and urinary tract infections.[8]

Eravacycline resistance in some bacteria is associated with upregulated, intrinsic multidrug resistant (MDR) efflux, and 16s rRNA or certain 30S ribosomal proteins. Additionally, some beta-lactamase producing isolates may also confer resistance to eravacycline.[1, 9]

Efficacy and Safety:

Tetraphase pursued four non-inferiority studies (IGNITE1, 2, 3, 4) evaluating eravacycline for complicated urinary tract infections (2 and 3) and intraabdominal infections (1 and 4). Only IGNITE1 has been published. IGNITE 2 and 3 did not meet non-inferiority for their primary endpoints.

The IGNITE1 study[10] evaluated the efficacy and safety of eravacycline compared with ertapenem in complicated intra-abdominal Infections (cIAI), in 541 hospitalized adult subjects. Eravacycline was administered intravenously at a dose of 1 mg/kg every 12 hours, and it was compared to ertapenem 1 mg/kg every 24 hours, for a minimum of 4 days and a maximum of 14 days. Eravacycline and ertapenem treatment were stopped when symptoms cIAI resolved, there was treatment failure, or the maximum allowed number of infusion days was reached.

It is important to note that critically ill patients (e.g., immunocompromised, organ failure, less than 6-8 week prognosis) were excluded. The number of carbapenem-resistant *Enterobacteriaceae* (CREs), 18 in each group, is too low to positively evaluate a potential therapeutic comparison or superiority of eravacycline against these microorganisms. Interestingly, the baseline pathogens for which the incidence of favorable responses was at least 10% higher in the eravacycline treatment group compared with the ertapenem treatment group included *Streptococcus constellatus, Citrobacter freundii, Klebsiella pneumoniae,* and *Bacteroides thetaiotaomicron.* Additionally, the favorable response in patients with baseline *Acinetobacter baumannii* was 100% in both treatment groups (8/8 for eravacycline and 5/5 for ertapenem). Ten patients receiving eravacycline had persisting isolates: 6 *Escherichia coli* and 1 each *Bacteroides species, Clostridia perfringens, Enterococcus durans, Hemophilus parainfluenzae,* and *Pseudomonas aeruginosa.* In the ertapenem treated patients (N=271), there was 1 *E. coli*, 2 *Bacteroides* species, and 2 *streptococci.*[8]

Evidence summative statement for the IGNITE1 Study: *Eravacycline demonstrated non-inferiority (not worse) to ertapenem (within 10% non-inferiority margin, 95% CI) in hospitalized patients with cIAI.*

The IGNITE4 study[11,12] though completed, has not been published. However, its data has been pooled with IGNITE1 and served as the basis for the new drug application submitted to the US FDA. This study evaluated the efficacy and safety of eravacycline compared with meropenem in complicated intra-abdominal Infections (cIAI), in 500 hospitalized adult subjects. Eravacycline was administered intravenously at a dose of 1 mg/kg every 12 hours and it was compared to meropenem 1 mg/kg every 8 hours, for a minimum of 4 days and a maximum of 14 days. Eravacycline and meropenem treatment were stopped when symptoms of cIAI resolved, there was treatment failure, or the maximum allowed number of infusion days was reached.

Evidence summative statement for the IGNITE4 Study: *Eravacycline demonstrated non-inferiority (not worse) to meropenem (within 12.5% non-inferiority margin, 95% CI) in hospitalized patients with cIAI.*

Table 2 outlines additional details for the IGNITE1 and 4 studies in cIAI.

Table 2. Evidence Review

Study/Design/Time Frame	Subjects/Criteria	Comparators	Outcomes	Results	Comments
IGNITE 1 study (NCT01844856)[8] Phase 3 Randomized, Multicenter, Double-Blind, Double Dummy, Prospective, Parallel, Non-inferiority trial (within 10% non-inferiority margin, lower limit of the 2-sided 95% CI) – Complicated intra-abdominal infections (cIAI) August 2013- August 2014	– N=541 adults **Inclusion Criteria:** – Male or female participant hospitalized for cIAI – At least 18 years of age (and not over 65 years of age for participants in India) – Evidence of a systemic inflammatory response – Abdominal pain or flank pain (with or without rebound tenderness), or pain caused by cIAI that is referred to another anatomic area – Able to provide informed consent – If male: must agree to use an effective barrier method of contraception during the study and for 90 days following the last dose if sexually active with a female of childbearing potential – If female, not pregnant or nursing or, if of childbearing potential: either will commit to use at least two medically accepted, effective methods of birth control (for example, condom, oral contraceptive, indwelling intrauterine device, hormonal implant /patch, injections, approved cervical ring) during study drug dosing and for 90 days following last study drug dose or practicing sexual abstinence **Exclusion Criteria:** – Unlikely to survive the 6-8 week study period – Renal failure – Presence or possible signs of hepatic disease – Immunocompromised condition, including known human immunodeficiency virus (HIV) positivity (requiring anti-retroviral therapy or with CD4 count <300),	– Eravacycline 1 mg/kg IV q12h (N=270); lost to follow up (LTF) (N=19) vs – Ertapenem 1 g IV q24h (N=271); LTF (N=21) – For 4 to 14 days	**Primary:** – Clinical response at the test-of-cure (TOC) visit in the microbiological intent-to-treat (Micro-ITT) population **Secondary:** – Clinical response at the test-of-cure (TOC) visit in the modified intent-to-treat (MITT) population – Clinical response at the test-of-cure (TOC) visit in the clinically evaluable (CE) population Time Frame: TOC visit: 25-31 days after the first dose of study drug	Eravacycline vs ertapenem; N (%) **Micro-ITT:** Clinical cure – 191 (86.8%) vs. 198 (87.6%) Clinical failure – 19 (8.6%) 11 (4.9%) Indeterminate/missing – 10 (4.5%) vs. 17 (7.5%) Difference: -0.80% (95%CI, −7.1% to 5.5%) **MITT:** Clinical cure – 235 (87%) vs. 238 (88.8%) Clinical failure – 19 (7%) 15 (5.6%) Indeterminate/missing – 16 (5.9%) vs. 15 (5.6%) Difference: 1.8% (95%CI, −7.4% to 3.8%) **CE:** Clinical cure – 222 (92.9%) vs. 225 (94.5%) Clinical failure – 17 (7.1%) 13 (5.5%) Difference: -1.7% (95%CI, -6.3% to 2.8%)	– Primary and secondary endpoints met non-inferiority margin – Eravacycline is not worse than ertapenem in the treatment of adults with CIAI – Most infections in this study were polymicrobial (>90%) – Gram-negative or aerobic organisms were isolated in 82% of patients – ESBLs were encountered in 9% of subjects [90% of subjects had beta lactams preoperatively] **Safety:** – Treatment emergent adverse events were higher in the eravacycline (113/270) than the ertapenem treatment group (75/268) [Nausea 8.15% vs 0.75%, phlebitis 2.96% vs 0.37% were higher in eravacycline group] – Serious adverse events reported for 17/270 (6.3%) in eravacycline vs 16/268 (5.97%) in ertapenem arm – 9 deaths unrelated to study therapy: 3 in eravacycline and 6 in ertapenem arm [pulmonary embolism (N=2), respiratory failure (N=3),multisystem organ failure (N=1), cardiac rhythm disturbances (N=2),and cerebrovascular accident (N=1)

Study/Design/Time Frame	Subjects/Criteria	Comparators	Outcomes	Results	Comments
	acquired immune deficiency syndrome (AIDS), organ (bone marrow) transplant recipients, and hematological malignancy. Immunosuppressive therapy, including use of high-dose corticosteroids (for example, >40 mg prednisone or equivalent per day for greater than 2 weeks) – History of hypersensitivity reactions to tetracyclines, carbapenems, β-lactam antibiotics or to excipients contained in the study drug formulations – Participation in any investigational drug or device study within 30 days prior to study entry – Known or suspected current Central Nervous System disorder that may predispose to seizures or lower seizure threshold – Previously received eravacycline in a clinical trial **Antibiotic-related exclusions:** – Receipt of effective antibacterial drug therapy for cIAI for a continuous duration of >24 hours during the 72-hour preceding enrollment (however, participants with documented cIAI [that is, known baseline pathogen] who have received at least 72 hours of antibiotic therapy and are considered treatment failures may be enrolled. Treatment failure is defined as persistent fever and/or clinical symptoms; or the development of a new intra-abdominal abscess after ≥72 hours of antibiotic therapy), or – Receipt of ertapenem or any other carbapenem, or tigecycline for the current infection or – Need for concomitant systemic antimicrobial agents other than study drug				

Study/Design/Time Frame	Subjects/Criteria	Comparators	Outcomes	Results	Comments
	– Refusal of mechanical ventilation, dialysis or hemofiltration, cardioversion or any other resuscitative measures and drug/fluid therapy at time of consent – Known or suspected inflammatory bowel disease or associated visceral abscess – The anticipated need for systemic antibiotics for a duration of more than 14 days – Systemic malignancy that required chemotherapy, immunotherapy, radiation therapy or antineoplastic therapy within the previous 3 months or that is anticipated to begin prior to the Test-of-Cure (TOC) visit				
IGNITE 4 study (NCT02784704)[9,10,13] Phase 3 Randomized, Multicenter, Double-Blind, Double Dummy, Prospective, Non-inferiority trial (within 12.5% non-inferiority margin, of the 2-sided 95% CI) – Complicated intra-abdominal infections (cIAI) (N=199) – Complicated appendicitis (N=301) October 2016- July 2017	– N=500 adults **Inclusion Criteria:** – Male or female participant hospitalized for cIAI – At least 18 years of age – Evidence of a systemic inflammatory response – Abdominal pain or flank pain (with or without rebound tenderness), or pain caused by cIAI that is referred to another anatomic area – Able to provide informed consent – If male: must agree to use an effective barrier method of contraception during the study and for 14 days following the last dose if sexually active with a female of childbearing potential – If female, not pregnant or nursing or, if of childbearing potential: either will commit to use at least two medically accepted, effective methods of birth control (for example, condom, oral contraceptive, indwelling intrauterine device, hormonal implant /patch, injections,	– Eravacycline 1 mg/kg IV q12h (N=250) vs – Meropenem 1 g IV q8h (N=249); – For 4 to 14 days Lost to follow up not provided	**Primary:** Clinical response at the test-of-cure (TOC) Visit in: – Microbiological intent-to-treat (Micro-ITT) population **Secondary:** Clinical response at the test-of-cure (TOC) Visit in: – Modified intent-to-treat (MITT) population – Clinically evaluable (CE) population	**Micro-ITT:** Clinical cure – 177 (90.8%) vs. 187 (91.2%) – <u>Difference:</u> -0.4% (95% CI: -6.3%, 5.3%) **MITT:** Clinical cure – 231 (92.4%) vs. 228 (91.6%) <u>Difference:</u> – -0.8% (95% CI: -4.1%, 5.8%) **CE:** Clinical cure – 218 (96.9%) vs. 222 (96.1%)	– Primary and secondary endpoints met non-inferiority margin – Eravacycline is not worse than meropenem in the treatment of adults with cIAI – Baseline isolates were cultured from 400 patients – The most common Gram-negative pathogens in the study included *Escherichia coli (260), Bacteroides spp (182), Streptococci (152), Enterococci (146), Staphylococcus aureus (110), Klebsiella pneumonia (62), Pseudomonas (39)* **Safety:** – There were no treatment-related serious adverse events in the trial – Treatment-emergent adverse event rates were similar in

Study/Design/Time Frame	Subjects/Criteria	Comparators	Outcomes	Results	Comments
	approved cervical ring) during study drug dosing and for 14 days following last study drug dose or practicing sexual abstinence **Exclusion Criteria:** – Unlikely to survive the 6-8 week study period – Creatinine clearance of ≤ 50 milliliter (mL)/minute – Presence or possible signs of significant hepatic disease – Immunocompromised condition, including known human immunodeficiency virus (HIV) positivity, transplant recipients, and hematological malignancy – History of moderate or severe hypersensitivity reactions to tetracyclines, carbapenems, β-lactam antibiotics, or to any of the excipients contained in the study drug formulations – Participation in any investigational drug or device study within 30 days prior to study entry – Known or suspected current central nervous system (CNS) disorder that may predispose to seizures or lower seizure threshold (for example, severe cerebral arteriosclerosis, epilepsy) **Antibiotic-related exclusions:** – Receipt of effective antibacterial drug therapy for cIAI for a continuous duration of >24-hours during the 72-hours preceding randomization [however, participants with documented cIAI (that is, known baseline pathogen) who have received at least 72-hours of antibiotic therapy and are considered treatment failures may be enrolled. Treatment failure is		[Time Frame: TOC visit: 25-31 days after first dose of study drug]	Difference: – -0.8% (95% CI: -2.9%, 4.5%)	both treatment groups (37.2% eravacycline vs 30.9% meropenem) – The most commonly reported drug-related adverse events for eravacycline were infusion site reactions, nausea and vomiting, each occurring at a rate of less than 5%

Study/Design/Time Frame	Subjects/Criteria	Comparators	Outcomes	Results	Comments
	defined as persistent fever and/or clinical symptoms; or the development of a new intra-abdominal abscess after ≥72 hours of antibiotic therapy], or – Receipt of meropenem or any other carbapenem, or tigecycline for the current infection, or – Need for concomitant systemic antimicrobial agents effective in cIAI other than study drug – Refusal of mechanical ventilation, dialysis or hemofiltration, cardioversion, or any other resuscitative measures and drug/fluid therapy at time of consent – Known or suspected inflammatory bowel disease or associated visceral abscess – The anticipated need for systemic antibiotics for a duration of more than 14 days – Systemic malignancy that required chemotherapy, immunotherapy, radiation therapy, or antineoplastic therapy within the previous 3 months or that is anticipated to begin prior to the Test-of-Cure (TOC) visit – Known at study entry to have cIAI caused by a pathogen(s) resistant to one of the study drugs				

CE: Clinically evaluable; cIAI: Complicated intraabdominal infection; cUTI: Complicated urinary tract infections; ESBLs: Extended spectrum beta lactamases; LTF: Lost to follow up; Micro-ITT: microbiological intent-to-treat; MITT: Modified intent-to-treat; TOC: Test of Cure

Warnings: [1]
Avoid/do not administer eravacycline in patient populations at risk for the following:

- Hypersensitivity reactions for any known/history of such to any tetracycline.
- Tooth discoloration and enamel hypoplasia during tooth development (e.g., pregnancy, breastfeeding, infancy, childhood)
- Reversible inhibition of bone growth (e.g., pregnancy, infancy, breastfeeding, childhood)
- *Clostridium difficile* associated diarrhea (CDAD)
- Males may experience lower sperm count and fertility during treatment

Institute appropriate therapy for overgrowth of non-susceptible organisms, including fungi, with the use of eravacycline.[1]

Discontinue eravacycline if any of the following adverse reactions are suspected, including photosensitivity, pseudotumor cerebri, and anti- anabolic action which has led to increased BUN, azotemia, acidosis, hyperphosphatemia, pancreatitis, and abnormal liver function tests.[1]

Drug Interactions: [1]

- Concomitant use of strong CYP3A inducers decreases the exposure of eravacycline, which may reduce its efficacy.
- Anticoagulants: Eravacycline may decrease plasma prothrombin activity in patients who are on anticoagulant therapy. Patients on concomitant therapy may require downward adjustment of their anticoagulant dosage.
- Concomitant use of tetracyclines and penicillins may decrease the bactericidal effects of penicillin leading to drug antagonism. This combination should be avoided.[14]

Dosing:[1]
In adult patients: 1 mg/kg intravenously every 12 hours of eravacycline; infused over approximately 60 minutes every 12 hours for 4 up to 14 days.

Hepatic, not renal, dose adjustments are necessary when dosing eravacycline.[1]

- Child Pugh A and B severity- no adjustments needed
- Child Pugh C severity - 1 mg/kg every 12 hours on day 1; then mg/kg every 24 hours
- Concomitant use of a strong CYP3A inducer - 1.5 mg/kg every 12 hours
- Concomitant use of a weak or moderate CYP3A inducer – No dosage adjustment needed

Medication Safety Issues:
Look Alike Sound Alike Medications: Evaluation of formulary medication list is important with new drugs to market for possible safety concerns (i.e., similar drug names that have/may lead to confusion/errors, restrictions on administration routes or dosing to prevent medication errors.

Competes with: Ceftazidime-avibactam (Avycaz) on current formulary for CRE infections

Developed: 9/18
Updated: 2/20

References:

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[4] Drugs@FDA: FDA Approved Drug Products. Eravacycline (XERAVA). Available at URL: https://www.accessdata.fda.gov/drugsatfda_docs/appletter/2018/211109Orig1s000ltr.pdf. Accessed 09/11/2018.
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[7] Nguyen F, Starosta AL, Arenz S, et al. Tetracycline antibiotics and resistance mechanisms. Biol Chem. 2014;395(5):559-75.
[8] Thaker M, Spanogiannopoulos P, Wright GD. The tetracycline resistome. Cell Mol Life Sci. 2010;67(3):419-31.
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[11] Clinical Trial ID NCT 02784704. Efficacy and Safety Study of Eravacycline Compared With Meropenem in Complicated Intra-abdominal Infections (IGNITE4). Available at URL: https://clinicaltrials.gov/ct2/show/NCT02784704?term=eravacycline&recrs=e&phase=23&rank=2. Accessed September 12, 2018.
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[13] Tsai L, Horn P, Solomkin J et al. Results of IGNITE4: A Phase 3 Study to Evaluate the Efficacy and Safety of Eravacycline versus Meropenem in Complicated Intra-abdominal Infections. Platform Presentation at 28th ECCMID Madrid, Spain.April 21-24th. Encore Poster Presentation at the 2018 Annual MAD-ID, Orlando, FL May 2018.
[14] Passarell JA, Meagher AK, Liolios K, et al. Exposure-response analyses of tigecycline efficacy in patients with complicated intra-abdominal infections. Antimicrob Agents Chemother. 2008;52(1):204-10.

Community Healthcare & Alliance Committee (No meeting held in May, 2020)

Finance, Operations & Planning Committee (No meeting held in May, 2020)

Audit, Compliance & Ethics Committee (No meeting held in May, 2020)

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

April 30, 2020 – 4:00 o'clock p.m.
Meeting Held via Teleconference

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held via teleconference at 4:00 p.m. on April 30, 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 via teleconference 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
Dr. Mark Yamanaka, Chief of Staff
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 Nygaard to approve the agenda as presented. Director Chavez seconded the motion. The motion passed unanimously (7-0) with a roll call vote.

3. Pledge of Allegiance

   Director Grass led the Pledge of Allegiance

4. Public Comments – Announcement

   Chairperson Grass read the Public Comments section listed on the April 30, 2020 Regular Board of Directors Meeting Agenda.

Mr. Edmundo Garcia, CNA Labor Representative requested to speak under Item No. 10, Comments from Members of the Public.

5. March, 2020 Financial Statement Results – Mr. Ray Rivas, Chief Financial Officer

Mr. Rivas reported on the current month financials as follows (Dollars in Thousands):

- Net Operating Revenue - $25,789
- Operating Expense - $30,768
- EBITDA – ($3,164)
- EROE – ($4,467)

Mr. Rivas reported on current month Key Indicators as follows:

- Average Daily Census - 138
- Adjusted Patient Days – 7,695
- Surgery Cases – 424
- ED Visits – 3,966

Mr. Rivas commented on the impact COVID-19 has had on the March financials, largely due to the elimination of elective surgeries, reduction in ED visits, reduction in average daily census and purchase of additional supplies in anticipation of a surge. Mr. Dietlin provided information on the Cares Act and other federal funding which has not provided significant relief to the District.

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.

Dr. Yamanaka presented the April Credentialing Actions Involving the Medical Staff and Allied Health Professionals, the Rules and Regulations, Standardized Procedures and Privilege Forms.

There were no questions or comments by Board members.

It was moved by Director Chavez to approve the April 2020 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee. Director Younger seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**Reno**
ABSENT:	**Directors:**	**None**

b) Consideration of Rules & Regulations:

1) Division of Medicine Rules & Regulations – Revised
2) Division of Subspecialty Surgery Rules & Regulations – Revised

It was moved by Director Nygaard to approve the Rules & Regulations as presented and recommended by the Medical Executive Committee. Director Chavez seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**Reno**
ABSENT:	**Directors:**	**None**

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

It was moved by Director Nygaard to approve the Standardized Procedures as presented and recommended by the Medical Executive Committee. Director Chavez seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**Reno**
ABSENT:	**Directors:**	**None**

d) Consideration of Privilege Forms:

1) Physician Assistant - Revised
2) Orthopedic Surgery - Revised
3) RNFA – Revised

It was moved by Director Chavez to approve the Privilege Forms as presented and recommended by the Medical Executive Committee. Director Nygaard seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**Reno**

ABSENT: Directors: None

9. Consideration of Consent Calendar

It was moved by Director Younger to approve the Consent Agenda. Director Nygaard seconded the motion.

It was moved by Director Schallock to pull the FY2020 Financial Statement Audit Proposal. Director Younger seconded the motion.

The vote on the motion minus the pulled item via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**Reno**
ABSENT:	**Directors:**	**None**

10. Discussion of items pulled from Consent Calendar

Director Schallock requested that Mr. Rivas provide an overview of the Audit Engagement Letter and the cost compared to last year. Mr. Rivas reviewed the terms of the proposal which includes the regular Financial Statement Audit and the Single Audit which is a regulatory requirement due to our loan with HUD. Mr. Rivas stated the fees represent an overall increase of approximately 1% or a little less than $2,000.

10. Comments by Members of the Public

Chairperson Grass recognized Edmundo Garcia, CNA Labor Representative. Mr. Garcia delivered a message on behalf of the nurses and healthcare workers. He commented on the COVID-19 unprecedented healthcare crisis and the challenges it has placed on the front-line caregivers.

11. Comments by Chief Executive Officer

Mr. Steve Dietlin, CEO provided a detailed report on COVID-19's impact on Tri-City Medical Center from a financial as well as staffing standpoint. He explained that the hospital is preparing for the highest volumes ever seen yet experiencing the lowest volumes which creates the need for flexibility including staff flexing and furloughs.

Mr. Dietlin also commented on PPE shortages both county and nationwide and expressed appreciation for staff who have worked together to manage our usage.

With regard to COVID-19 testing, the hospital does have the capability to do on-site testing in a 30-45 minute time frame; however the challenge has been to get the cartridges to do the testing and this has been an issue county-wide.

Mr. Dietlin emphasized that hospitals continue to be a safe place to go.

A daily briefing is distributed to all staff and Board members which contains important information and data related to the Medical Center's response to the COVID-19 pandemic.

In closing, Mr. Dietlin thanked all of our team members and first responders as well as organizations that have donated food and supplies.

12. Board Communications

Director Chavez stated he supports the comments made by Mr. Dietlin with regard to our staff and their safety.

Director Chavez commented on the COVID-19 pandemic noting at the present time there are 3,042 reported cases in San Diego County with 761 hospitalizations. Of the 3,042 reported cases 151 of those are in Oceanside, Carlsbad and Vista. Currently there are five positive COVID-19 inpatients at Tri-City Medical Center. He urged everyone to mask up and practice good hand hygiene and social distancing.

Both Director Coulter and Younger expressed their appreciation for everyone's hard work and Administration's efforts in maintaining a safe environment for front line staff.

Direction Reno had no comments.

Director Schallock expressed his appreciation to Mr. Dietlin for his informative update to the Board. He also expressed his appreciation to the physicians, nurses and all the staff for their hard work and dedication to our patients. Director Schallock commented that it is an extremely stressful time with many challenges which will continue for the foreseeable future.

Director Nygaard thanked the physicians, nurses and staff for the sacrifices they have made to keep our community healthy. She noted the importance of staying home and masking up and social distancing when it is necessary to be out in public.

13. Report from Chairperson

Chairperson Grass stated the COVID-19 Pandemic is unprecedented. Healthcare professionals are on the front line and they continue to provide compassionate support for our patients with a human touch.

Chairperson Grass also recognized the Environmental Services Staff for their sanitation efforts as well as the Food and Nutrition staff who continue to serve our patients with hot nutritious meals. She stated every staff member has a role and one is no more important than another. She expressed her appreciation from the C-Suite down.

4. There being no further business Chairperson Grass adjourned the meeting at 4:20 p.m.

Leigh Anne Grass, Chairperson

ATTEST:

Julie Nygaard, Secretary

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	15			207
FY19	18	29	19	27	18	24	22	16	23	30	25	24	226

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	5			86
FY19	10	12	3	7	7	9	10	4	16	15	11	12	93

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	7			103
FY19	19	16	12	16	12	16	17	13	18	16	10	15	155

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	14			248
FY19	20	23	18	22	17	21	19	16	18	12	20	24	186

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	38	33	23	31	35	31	26	29	20	12			273
FY19	31	31	27	35	38	31	23	40	36	24	29	36	316

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	-	-	-	-	-	-	-	-	-	3.0

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	7.0			6.4
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	6.7

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	6.3			9.6
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	10.3

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	124.0			145.0
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	154.0

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	113			1,485
FY19	186	202	170	187	185	166	170	150	177	131	146	156	1,724

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	5			98
FY19	8	10	6	8	3	15	6	9	11	10	20	13	86

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	5			90
FY19	3	4	3	13	13	6	11	17	6	10	7	9	86

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	4			55
FY19	8	8	6	8	4	14	8	10	16	6	7	5	88

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	1.69			1.83
FY19	1.79	1.83	1.90	1.78	1.78	1.70	1.72	1.73	1.75	1.82	1.80	1.79	1.78

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

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	50.5			57.8	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	53.1	

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	97.3			91.9	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	88.6	

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY20	($476)	($494)	($759)	($311)	($1,036)	($1,040)	($860)	($735)	($4,467)	$1,921			($8,257)	$684
FY19	($478)	($121)	$119	$254	$342	$236	($527)	$99	$206	$885	$904	($6,138)	$1,015	

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%	9.94%			-3.03%	0.23%
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%	0.34%	

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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)	$3,159			$3,566	$ 12,455
FY19	$796	$1,168	$1,417	$1,561	$1,618	$1,544	$826	$1,468	$1,548	$2,219	$2,221	($4,712)	$14,165	

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%	16.35%			1.31%	4.23%
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%	4.77%	

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	7.02	7.27			6.76	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	6.86	

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	$51.2			
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	

Tri-City Medical Center — ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending April 30, 2020

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term 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
JDS FINCO LLC 499 N EL Camino Real Encinitas, CA 92024 V#83694	Approx 2,460	$2.15	(a)	7,011.00	05/01/20	05/30/21	**Oceanside MOB** 499 N EL Camino Real Encinitas, CA 92024	7082
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	04/30/20	**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				$ 178,225.47				

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending April 2020

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6185	ONS/ONCC CHEMOTHERAPY RENEWAL	41420 EDU	103.00	77154	DEBBIE KEVINS
6185	ONS/ONCC CHEMOTHERAPY RENEWAL	41420 EDU	103.00	82087	DIVINA SCHWARZEL
8532	CERNER TRAINING	40920 EDU	247.96	83606	LYNNE LUEDTKE
8740	PEDATRIC LIFE SUPPORT COURSE	41620 EDU	100.00	83708	MARIA DE JESUS BARRERA
8740	ADVANCED CRITICAL CARE COURSE	41620 EDU	160.00	79416	REBECCA SIMMONS
8740	CLINICAL NURSE SPECIALIST CERTIFICATION	41620 EDU	200.00	81826	MELINDA RUIZ
8740	POINT OF CARE SPECIALIST CERTIFICATION	41620 EDU	200.00	83710	REGIN CLENN ORTIZ
8740	PEDIATRIC ADVANCED LIFE SUPPORT	41620 EDU	200.00	83711	JENNIFER WYATT

**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.