TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
June 25, 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: 920 9941 8716; Passcode: 847016

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	Introduction & Welcome: Candice Parras, Chief, Patient Care Services	5 min.	Chair
6	May, 2020 Financial Statement Results	10 min.	CFO
7	New Business – a) Consideration to approve Resolution No. 799, A Resolution of the Tri-City Healthcare District Establishing the Appropriations Limit for Tri-City Healthcare District for the Fiscal Year Commencing July 1, 2020 and Ending June 30, 2021 b) Consideration to certify a recognized Employee Organization as the exclusive bargaining representative for the following classification of	5 min. 5 min.	CFO

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
	employees in Rehab Services and to accrete these into the existing SEIU-UHW Contract: 1) Speech Pathologist 2) Speech Pathologist, Lead		
8	Old Business - None	--	--
9	Chief of Staff a) Consideration of June 2020 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on June 22, 2020. b) Consideration of Rules & Regulations 1) Department of Pediatrics 2) Department of Family Medicine	5 min.	COS
10	Consideration of Consent Calendar ***Requested items to be pulled require a second.*** (1) Approval of Dr. Chris Guerin, Medical Director for the Diabetic Services program for a term of 24 months beginning July 1, 2020 through June 30, 20222, not to exceed an average of 16 hours per month or 192 hours annually, at an hourly rate of 16 hours per month or 192 hours annually, at an hourly rate of $150 for an annual cost of $28,800 and a total cost for the term of $57,600. (2) Approval of an agreement with Dr. John Lafata, Medical Director for the Utilization Review/DRG program for a term of 24 months, beginning July 1, 2020 through June 30, 2022, not to exceed 30 hours per month or 360 hours annually, at an hourly rate of $170, for an annual cost not to exceed $61,200 and a total cost for the term, not to exceed $122,400. (3) Approval of an agreement with Dr. Anitha Rajamanickam, Cardiovascular Health Institute Quality Committee Member, for a term of 12 months, beginning July 1, 2020 through June 30, 2021, not to exceed two hours per month at an hourly rate of $210.00 for an annual and term cost of $5,040. (4) Approval of an agreement with Dr. Mark Yamanaka, ICU Medical Director, for a term of 12 months, beginning July 1, 2020 through June 30, 2021, not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $175.00 for an annual and total term cost of $42,000. (5) Approval of an agreement with Drs. Sandra Lopez, Lisa Leonard, Melissa Hawkins, Christos Karanikkis, Maria Quan, Eimaneh Mostofian, Rahele Mazarei, Tannaz Ebrahimi-Adib, Jan Penvose-Yi, Marlene Pountney as the OB/GYN ED On Call coverage physicians for a term of 24 months, beginning July 1, 2020 through June 30, 2022, at a daily rate of $800 (weekday) and $1,000 (weekend/holiday), for an annual cost of $203,200, for weekdays and $111,000 for weekends/holidays for a total cost for the term of $628,400. (6) Approval of an agreement with Drs. David Amory, Eric Stark, David	10 min.	Standard

	Agenda Item	Time Allotted	Requestor

Daugherty, Andrew Hartman, Harish Hosalkar, Grant Seiden, as the Orthopedic ED On-Call coverage physicians for a term of 24 months, beginning July 2, 2020 through June 30, 2022, at a daily rate of $1,500 Monday-Friday and $1,650 Saturday-Sunday for a total cost for the term of $1,126,200.

(7) Approval of an agreement with North Coast Pathology Medical Group for Clinical & Anatomic Pathology Laboratory services for a term of 36 months, beginning July 1, 2020 through June 30, 2023, at an annual cost of $695,000 and a total cost for the term of $2,085,000.

(8) Approval of an agreement with Drs. Mark O'Brien and Richard Bart Day as Co-Medical Directors for the Hospitalist program for a term of 24 months, beginning July 1, 2020 through June 30, 2022, for up to 35 hours per month or 420 hours annually, at an hourly rate of $285 for an annual cost of $120,000 and a total cost for the term, not to exceed $240,000.

(9) Administrative & Board Committees

A. Policies

1) Patient Care Services Policies & Procedures
a) Activated Clotting Time Testing by Medtronic ACT Plus Procedure
b) Amnisure Placental Alpha – 1 Microglobulin (PAMG1) Test for Rupture of Fetal Membranes (ROM) – Procedure
c) Conflict – Ethical Issues in Managing Patient Care
d) Femostop Compression Device Procedure
e) Glucose Point of Care Testing using the Nova StatStrip Blood Glucose Meter Procedure
f) High Level Disinfection Procedure
g) Justice Involved Patients Policy
h) Nitrazine Test on Vaginal Fluid Procedure
i) Pulse Oximetry Procedure (DELETE)
j) Surgical Attire Policy
k) Surgical Skin Stapling
l) Urine PH Procedure (DELETE)

2) Administrative Policies & Procedures
a) Parking Program 261
b) Weapons on Medical Center Campus 284

3) Unit Specific – Infection Control
a) Epidemiologic Investigation of a Suspected Outbreak – IC 3
b) Hand Hygiene – IC 8
c) Management of Patients with HIV-Infection/AIDS – IC.8

4) Unit Specific – NICU
a) Admission and Discharge Criteria for the NICU
b) Breastfeeding for the Term and Late Pre-Term Infant in the NICU (DELETE)
c) Developmental Supportive Care in the NICU
d) High Risk Infant Follow-up Program
e) Palliative Care of the Neonates at the End of Life
f) Skin to Skin Contact (DELETE)

5) Unit Specific – Outpatient Specialty Clinic

	Agenda Item	Time Allotted	Requestor
	a) Specimen Transport (DELETE) **5) Unit Specific – Surgical Services** a) After Hours Tissue Receiving Policy b) Autologous Tissue Preservation and Storage c) Freeze-Dried Room Temperature Tissue Policy d) Scope of Service for Surgical Services Policy **6) Unit Specific – Wound Hyperbaric Oxygen Therapy** a) HBOT Consultant (10) Board Committees **A. Community Healthcare Alliance Committee** Director Chavez, Committee Chair *(No meeting held in June, 2020)* **B. Finance, Operations & Planning Committee** Director Nygaard, Committee Chair Open Community Seats – 0 *(No meeting held in June, 2020)* **C. Audit, Compliance & Ethics Committee** Director Younger, Committee Chair Open Community Seats – 0 *(No meeting held in June, 2020)* (11) Minutes – Approval of: a) May 28, 2020, Regular Meeting (12) Meetings and Conferences – None (13) Dues and Memberships - None (14) Reports (a) Dashboard – Included (b) Construction Report – None (c) Lease Report – (May, 2020) (d) Reimbursement Disclosure Report – (May, 2020) (e) Seminar/Conference Reports – None		CHAC Comm. FO&P Comm. Audit, Comp. & Ethics Comm. Standard
11	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
12	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
13	Comments by Chief Executive Officer	5 min.	Standard
14	Board Communications (three minutes per Board member)	18 min.	Standard
15	Report from Chairperson	3 min.	Standard
16	Total Time Budgeted for Open Session	1 hour	
17	Adjournment		

RESOLUTION NO. 799

A RESOLUTION OF THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT ESTABLISHING THE APPROPRIATIONS LIMIT FOR TRI-CITY HEALTHCARE DISTRICT FOR THE FISCAL YEAR COMMENCING JULY 1, 2020 AND ENDING JUNE 30, 2021 IN ACCORDANCE WITH ARTICLE XIII B OF THE CONSTITUTION OF THE STATE OF CALIFORNIA; CODE OF THE STATE OF CALIFORNIA

WHEREAS, Section 1 of Article XIII B of the Constitution of the State of California provides that the total annual appropriations of each local government shall not exceed the appropriations limit of such entity of government for the prior year, adjusted for changes in the cost of living and population, subject to certain specified exceptions in said Article; and

WHEREAS, Section 8 of Article XIII B of the Constitution of the State of California defines "Appropriations subject to limitation" of an entity of local government as "any authorization to expand during a fiscal year the proceeds of taxes levied by or for that entity and the proceeds of state subventions to that entity" (other than subventions made pursuant to new programs or services mandates by the State Legislature) "exclusive of refunds to taxes"; and

WHEREAS, Section 7910 of the Government Code of the State of California provides that each year the governing body of each local jurisdiction shall, by resolution, establish its appropriations limit for the following fiscal year pursuant to Article XIII B of the Constitution of the State of California at a regularly scheduled meeting or noticed special meeting; and

WHEREAS, the documentation used in determining the appropriations limit adopted in this resolution has been available to the public for fifteen (15) days prior to the adoption of this resolution.

NOW, THEREFORE, THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT DOES HEREBY RESOLVE AND ORDER AS FOLLOWS:

1. The appropriations limit for TRI-CITY HEALTHCARE DISTRICT, pursuant to Article XIII B of the Constitution of the State of California for the fiscal year commencing July 1, 2020 and ending June 30, 2021 is not to exceed $16,014,429.

2. In accordance with Section 2, Article XIII B of the Constitution of the State of California, any revenues received by TRI-CITY HEALTHCARE DISTRICT in excess of that

amount, which is appropriated in compliance with Article XIII B of the Constitution of the State of California, during the fiscal year shall be returned by a revision of tax rates or fee schedules within the next two subsequent fiscal years.

ADOPTED, SIGNED AND APPROVED this 25th day of June, 2020.

Leigh Anne Grass, Chairperson of the
TRI-CITY HEALTHCARE DISTRICT and
of the Board of Directors thereof

ATTEST:

Julie Nygaard, Secretary of the
TRI-CITY HEALTHCARE DISTRICT
and of the Board of Directors thereof

STATE OF CALIFORNIA)
)
COUNTY OF SAN DIEGO)

ss.

I, Julie Nygaard, Secretary of TRI-CITY HEALTHCARE DISTRICT and of the Board of Directors thereof, do hereby certify that the foregoing Resolution was duly adopted by the Board of Directors of said District at a Regular Meeting of said Board held on the 25th day of June, 2020, and that it was adopted by the following vote:

AYES:	**DIRECTORS:**	**None**
NOES:	**DIRECTORS:**	**None**
ABSTAIN:	**DIRECTORS:**	**None**
ABSENT:	**DIRECTORS:**	**None**

Julie Nygaard, Secretary
of the TRI-CITY HEALTHCARE DISTRICT
and of the Board of Directors thereof

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
June 10, 2020

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 6/26/2020 – 5/31/2022)

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 6/26/2020 through 5/31/2022:

- **BLASKIEWICZ, Donald MD/Neurosurgery(UCSD)**
- **FILIP, Irina MD/Psychiatry(Vituity)**
- **GARFF, Kevin MD/Ophthalmology(Prestera Eye Medical Group)**
- **LANE, Richard MD/Neurology (North County Neurology)**
- **LAUFIK, Martin MD/Radiology (San Diego Imaging)**
- **MEIXEL, Antonie MD/Neonatology (North County Neonatology)**
- **NUNEZ, Willie MD/Teleradiology (StatRad)**
- **OMURO, Arthur DO/Neurology (North County Neurology)**
- **PATEL, Cecil MD/Radiology (San Diego Imaging)**
- **PEROTTI, Deena MD/Anesthesiology (ASMG)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
June 10, 2020

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 7/01/2020 – 6/30/2022)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 7/01/2020 through 6/30/2022, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- AHMED, Mohammed, MD/Psychiatry/Active
- ARRIETA, Iris, MD/Obstetrics & Gynecology/Provisional
- BHARNE, Anjali, MD/Oncology/Active
- BOONJINDASUP, Aaron, MD/Urology/Active
- CHIANG, Pengta, MD/Emergency Medicine/Active
- CHU, James, MD/Pediatric Cardiology/Active Affiliate
- CLANCY, Tara, DO/Internal Medicine/Refer and Follow
- EL-SHERIEF, Karim, MD/ Cardiology/Active
- EVTIMOV, Stoimen, MD/Internal Medicine/Active
- FOSTER, Alexander, MD/Ophthalmology/Provisional
- GARNER, Darin, MD/Emergency Medicine/Active
- GOLD, Evan, DMD/Oral & Maxillofacial Surgery/Refer and Follow
- HERGESHEIMER, Charles, MD/Internal Medicine/Refer and Follow
- HOLMES, Russell, MD/Family Medicine/Active
- KARANIKKIS, Christos, DO/Obstetrics & Gynecology/Active
- KOKA, Anuradha, MD/Radiation Oncology/Active Affiliate
- KRALL, Peter, MD/Ophthalmology/Active
- MATTHEWS, Oscar, MD/ Cardiology/Active

Attachment B

- MCCAMMACK, Bradley, MD/Pediatrics/Active
- MILLER, Jeffrey, MD/Diagnostic Radiology/Active
- MOVAHHEDIAN, Hamid, MD/Neonatology/Active
- NAUDIN, Veronica, MD/Pediatrics/Active
- PAZ, Alejandro, MD/Family Medicine/Refer and Follow
- PENRY, Jackson, MD/Diagnostic Radiology/Active
- PERKINS, Rachel, MD/Pediatrics/Active
- PHAM, Martin, MD/Neurological Surgery/Provisional
- RYEL, Justin, MD/Emergency Medicine/Provisional
- SHETH, Manish, MD/Psychiatry/Active
- SOUZA, Victor, MD/Internal Medicine/Active
- SUBRAMANIAN, Rupa, MD/Oncology/Active
- VRIDHACHALAM, Sanjeevi, MD/Teleradiology/Active Affiliate
- WADHWA, Ashish, MD/Otolaryngology/Active Affiliate

RESIGNATIONS: (Effective date 6/30/2020 unless otherwise noted)

Automatic Resignation:

- PRETORIUS, Gert, MD/Thoracic Surgery

Voluntary:

- CLARKSON, Chunjai, MD/Obstetrics & Gynecology
- NGUYEN, Vu, MD/Dermatology
- PERRICONE, Anthony, MD/Cardiothoracic Surgery
- VASHISHTA, Rishi, MD/Anesthesiology

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
June 10, 2020

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

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

- **STERN, Mark, MD** — **Orthopedic Surgery**

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given two extensions months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and are approved for an additional 3 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by **September 30, 2020** would result in these privileges automatically relinquishing.

- **AFRA, Robert, MD** — **Orthopedic Surgery**
- **ANTOUN, David, MD** — **Internal Medicine**
- **COHEN, David, MD** — **Cardiology**
- **JAMSHIDI-NEZHAD, Mohammad, DO** — **General and Vascular Surgery**
- **KUSHNARYOV, Anton, MD** — **Otolaryngology**
- **SHIN, Heamin, DPM** — **Podiatric Surgery**

ADDITIONAL PRIVILEGE REQUEST (Effective 6/25/2020)

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

- **ANTOUN, David MD** — **Internal Medicine**
- **BARCARSE, Erin MD** — **OB/GYN**

VOLUNTARY RELINQUISHMENT OF PRIVILEGE (Effective 6/25/2020)

The following practitioners relinquished the following privilege(s):

- **KABRA, Ashish MD** — **Cardiology**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
June 10, 2020

PROCTORING RECOMMENDATIONS

- **KUSHNARYOV, Antoun MD** **Otolaryngology**

I. **MEMBERSHIP**

The Department of Pediatrics consists of physicians who are board certified by the American Board of Pediatrics or are board-eligible; having completed an ACGME approved residency in Pediatrics, and who are actively progressing towards certification. Pediatricians who admit and care for neonates in the Neonatal Intensive Care Unit (NICU) must be members of the Division of Neonatology.

II. **FUNCTIONS**

The general functions of the Department of Pediatrics shall include:

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

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

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

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

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

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

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

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

I. Approve On-Going Professional Practice Evaluation (OPPE) indicators and formulate thresholds; and
   Formulate recommendations for Department rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. **DEPARTMENT MEETINGS;**

The Department of Pediatrics meets quarterly and no less than three (3) times per year or at the discretion of the Chair

Twenty-five percent (25%) of the Active Department members, but not less than five (5) members, shall constitute a quorum at any meeting.

IV. **DEPARTMENT OFFICERS**

A. The Department shall have 3 officers: a Chairperson, a Vice-Chairperson, and a Quality Review Representative. The officers must be members of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the Department. The Vice-Chairperson shall be the Chairperson-Elect and may also serve as the Quality Review Representative.

B. The Chairperson and Vice-Chairperson shall be elected every two years by the Active members of the Department who are eligible to vote. The Chair shall be elected by a simple majority of the members of the Department. The notice for elections is given at least one month prior to the meeting date.

C. The Department Chair shall serve a two-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses Medical Staff membership or clinical privileges in the department. Department officers shall be eligible to succeed themselves if elected.

D. The Vice-Chairperson succeeds the Chairperson after his/her term has expired unless there is an objection by a majority of the Active members of the Department who are eligible to vote.

E. The Quality Review Representative serves a two-year term and is elected by the Active members of the Department who are eligible to vote. The Quality Review Representative serves as the Chair of the Pediatric Quality Review Committee (QRC), and attends Medical Staff QA/PI/PSC meetings. Every effort will be made to appoint members to the QRC from each major group and a representative from the unassigned call panel for ED.

V. DUTIES OF THE DEPARTMENT CHAIR

A. The Department Chair shall assume the following responsibilities:

1. Be accountable for the professional and administrative activities of the Department;
2. Ongoing monitoring of the professional performance of all individuals who have delineated clinical privileges in the Department.
3. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form.
4. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department;
5. Recommend clinical privileges for each member of the Department;
6. Assure that the quality, safety and appropriateness of patient care provided by members of the Department are monitored and evaluated; and
7. Other duties, as recommended from the Medical Executive Committee.

VI. PRIVILEGES

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

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

C. Requests for privileges in the Department of Pediatrics are evaluated based on the practitioner's education, training, experience, demonstrated professional competence and judgment, active clinical performance, documented cases of patient care and are granted based on department specified criteria. Recommendations for privileges are made to the Credentials Committee and to the Medical Executive Committee. Practitioners practice only within the scope of their privileges as defined within these Rules and Regulations.

~~1. **Nurse Practitioners:** Nurse practitioner means a registered nurse who posseses additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary care and who has been prepared in a program. The nurse practitioner shall function under standardized procedures or protocols covering the care delivered by the nurse practitioner. The nurse practitioner and his/her supervising physician who shall be a pediatrician will develop the~~

~~standardized procedure or the protocols with the approval of the Department of Pediatrics.~~

D. Classifications of Newborns:
   1. Level 1: Newborns greater than 2000 grams and 35 6/7 weeks GA, without any of the diagnoses or symptoms listed in VI (E)(2).
   2. Level 2: Newborns needing intermediate or continuing care; criteria as follows:
      i. Weight greater than 2000 grams at birth, r/o sepsis during an observational period, if consistently stable without additional signs of illness.
      ii. Tachypnea, TTN, or other mild respiratory illness, otherwise stable, with oxygen needs <40%, and no oxygen needs over six (6) hours.
      iii. Hypoglycemia (without other risk factors such as suspected sepsis or respiratory distress) with a normal exam and stable vital signs, responsive to oral therapy.
      iv. Feeding problems in a newborn greater than 2000 grams and 35 6/7 weeks gestational age (GA), with no concerns about GI perforation or anomalies.
   3. Hyperbilirubinemia requiring phototherapy, unlikely to require an exchange transfusion, otherwise stable, currently 35 6/7 weeks GA and 2000 grams.

If the infant status changes to meet the Level 3 criteria (per NICU unit-specific policy "Admission and Discharge Criteria for the NICU"), a neonatology consult is required. The consultation will be requested by the attending pediatrician who, in collaboration with the neonatologist, will determine if care should be transferred to a neonatologist.

VII. REAPPOINTMENT OF CLINICAL PRIVILEGES

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

VIII. PROCTORING OF PRIVILEGES

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

B. All Active members of the Department will act as proctors. It is the responsibility of the Department Chair to inform the monitored member whose proctoring is being continued whether the deficiencies noted are based on current clinical competence, practice behavior, or the ability to perform the requested privilege(s). Colleagues who cover on-call for an assigned proctor should be aware, accessible, and amenable to providing proctoring in the place of that member, if needed.

C. For invasive cases, proctor must be present for the procedure for a sufficient period of time to assure himself/herself of the member's competence. For noninvasive cases the proctor may review case documentation (i.e. H&P) entirely to assure himself/herself of the practitioner's competence.

D. In elective cases, arrangements shall be made prior to scheduling i.e., the proctor shall be designated at the time the case is scheduled.
E. The member shall have free choice of suitable consultants and assistants.
F. When the required number of cases has been proctored, the Department Chair must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.
G. A form shall be completed by the proctor and should include comments on diagnosis, procedural technique, and overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Medical Staff Office.
H. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.
I. Members of other departments, such as the Emergency Department or Anesthesiology Department, can proctor an appropriate procedure, but cannot proctor admissions.
J. It is the responsibility of the member to notify a proctor when one is needed.

IX. DEPARTMENT QUALITY REVIEW AND MANAGEMENT

The Department of Pediatrics will have a Quality Review Committee (QRC) comprised of no less than four (4) Department members. The QRC chair is the Department's representative to the Medical Staff Medical Quality Peer Review Committee. QRC members are able to succeed themselves. The QRC will meet at least four (4) times per year. Refer to Section II "FUNCTIONS" above as applicable.

A. General Function

The QRC provides systematic and continual review, evaluation, and monitoring of the quality and safety of care and treatment provided by the Department members and to pediatric patients in the hospital.

X. NICU M&M COMMITTEE

XI. The Department of Pediatrics will have an NICU Mortality & Morbidity (M&M) Committee that will meet together with Pediatric Quality Review Committee at least quarterly to discuss neonatal cases and issues related to neonatal care. The NICU M&M shall be composed of the members of the Neonatology Division. Representatives from the Department of Obstetrics/Gynecology shall be invited. Nursing or respiratory may also be invited to discuss any issues pertinent to a specific case. The Committee shall maintain a record of its activities and report to the Department of Pediatrics QRC. NICU Mortality & Morbidity (M&M) Committee shall report any inquiries to NICU Perinatal Collaborative meeting.

~~The Department of Pediatrics will have an NICU Mortality & Morbidity (M&M) Committee that meets at least quarterly to discuss neonatal cases and issues related to neonatal care. The NICU M&M shall be composed of the members of the Neonatology Division. Representatives from the Department of Obstetrics/Gynecology and nursing shall be invited. The Committee shall maintain a record of its activities and report to the Department of Pediatrics QRC.~~

APPROVALS:

Department of Pediatrics: ~~8/17~~ 6/20
Medical Executive Committee: ~~3/18~~

Board of Directors: ~~3/18~~

I. **MEMBERSHIP**

The Department of Family Medicine consists of members who have successfully completed an accredited residency program in Family Medicine and are Board Certified or Board Eligible in Family Medicine, or have successfully completed comparable training. This would include Doctors of osteopathy who have been Board Certified or are Board Eligible by the American Osteopathic Board of General Practitioners or its equivalent. Grandfather clause: Established members of the department who do not meet these criteria may remain members of the Family Medicine Department if they otherwise are in compliance with departmental/medical staff rules and regulations.

II. **RESPONSIBILITIES**

The Department of Family Medicine shall be responsible for assuring ethical and professional practice of its staff member(s) and shall be dedicated to safe, quality and high standards of patient care.

III. **SCOPE OF SERVICE**

A. Diagnosis and management of acute, chronic, and emergency medical and surgical conditions.
B. Provision of medical care and service provided in the inpatient, emergency room, and outpatient setting.
C. Performance of invasive and non-invasive diagnostic and therapeutic modalities.

IV. **FUNCTIONS**

The general functions of the Department of Family Medicine shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department and the
B. Recommend to the Medial Executive Committee guidelines for the granting of clinical privileges.
C. Conduct, participate in, and recommend continuing medical education programs pertinent to the department clinical practice.
D. Review and evaluate department adherence to:
    1. Medical Staff Policies and Procedures
    2. Sound principles of clinical Medicine
E. Submit written minutes to the Medical Quality Peer Review Committee and Medical Executive Committee concerning:
    1. The department's review and evaluation activities, action taken thereon, and the results of such action;
    2. Recommendations for maintaining and improving of the quality of patient care and patient safety provided in the department and the hospital;
    3. Recommend/request Focused Professional Medicine Evaluation as indicated for Medical Staff members (pursuant Medical Staff Policy #509);
    4. Approval of On-going Professional Medicine Evaluation Indicators.
F. Establish such committees or other mechanisms as necessary and desirable to perform properly the function assigned to it, including proctoring. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified.
G. Formulate recommendations for Department Rules and Regulations reasonable necessary for the proper discharge of its final responsibilities subject to the approval of the Medical Executive Committee.

V. **DEPARTMENT MEETINGS**

A. Frequency: The Department of Family Medicine shall meet at least quarterly and at the discretion of the chair for additional meeting requests. The department will consider findings from the

ongoing monitoring and evaluation of the quality and appropriateness of care and treatment provided to patients. Minutes shall be transmitted to the Medical Quality Peer Review Committee and the Medical Executive Committee on a quarterly basis.

B. Quorum: Twenty-five (25) percent of the active department members, but not less than two members, shall constitute a quorum at any meeting.

VI. **DEPARTMENT OFFICERS**

A. The department shall have a Chairman who shall be a member of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in the clinical areas covered by the department.

B. The Department Chairman shall be elected two years by the Active Staff members of the department who are eligible to vote. Vacancies of any office for any reason shall be filled for the unexpired term through a special election.

C. The Department Chairman shall serve a ~~one~~two-year term which coincides with the Medical Staff year unless they resign, are removed from office, or lose their Medical Staff membership or clinical privileges within the department. Department officers shall be eligible to succeed themselves.

VII. **DUTIES OF THE DEPARTMENT CHAIRMAN**

The Department Chairman shall assume the following responsibilities of the Department:

A. Be accountable for all professional and administrative activities within the department;

B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the department;

C. Recommend to the Medical Executive Committee the criteria for clinical privileges in the department;

D. Recommend clinical privileges for each member of the department;

E. Assure that the quality and appropriateness of patient care only within the scope of their privileges as defined within their delineated privilege card;

F. Assure that the quality, safety and appropriateness of patient care provided with the Department are monitored and evaluated through Ongoing Professional Practice Evaluation;

G. Continuously assess and improve the quality of care and safety services provided in the department.

H. Other duties as may be assigned, in accordance with the Medical Staff Bylaws;

I. Attend Medical Executive Committee Meetings.

VIII. **PRIVILEGES:**

Requests for privileges in Family Medicine shall be evaluated on the individual applicant's documented training and/or experience, demonstrated abilities, current clinical competence, judgment and character. Practitioners practice only within the scope of their privileges. Recommendations for privileges are made to the Credentials and Medical Executive Committee with the Hospital Board granting final approval in accordance with the Medical Staff Bylaws. All privileges for physicians are maintained on Tri-City Medical Center's Intranet and a hard copy within the Medical Staff Department.

IX. **REQUEST FOR PRIVILEGES**

Family Medicine: Physicians requesting Family Medicine privileges are qualified to admit and care for patients with medical problems without consultation. They are expected to have training and/or experience on a level commensurate with that provided by a residency in the specialty of Family Medicine or its equivalent, are qualified to write History and Physicals, and Consult notes for inpatients, outpatients, Emergency Room patients, and pre-op. Family Medicine Physicians are expected to ask for consultation when:

A. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life threatening illness.
B. Unexpected complications arise which are outside this level of competence.
C. Specialized treatment or procedures are contemplated with which they are not familiar.
   1. Pediatric: Physicians requesting pediatric privileges are qualified to care for patients with medical problems without consultation. They are expected to have training and/or experience on a level commensurate with that provided by a residency in the specialty of Family Medicine or its equivalent. Physicians with this classification are required to obtain consultation by a pediatrician or other appropriate sub-specialist if the patient is not responding to the treatment being rendered.
   2. Obstetrics and Gynecology: Physicians requesting these privileges are qualified to care for uncomplicated obstetrical and/or gynecological patients. They are expected to have training and or experience on a level commensurate with that provided by residency in Family Medicine. Physicians with this classification are required to obtain consultation by an Obstetrician or other appropriate sub-specialist if the patient is not responding to the treatment being rendered.
   3. Surgical Assistant: Physicians requesting basic surgical privileges will be required to provide documentation of training and/or experience, demonstrated abilities, and current competence as stated in the Medical Staff Policy #536.

X. REAPPOINTMENT

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

XI. PROCTORING OF PRIVILEGES

A. Family Medicine Privileges
   1. Each physician's initial or additional privileges shall be proctored by a member of the Department of Family Medicine for at least six (6) cases or until his/her privilege status is established or by a recommendation from the department.
   2. If admitting into ACCU or IMC two (2) of the six (6) must be concurrent ICU/Telemetry cases, all other cases may be concurrently or retroactively reviewed. If at the conclusion of this proctoring process, the Chairman (based on the proctor's evaluation), cannot certify that the practitioner is qualified to perform unsupervised care with respect to the requested privileges, proctoring of additional cases will be required.
   3. Physicians applying for History and Physical privileges only may satisfy proctoring requirements by submitting 6 H&P's for retrospective or concurrent review.
   4. Applicants for Medical Staff privileges may utilize proctored cases from a hospital where they are on the Active Staff to meet the proctoring requirements, except for ICU/Telemetry privileges. ICU/Telemetry privileges will not be granted until two (2) cases are proctored satisfactorily at Tri-City Medical Center.
   5. Procedural privileges will be renewed if the minimum number of cases is met over a two-year period from any and all institutions where the physician has privileges. If the minimum number of cases is not performed, the physician will be required to undergo proctoring for all procedures that were not satisfied. If proctoring requirements are met, the physician will have his/her privileges renewed for a two-year period. If the proctoring requirements are not met, the physician will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

6. Supervision: Supervision of the member by the proctor will emphasize concurrent chart review and include direct observation in the case of procedural techniques.
7. Responsibility of Medical Staff member: The medical staff member must notify his proctor at the time of a case admission or procedure. If the proctor is not available the member must notify another physician. If the admission or procedure is being done on an emergent basis and no proctor is available, an appropriate proctor must be informed at the earliest appropriate time following the procedure.
8. Eligible Proctors: All active staff members of the Department of Family Medicine will act as proctors. An Associate of the new member may monitor 50% of the required proctoring.

B. Pediatric Privileges

Members requesting pediatric privileges must be proctored for at least two (2) cases by a Family Medicine physician who has been granted pediatric privileges, or a pediatrician. If the Chairman of the Department of Family Medicine cannot certify that the practitioner is qualified for unsupervised care of pediatric patients, additional cases will be required.

C. Obstetrical and Gynecological Privileges

1. Obstetrics: Members requesting obstetrical privileges must be proctored for at least five (5) cases by an Ob/Gyn or a Family Medicine physician who has been granted obstetrical privileges and has completed proctoring by demonstrating competency in these procedures. If the chairman of the Department of Family Medicine cannot certify that the practitioner is qualified for unsupervised care of obstetrical privileges, additional cases will be required.
2. Gynecology: Members requesting gynecological privileges must be qualified to medically care for uncomplicated gynecological patients. They must be proctored for at least five (5) satisfactory admissions by a family physician who has been granted gynecological privileges or an Ob/Gyn physician. If the chairman of the Department of Family Medicine cannot certify that the practitioner is qualified for unsupervised care of gynecological patients additional cases will be required.

XII. EMERGENCY DEPARTMENT CALL

A. Medical Staff department members will participate in the Emergency Department call Roster or consultation panel as determined by the medical staff (Ref. P&P #520).

B. Provisional or Courtesy Staff can be on the unassigned call panel at the discretion of the Department Chair after membership is approved by the Board of Directors.

C. It is the policy of the Emergency Department that when a patient indicates that he or she has been previously treated by a staff member, that member will be given the opportunity to provide further care. The contact member of the Department of Family Medicine will then determine whether to provide further care to an emergency department patient based upon the circumstances of the case. If the member declines, any necessary and/or special care will be provided by the on-call physician.

XIII. DEPARTMENT QUALITY REVIEW AND MANAGEMENT

The Department of Family Medicine Quality Review Committee will be combined with the Internal Medicine Quality Review Committee. The combined Quality Review Committee (Q.R.C.) will be comprised of no less than 2 department members for Family Medicine and 2 department members for Internal Medicine. The committee chairman will alternate between the Department of Family Medicine and the Division of Internal Medicine and each department/ division will have a representative to the Medical Staff QA/PI/PS Committee The Department Chairperson shall appoint the remaining members for a 2-year term. Committee members are able to succeed themselves. At least one member from each department/division will be on the Q.R.C., if possible. The Q.R.C. will meet at least four (4) times per year.

A. General Function: The Q.R.C. provides systematic and continual review, evaluation, and monitoring of the quality and safety of care and treatment provided by the department members and to patients in the hospital.

B. Specific Functions: The Q.R.C. is established to:
1. Identify important elements of patient care in all areas in which it is provided.
2. Establish performance monitoring indicators and standards that are related to these elements of care.
3. Select and approve their performance monitoring indicators.
4. Integrate relevant information for these indicators, and review quarterly by QRC Committee
5. Formulate thresholds for evaluation related to these performance monitoring indicators
6. Review and evaluate physician practice when specific thresholds are triggered
7. Identify areas of concern and opportunities to improve care, safety and educate department members based on these reviews.
8. Highlight significant clinical issues and present the specific information regarding qualify of care to the appropriate department member, in accordance with Medical Staff By-Laws.
9. Request, if needed, Focused Professional Practice Evaluation when/if questions arise regarding a physician's practice.
10. Monitor and review the effectiveness of any intervention and document any change.

C. Other functions:
1. Assist in the reappointment process, through retrospective review of charts.
2. Review any issues related to Family Medicine that are forwarded for review by other departments.
3. Assist in the collection, organization, review, and presentation of data related to patient care, safety, and department clinical pathways
4. Review cases involving death(s) in the hospital as applicable by approved departmental indicators.

D. Reports:
Minutes are submitted to the Medical Staff Medical Quality Peer Review Committee and the M.E.C. The Q.R.C. will provide minutes and as needed verbal or written communication regarding any general educational information gleaned through chart review or the Performance Improvement process to the department members and to Medical Quality Peer Review Committee.

APPROVALS:

Department of Family Medicine:	~~10/27/2016~~6/20
Medical Executive Committee:	~~11/28/2016~~
Board of Directors:	~~12/08/2016~~

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 25, 2020
Medical Director Agreement for Diabetes Services Program

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

Physician's Name: Chris Guerin, M.D.

Area of Service: Diabetic Services Program

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	24 month (Term) Cost
$150	16	192	$2,400	$28,800	$57,600

Position Responsibilities:

- Functions as the Medical Director for TCMC's Diabetes Program
- Develops, implements and monitors Diabetic planning to ensure patient care quality and regulatory compliance.
- TCMC's Diabetic Program has achieved certification from TJC. As a requirement to maintain accreditation the program must have physician oversight (i.e. Medical Directorship).

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: Diane Sikora, Sr. Director-Nursing Services / Candice Parras, Chief Patient Care Services Officer

Motion:
I move that the TCHD Board of Directors authorize Dr. Chris Guerin as the Medical Director for the Diabetic Services Program for a term of 24 months beginning July 1, 2020 and ending June 30, 2022. Not to exceed an average of 16 hours per month or 192 hours annually, at an hourly rate of $150 for an annual cost of $28,800, and a total cost for the term of $57,600.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 25, 2020
Medical Director Agreement for Utilization Review / DRG Program

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

Physician's Name: John LaFata, M.D.

Area of Service: Utilization Review / DRG Program

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

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES *(Verified by MD Ranger)*

Rate/Hour	Hours per Month Not to Exceed	Hours per Year Not to Exceed	Monthly Cost Not to Exceed	Annual Cost Not to Exceed	24 month (Term) Cost Not to Exceed
$170	30	360	$5,100	$61,200	$122,400

Position Responsibilities:

- CMS "Conditions of Participation" and California Title XXII requirement the Utilization Review (UR) committee ensures DRG program compliance
- Dr. LaFata is the Medical Director of the UR Committee and he provides physician input, committee direction and medical staff liaison
- Renewal same rate

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: Lisa Stroud, Director-Case Management / Scott Livingstone, Chief Operating Officer

Motion:
I move that the TCHD Board of Directors authorize Dr. John LaFata as the Medical Director for the Utilization Review / DRG program for a term of 24 months, beginning July 1, 2020 and ending June 30, 2022. Not to exceed 30 hours per month or 360 hours annually, at an hourly rate of $170, for an annual cost not to exceed $61,200, and a total cost for the term not to exceed $122,400.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 25, 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

Physician's Name: Anitha Rajamanickam, M.D.

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	$5,040	$5,040

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, Director-Cardiovascular Service Line / Scott Livingstone Chief Operating Officer

Motion:
I move that the TCHD Board of Directors authorize the agreement with Dr. Anitha Rajamanickam as a Cardiovascular Health Institute – Quality Committee members for a term of 12 months, beginning July 1, 2020 – ending, 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: June 25, 2020
PHYSICIAN AGREEMENT for Medical Director, Intensive Care Unit (ICU)

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

Physician's Name: Mark Yamanaka, M.D.

Area of Service: ICU

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	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 Month (Term) Cost
$175	20	240	$3,500	$42,000	$42,000

Position Responsibilities

- Provides clinical documentation
- Utilization review of program
- Evaluates and establishes policies and procedures and protocols for ICU
- Recommending, developing and implementing new services
- Facilitates effective communication
- Assists with interviewing new staff
- Assists in public education
- Attends hospital meetings as requested

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: Diane Sikora, Sr. Director-Nursing Services / Candice Parras, Chief Patient Care Services Officer

Motion:
I move that the TCHD Board of Directors authorize Dr. Mark Yamanaka as the ICU Medical Director for a term of 12 months, beginning July 1, 2020 and ending June 30, 2021. Not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $175 for an annual and total term cost of $42,000.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 25, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – OB/GYN

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

Physician's Names: Sandra Lopez, M.D.; Lisa Leonard, M.D.; Melissa Hawkins, M.D.; Christos Karanikkis, D.O.; Maria Quan, M.D.; Eimaneh Mostofian, M.D.; Rahele Mazarei, D.O.; Tannaz Ebrahimi-Adib, M.D.; Jan Penvose-Yi, M.D.; Marlene Pountney, M.D.

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

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: OB-GYN

OB-GYN - Rate/Day	Panel Days per Year	Panel Annual Cost
Weekday $800 Weekend/holiday $1000	FY21: 254 FY21: 111	$203,200 $111,000
Weekday $800 Weekend/holiday $1000	FY22: 254 FY22: 111	$203,200 $111,000
	Total Term Cost:	**$628,400**

Position Responsibilities:

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

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

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

Motion: I move that the TCHD Board of Directors authorize Drs. Sandra Lopez, Lisa Leonard, Melissa Hawkins, Christos Karanikkis, Maria Quan, Eimaneh Mostofian, Rahele Mazarei, Tannaz Ebrahimi-Adib, Jan Penvose-Yi, Marlene Pountney as the OB/GYN ED On-Call coverage physicians for a term of 24 months, beginning July 1, 2020 and ending June 30, 2022 at daily rate of $800 (weekday) and $1,000 (weekend/holiday), for the annual costs of $203,200 for weekdays and $111,000 for weekends/holidays for a total cost for the term of $628,400.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 25, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Orthopedics

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

Physician's Name: David Amory, M.D.; Eric Stark, M.D.; David Daugherty, M.D.; Andrew Hartman, M.D.; Harish Hosalkar, M.D.; Grant Seiden, M.D.

Area of Service: Emergency Department On-Call: Orthopedics

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: Orthopedics

Rate/Day	Panel Days per Year	Panel Annual Cost
Monday-Friday: $1,500	FY21 & FY22: 522	$783,000
Saturday-Sunday: $1,650	FY21 &FY22: 208	$343,200
	Total Term Cost:	**$1,126,200**

Position Responsibilities:

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

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

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

Motion: I move that the TCHD Board of Directors authorize David Amory, M.D.; Eric Stark, M.D.; David Daugherty, M.D.; Andrew Hartman, M.D.; Harish Hosalkar, M.D.; Grant Seiden, M.D., as the orthopedic ED On-Call coverage physicians for a term of 24 months, beginning July 1, 2020 and ending June 30, 2022, at a daily rate of $1,500 Monday-Friday and $1,650 Saturday-Sunday for a total cost for the term of $1,126,200.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 25, 2020
Medical Staff Leadership Agreement – Clinical & Anatomic Pathology Services

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

Physician's Name: Marcus Contardo, M.D. (North Coast Pathology Medical Group, NCPMG)
Area of Service: Clinical & Anatomic Pathology Services
Term of Agreement: 36 months, Beginning, July 1, 2020 – Ending, June 30, 2023
Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

Monthly Cost	Annual Cost	36 month (Term) Cost
$57,917	$695,000	$2,085,000

Position Responsibilities:

- NCPMG will exclusively provide all anatomic pathology and clinical pathology (laboratory medicine) professional services in the Department.
- NCPMG will provide an exclusive full-time pathologist Laboratory Director for the Clinical Laboratory and Department of Pathology.
- NCPMG will ensure that there are sufficient physicians available as needed and/or on-call for the Department seven days per week, 24 hours per day.
- NCPMG will provide oversight of all professional services in the Department.
- Assist TCHD in developing, implementing and evaluating a utilization review program, a quality assurance program and a risk management program for the Department.
- Assist TCHD in establishing and evaluating policies, procedures, and protocols for patient care in Pathology and Lab.
- Assist TCHD in meeting accreditation and licensing requirements of the College of American Pathologists, the Joint Commission, the FDA and the CA DHS.
- Assist TCHD in negotiating contracts with providers of outside materials and reference services to the Clinical Laboratory.

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: Scott Livingstone, Chief Operating Officer

Motion: I move that the TCHD Board of Directors authorize the agreement with North Coast Pathology Medical Group for Clinical & Anatomic Pathology Laboratory services for a term of 36 months, beginning July 1, 2020 and ending June 30, 2023 at an annual cost of $695,000, and a total cost for the term of $2,085,000.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 25,2020
PHYSICIAN AGREEMENT for HOSPITALIST PROGRAM CO-MEDICAL DIRECTORSHIP

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

Physician's Name(s): Mark O'Brien,D.O. and Richard Bart Day, M.D.
Area of Service: Co-Medical Directorship – Coastal Hospitalist Medical Associates, Inc.

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	Not to Exceed Hours per Month	Not to Exceed Hours per Year	Monthly Cost Not to Exceed	Annual Cost Not to Exceed	Total Term Not to Exceed
$285	35	420	$10,000*	$120,000	$240,000

***The amount was included in the total hospitalist coverage stipend per the renewal effective 9/1/2019.**

Position Responsibilities/Scope: Physicians will serve as Co-Medical Directors and shall be responsible for the medical direction of the hospitalist program and perform administrative services as outlined in the Hospitalist Services Coverage Agreement. Duties include:

- Establishing and evaluating policies, procedures and protocols for patient care
- Assure adequate coverage and supervision is provided for clinical services activities performed within Department during hours of operation
- Developing, implementing and evaluating a utilization review program, a quality assurance program and a risk management program
- Providing education to physicians regarding changes in medical standards of care and exceeding patient expectations
- Recommending, developing and implementing new services

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

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

Motion: I move that the TCHD Board of Directors authorize physicians Mark O'Brien,D.O. and Richard Bart Day, M.D. as Co-Medical Directors for the Hospitalist program for a term of 24 months, beginning July 1, 2020 and ending June 30, 2022, for up to 35 hours per month or 420 hours annually, at an hourly rate of $285 for an annual cost of $120,000 and a total cost for the term not to exceed $240,000.

ADMINISTRATION CONSENT AGENDA
June 16th, 2020

CONTACT: Candice Parras, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Activated Clotting Time Testing by Medtronic ACT Plus Procedure	2 Year Review	Forward To BOD For Approval
2. Amnisure Placental Alpha - 1 Microglobulin (PAMG1) Test for Rupture of Fetal Membranes (ROM) - Procedure	2 Year Review	Forward To BOD For Approval
3. Conflict- Ethical Issues in Managing Pt Care	3 Year Review, Practice Change	Forward To BOD For Approval
4. Femostop Compression Device Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
5. Glucose Point of Care Testing using the Nova StatStrip Blood Glucose Meter Procedure	Practice Change	Forward To BOD For Approval
6. High Level Disinfection Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
7. Justice Involved Patients Policy	3 Year Review	Forward To BOD For Approval
8. Nitrazine Test on Vaginal Fluid Procedure	2 Year Review, Practice Change	Forward To BOD For Approval
9. Pulse Oximetry Procedure	DELETE	Forward To BOD For Approval
10. Surgical Attire Policy	3 Year Review, Practice Change	Forward To BOD For Approval
11. Surgical Skin Stapling	3 Year Review	Forward To BOD For Approval
12. Urine PH Procedure	DELETE	Forward To BOD For Approval
Administrative Policies & Procedures		
1. Parking Program 261	3 Year Review, Practice Change	Forward To BOD For Approval
2. Weapons on Medical Center Campus 284	3 Year Review, Practice Change	Forward To BOD For Approval
Unit Specific		
Infection Control		
1. Epidemiologic Investigation of a Suspected Outbreak - IC 3	3 Year Review, Practice Change	Forward To BOD For Approval
2. Hand Hygiene - IC 8	3 Year Review, Practice Change	Forward To BOD For Approval
3. Management of Patients with HIV-Infection/AIDS - IC. 8	3 Year Review	Forward To BOD For Approval
NICU		
1. Admission and Discharge Criteria for the NICU	2 Year Review, Practice Change	Forward To BOD For Approval
2. Breastfeeding for the Term and Late Pre-Term Infant in the NICU	DELETE	Forward To BOD For Approval
3. Developmental Supportive Care in the NICU	2 Year Review, Practice Change	Forward To BOD For Approval

ADMINISTRATION CONSENT AGENDA
June 16th, 2020

CONTACT: Candice Parras, CNE

Policies and Procedures	Reason	Recommendations
4. High Risk Infant Follow up Program	2 Year Review, Practice Change	Forward To BOD For Approval
5. Palliative Care Of the Neonates at the End of Life	2 Year Review, Practice Change	Forward To BOD For Approval
6. Skin to Skin Contact	DELETE	Forward To BOD For Approval
Outpatient Specialty Clinic		
1. Specimen Transport	DELETE	Forward To BOD For Approval
Surgical Services		
1. After Hours Tissue Receiving Policy	NEW	Forward To BOD For Approval
2. Autologous Tissue Preservation and Storage	NEW	Forward To BOD For Approval
3. Freeze-Dried Room Temperature Tissue Policy	3 Year Review, Practice Change	Forward To BOD For Approval
4. Scope of Service for Surgical Services Policy	3 Year Review, Practice Change	Forward To BOD For Approval
Wound Hyperbaric Oxygen Therapy		
1. HBOT Consultation	3 Year Review	Forward To BOD For Approval

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**ACTIVATED CLOTTING TIME TESTING BY MEDTRONIC ACT PLUS**
Purpose:	To accurately measure the clotting time of heparinized patients.
Supportive Data:	Authorized to perform procedure: RN, LVN, Perfusionist, CV tech with appropriate orientation, training, and competency validation. ACT testing is under the direction, authority, jurisdiction and responsibility of the Laboratory Director.
Equipment:	Medtronic ACT Plus Medtronic ACTtrac (electronic QC) Temperature Verification Cartridge CLOTtrac HR controls Syringes, no larger than 10 mL 19 gauge blunt tip needle or other blood collection needle HR-ACT cartridges

A. **SPECIMEN:**

1. Fresh whole blood collected during angiogram or operative procedure, ~~four-hundred (400)~~ microliters per cartridge channel.
2. Fresh whole blood specimens should be tested as quickly as possible following sample collection. Test within sixty (60) seconds when there is no anticoagulant on board. Test within two (2) minutes when the sample is heparinized.

B. **PROCEDURE:**

1. HR-ACT Patient Test:
   a. From the Main Menu, select HR-ACT as the cartridge type.
      i. Note: Lot numbers and expiration dates for cartridges and controls must be entered prior to running a test (see below).
   b. Verify the correct Patient ID in the upper right hand corner of the screen. If the ID is not correct, from the Main Menu enter the Patient ID (10-digit financial number / i.e. 600 #) and User ID (employee ID) numbers.
   c. Pre-warm the cartridge for at least three (3) to five (5) minutes (up to twelve (12) hours).
   d. Tap or shake the HR-ACT cartridge to re-suspend the kaolin activator.
   e. Using a syringe and blunt tip needle, fill each cartridge chamber with the appropriate patient sample to the level between the fill lines (400 microliters per channel).
   f. Insert the cartridge into the ACT Plus, and close the actuator heat block to initiate the test.
   g. Clot formation is signaled by an audible tone, the actuator heat block opens and the results are displayed.
   h. Manually Transmit Patient Tests to the lab data manager and the patient's electronic **health record**~~chart~~: From the main menu, select Transmit Test Results. Select Transmit Patient Tests. Exit to the main menu.
2. To Remove and Add a New Cartridge Lot/ Exp Date:
   a. From the Main Menu select Cartridge Lot.
   b. Use the Up/Down arrows to select HR-ACT.
   c. Press Remove Lot.
   d. Use the Up/Down arrows to select and highlight the lot to be removed.
   e. Press Remove Selected Lot to delete the selected cartridge lot number.
   f. Press Add Lot Number and enter the lot number with the barcode scanner. The lot number and expiration date will populate their respective fields.

Patient Care Services Content Expert ~~Department~~ Review	Clinical Policies & Procedures	Nursing Executive Committee	Department of Pathology	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
01/07, 10/10,01/14, 11/15, 12/19	11/10, 02/14, 12/15, 01/20	11/10, 02/14, 01/16, 02/20	04/18, 04/20	03/14, 04/18, 05/20	06/20	01/11, 04/14, 05/18, n/a	01/11, 04/14, 05/18

3. To Remove and Add a New Control Lot/ Exp Date:
   a. From the Quality Control Menu select Control Lot.
   b. Use the Up/Down arrows to select the control type.
   c. Press Remove Lot.
   d. Use the Up/Down arrows to select and highlight the lot to be removed.
   e. Press Remove Selected Lot to delete the selected lot number.
   f. Press Add Lot Number and enter the lot number with the barcode scanner. The lot number and expiration date will populate their respective fields.
   g. Press Set Range and enter the control range.
   h. Press Enter to confirm the range.

C. **PRINCIPLE:**

1. The ACT Plus is a coagulation instrument intended for determining coagulation endpoints in fresh whole blood; the endpoint is formation of fibrin. The clotting times are performed in duplicate and the results for each channel, the average of the two channels and the difference are displayed.
2. High Range ACT (HR-ACT): The HR-ACT is a kaolin activated clotting time test performed on fresh whole blood where the heparin concentration is one (1) unit/ mL or higher.

D. **QUALITY CONTROL (QC):**

1. If proper QC is not performed or is out of range, the QC lockout feature will be engaged preventing patient testing until QC status is acceptable.
2. Quality Control testing for the ACT Plus is performed using a combination of liquid controls and electronic (ACTtrac) controls. According to Clinical Laboratory Improvement Amendments (CLIA) guidelines, two (2) levels of control for coagulation procedures should be performed every eight hours of patient testing.
3. Electronic Control: The ACTtrac is a battery-powered software used to identify instruments that no longer fall within mechanical calibration specifications.
   a. To perform an ACTtrac test:
      i. From the Main Menu, select ACTtrac as the cartridge type.
      ii. Enter zero (0) as the Patient ID and the appropriate User ID. (The system will not accept user ID's that have not been entered into the data management program).
      iii. Select the Quality Control menu. Select Control Type, press key until the same control range as selected on the ACTtrac is displayed. Verify the control lot #. Press Enter to confirm.
      iv. Place ACTtrac into the heat block and close to start the test. The test is complete upon hearing an audible tone with the results displayed.
      v. Push the Quality Control button again and select the second range to be tested by pressing the Control Type key until the same range to be tested on the ACTtrac is displayed. Press Enter to confirm.
      vi. Place ACTtrac into the heat block and close to start the test. The test is complete upon hearing an audible tone with the results displayed.
      vii. The ACT Plus will indicate if the QC passed or failed. This will complete the level one and level two electronic controls required every eight hours when the ACT Plus is in use.
4. Liquid Controls: Two (2) levels of liquid control are performed for the HR-ACT (CLOTtrac HR normal and abnormal). Used in conjunction with the ACTtrac electronic control, liquid controls are performed every seven days and with a change in cartridge lot number or new Shipment.
   a. Control storage and stability: Store controls in the refrigerator, between 2° and 10°C.
   b. Controls are stable until the expiration date on the package when stored at refrigeration temperatures. CLOTtrac controls are stable for two (2) hours following reconstitution.
   c. Preparation: Follow instructions on current package insert of controls if different than below.

i. Remove controls and deionized water diluent from the refrigerator and bring to room temperature for approximately ten (10) minutes.
ii. Add 1.8 mL of deionized water to the lyophilized sheep blood.
iii. Allow at least ten (10) minutes for adequate rehydration of the normal control and twenty-five (25) minutes for rehydration of the abnormal control. Do not agitate or mix until completely rehydrated.
iv. Shake the control vigorously to mix until the red blood cells are uniformly dispersed and the control is completely reconstituted.

d. Performance:
i. Select HR-ACT as the cartridge type.
ii. Enter zero (0) as the Patient ID and the appropriate User ID.
iii. Select Quality Control. Select Control Type, press key until the correct control HR-NM or HR-AB is displayed. Press Enter to confirm. The current control lot number will be displayed.
1) Note: Lot numbers and expiration dates for cartridges and controls must be entered prior to running a test (see below).
iv. Pre-warm the cartridge for at least three (3) to five (5) minutes (up to twelve [12] hours).
v. Tap or shake the HR-ACT cartridge to re-suspend the kaolin activator.
vi. Using a syringe and blunt tip needle, fill each cartridge chamber with the appropriate control to the level between the fill lines ~~(four-hundred (400)~~ microliters per channel).
vii. Insert the cartridge into the ACT Plus and close the actuator heat block to initiate the test.
viii. The ACT Plus will incubate the control sample for ~~three-hundred (300)~~ seconds and then begin the clot detection cycle.
ix. Clot formation is signaled by an audible tone, the actuator heat block opens and the results are displayed. The ACT Plus will indicate if the QC passed or failed.

5. Transmit Data: Quality Control Data must be manually transmitted to the laboratory data manager (via network connection). Each week, after performing liquid controls, transmit data.
a. From the Main Menu, select Transmit Test Results.
b. Press Transmit Unsent QC tests.
c. Press Transmit Unsent Patient tests.
d. Exit to the Main Menu.

E. CALCULATIONS:

1. The ACT Plus calculates the mean or average clotting time for the duplicate channels and the difference in seconds between channels when a High Range ACT test is performed.

F. REFERENCE RANGE:

1. Duplicate clotting times for the HR-ACT should fall within 10% of each other for baseline or normal samples and 12% of each other for prolonged or heparinized samples. The operable range of the Instrument is 25 – 999 seconds.
a. Normal Un-Heparinized Range: 96 – 172 sec
b. Therapeutic Range:
i. OR greater than or equal to (≥) 480 sec
ii. Cath Lab greater than or equal to (≥) 200 sec; based on clinical judgment
iii. IR greater than or equal to (≥) 200 sec; based on clinical judgment

G. NOTES AND LIMITATIONS:

1. The HR-ACT is intended for use with fresh whole blood where the heparin concentration is one (1) units/mL or greater. During cardiopulmonary bypass the HR-ACT may be affected by the following: dilution of plasma coagulation factors, the use of citrated blood products, use of anti-platelet agents, hypothermia, change in platelet number or function.

2. Interfering Substances: Activated blood specimens, either in-vivo (patient's coagulation mechanism activated) or in-vitro, due to improper sample collection and handling may cause erroneous results. Sample collection and testing should be repeated if improper collection is suspected or if test results are questionable.

H. **MAINTENANCE:**

1. Record Maintenance on the Instrument Maintenance Log.
2. Routine Cleaning: Clean the exposed surfaces of the actuator and dispenser and the instrument case using a hospital approved disinfectant between patients' testing
3. Discard all of the completed testing materials and controls in the provided and approved waste containers.
4. Temperature Verification: Verification of the ACT Plus heat block should be performed once a month and may be done with a Temperature Verification Cartridge that is supplied with the instrument or with calibrated thermometer and water-filled cartridge.
   a. Using the Temperature Verification Cartridge:
      i. From the Quality Control menu enter User ID.
      ii. Select Temperature Adjustment.
      iii. Insert the Temperature Verification Cartridge into the actuator heat block.
      iv. Wait 10 minutes for temperature equilibration to occur.
      v. Press the button on the Temperature Verification Cartridge for temperature reading.
      vi. Enter the reading from the Temperature Verification Cartridge using the numeric keypad. The entered value will appear highlighted in the Thermometer Reading on the display.
      vii. Press Enter to confirm.
      viii. Select Repeat Adjustment variable function key to repeat the temperature adjustment if necessary.
   b. Using a Thermometer:
      i. From the Quality Control menu enter User ID.
      ii. Remove the plunger assembly from a cartridge and fill with 0.2 to 0.3 mL of water.
      iii. Insert the cartridge into the actuator heat block.
      iv. Select Temperature Adjustment.
      v. Place a calibrated thermometer in one of the cartridge reaction chambers.
      vi. After about 5 minutes check the thermometer reading.
      vii. Enter the reading from the thermometer using the numeric keypad. The entered value will appear highlighted in the Thermometer Reading on the display.
      viii. Press Enter to confirm.
      ix. Select Repeat Adjustment variable function key to repeat the temperature adjustment if necessary.
   c. Notes:
      i. The instrument displayed temperature and thermometer measured temperature should read between 36.5° C to 37.5° C.
      ii. The thermometer temperature should be within ± 0.5° C of the instrument displayed temperature.
      iii. The time, date and temperatures of the thermometer and the display will be logged in the instruments temperature log.
      iv. Wait a minimum of 10 minutes before repeat adjustments are performed.
      v. Values must be between 35° C and 39° C.
5. Actuator Assembly Cleaning:
   a. The Actuator Assembly should be cleaned monthly or as soon as possible after contamination with blood. The exposed surfaces of the actuator assembly (with the actuator heat block in the open position) should be cleaned with one of following

cleaning detergents: isopropyl alcohol, methanol, propyl alcohol, glutaraldehyde, bleach, ethanol, Liqui-Nox®, parachlorometaxylenol, hydrogen peroxide, or mild detergent.

i. Dip a swab in cleaning solution.
ii. Swab the flag lift wire, removing all blood.
iii. Swab inside the actuator assembly cover, especially the detector and emitter areas of the photo-optical sensor. Remove any excess cleaning solution with a dry swab. If blood should get into the detector of the lamp area and cannot be removed with a swab, Error Code "4" may be displayed.

I. **TROUBLESHOOTING:**

1. Refer to the ACT Plus Operator's Manual for Cause and Resolution for System Messages.

J. **REFERENCE(S):**

1. Medtronic ACT Plus Automated Coagulation Timer Operators Manual. Rev. 1.0, 4/04.
2. ACT Plus Individualized Quality Control Plan (IQCP) in Point of Care/ Lab binder.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**AMNISURE PLACENTAL ALPHA-1 MICROGLOBULIN (PAMG1) TEST FOR RUPTURE OF FETAL MEMBRANES (ROM)**
Purpose:	To assist in the evaluation of vaginal fluid for the presence of amniotic fluid.
Supportive Data:	The AmniSure ROM test detects ruptured membranes by detecting placental alpha-1 microglobulin (PAMG-1), a protein marker in the amniotic fluid in vaginal secretions of pregnant women. This test is used for definitive purposes. CLIA classified as Moderately Complex.
Equipment:	Test kit (with sterile swab, solution vial, test strip) Timer (with attached vial holder)

A. **PRINCIPLE:**

1. AmniSure ROM test is a rapid, non-instrumented, qualitative test for the detection of amniotic fluid in vaginal discharge of pregnant patients who report signs, symptoms, or complaints suggestive of rupture of membranes. Premature Rupture of Membranes (PROM) prior to 37 weeks' gestation complicates up to 12% of all pregnancies.
2. AmniSure uses the principle of immunochromatography to detect human PAMG-1 (placental alpha-1 microglobulin) protein present in amniotic fluid of pregnant women. Placental Microglobulin was selected as a marker of fetal membrane rupture due to its unique characteristics (i.e. high level in amniotic fluid, low level in blood, and extremely low background level in cervico-vaginal discharge when the membranes are intact).

B. **PROCEDURE:**

1. Store the kit in a dry place at 4° to 24° C (40° to 75° F). DO NOT FREEZE. When stored as recommended the test is stable until the "use by" date on the foil pouch. Use within 6 hours after removing from foil pouch. Check integrity of package prior to use, and ensure that no excessive moisture is noted and no mechanical damage to the test strip is seen.
2. Open the test kit and remove contents.
3. Shake the solvent vial to make sure ~~that~~ all the liquid in the vial settles to the bottom.
4. Open the solvent vial and place into vertical position. The metal loop on the side of the timer is the vial holder. You may place the solvent vial in this holder.
5. Specimen Collection and patient Identification:
   a. Identify patient per Patient Care Services Policy: Identification, Patient
   b. Speculum examination is not required.
   c. Position patient lying flat on back.
   d. Wear gloves for infection prevention. Collect sample of vaginal discharge using sterile vaginal swab provided in kit.
      i. Remove swab from packaging using care not to touch anything prior to insertion into vagina.
      ii. Holding swab in the middle of the stick carefully insert the polyester tip of the swab into the vagina until fingers contact the skin no more than 2-3 inches (5-7 cm) deep.
      iii. Withdraw swab after one minute has elapsed.
6. Place the swab into the vial.
7. Rinse the swab by rotating for one minute.
8. Tear open the foil pouch at the test notches and remove the AmniSure test strip.
9. Dip the white end of the strip (marked with arrows) into the solvent.
10. Allow the strip to remain in solvent for 10 minutes, unless two lines are clearly visible.
    a. Note: a strong leakage will make results visible within minutes, while a small leak may take the full time. A negative result must not be read until the full 10 minutes has

Patient Care Services Content~~Depart ment~~ Review	Clinical Policies & Procedures	Nursing Executive Committee	Department of Pathology	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
05/13, 11/15, **12/19**	06/13, 12/13, 12/15, **01/20**	12/13, 01/16, **02/20**	04/18, **04/20**	01/14, 04/18, **05/20**	**06/20**	04/14, 05/18, **n/a**	04/14, 05/18

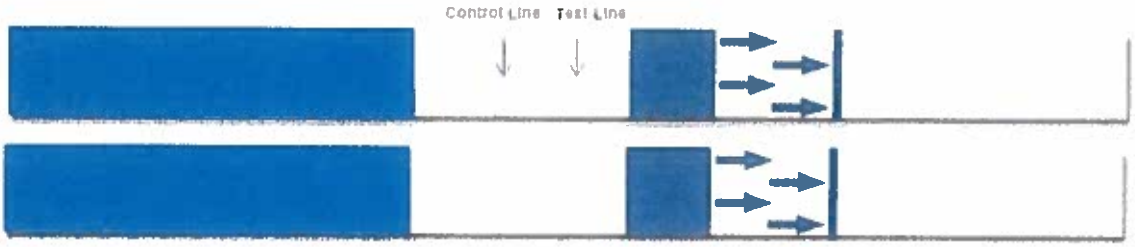
elapsed.

11. Read the results by placing the strip on a clean, dry flat surface.
12. Do not read or interpret after 15 minutes have passed since placing the strip into the vial (or after 5 minutes from removing from vial).
13. Discard the testing and sampling materials into the waste management container.

C. **REPORTING RESULTS:** There are three possible result interpretations:

1. No membrane rupture (control line present)

2. There is a rupture (control line and test line present) [Test line may be very faint and/or broken. This is still considered positive.]



3. Test invalid (control line not present)

4. Notes:
   a. The darkness of the lines may vary—do not try to interpret the test result based on the darkness of the line.
   b. The test is valid even if the lines are faint or uneven.
5. For each test the following must be documented:
   a. Date and time of testing
   b. Operator's identification
   c. Internal QC
   d. Patient result

D. **DOCUMENTATION:**

1. Document according to current departmental procedures.
2. In I-View, first document the internal controls (internal qc, daily qc)
   a. Pass = control line in the control region and background clears. Ok to report patient test.
   b. Fail = control line absent and/or the background does not clear. Repeat patient with new test kit.
3. Once the internal QC is documented as "Pass", document the results as Positive or Negative.

E. **QUALITY CONTROL:**

1. Initial validation of internal control by demonstration of concordance with external controls was performed by the lab prior to test implementation.
2. External controls (positive and negative) must be performed upon every new lot, shipment, monthly on every box currently in use and if there is suspicion that the product performance is compromised.
3. Perform positive and negative QC procedure.
   a. Positive control: use commercial stabilized positive control purchased through manufacturer, or use known Amniotic Fluid.
   b. Negative control: use saline solution.

4. Daily (or day-of-testing) controls may be limited to the internal procedural control. Internal controls validate that adequate sample volume was present and adequate capillary migration of the sample has occurred.
5. To interpret internal controls:
   a. Positive control: a colored line appearing on the control region
   b. Negative control: a clear background on the control region.
   c. Patient tests where the control line is not present or the background has not cleared must not be reported. Repeat testing with a new Amnisure test strip.
6. Procedure for Liquid External Controls:
   a. Obtain liquid external controls (quality controls, QC, controls) from the lab's temperature controlled freezer and keep in a temperature controlled refrigerator in the unit prior to testing.
   b. PAMG-1 is present (positive) or absent (negative) from the vials. SKIP the swab collection steps.
   c. Use the solvent vials provided by the laboratory. Save the unused solvent vials from the test kits and return to the lab with results.
   d. Open the vial provided by the lab, place in the vial holder
   e. Tear open the foil pouch at the test notches and remove the AmniSure test strip.
   f. Dip the white end of the strip (marked with arrows) into the solvent.
   g. Allow the strip to remain in solvent for 10 minutes, unless two lines are clearly visible.
   h. Read the results by placing the strip on a clean, dry flat surface.
   i. Do not read or interpret after 15 minutes have passed since placing the strip into the vial (or after 5 minutes from removing from vial).
7. To interpret external liquid controls:
   a. Positive control = Positive, line in control region and line in test region (2 lines).
   b. Negative control = Negative, line in control region and NO line in the test region (1 line).
   c. Controls PASS if the positive control is positive and the negative control is negative. Test kits are ok to use for patient testing.
   d. Controls FAIL if the positive control is not positive, the negative control is not negative and/or the control line does not appear. DO NOT use test kits for patient testing. Contact the Laboratory.

F. **LIMITATIONS:**

1. Expect discrepant results from other methods used to test for ruptured membranes (Nitrazine, Ferning, and Pooling). AmniSure is more accurate and more sensitive than the other methods, and except in rare cases (with interfering substances or deviated procedure), should be considered correct.
2. Test strip must be used within 6 hours from removing from foil pouch.
3. A significant presence of blood on the swab can cause the test to malfunction. Do not report results. The test still functions properly with only a trace amount of blood on the swab.
4. Do not interpret results greater than 15 minutes after placing the test strip into the vial.
5. False negative results may occur when the sample is taken more than 12 hours after the fetal membrane rupture has occurred.
6. Test should not be performed within 6 hours after the removal of disinfectant solutions or medications from the vagina.
7. Test should be run immediately after sample is obtained. If sample can not be processed immediately for testing, it must be run within 30 minutes from collection time.

G. **INTERFERING SUBSTANCES:**

1. Vaginal infections, urine and sperm do not interfere with results.
2. The performance of AmniSure has not been established in the presence of the following contaminants; meconiumn, anti-fungal creams or suppositories, KY Jelly, baby powder (starch and talc), Replens, and baby oil.

H. **RELATED DOCUMENTS:**

1. Patient Care Services Policy: Identification, Patient

I. **REFERENCES:**

1. AminSure International US package insert. ASP 1100-US0002. 8/10/2010
2. AmniSure Individualized Quality Control Plan (IQCP) in Point of Care/Lab binder

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES ~~MANUAL~~

ISSUE DATE:	**10/75**	**SUBJECT:**	**Conflict/Ethical Issues in Managing Patient Care**
REVISION DATE:	**9/91; 1/97; 6/97; 4/00, 7/03, 3/06 6/09; 03/11**	**POLICY NUMBER:**	**8610-344**

Patient Care Services Content Expert Approval:	**04/20**
Clinical Policies and Procedures I: 06/14	**04/20**
Nursing Executive Committee Approval:	**~~10/14~~05/20**
Pharmacy &Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/14~~05/20**
Administration Approval:	**06/20**
Professional Affairs Committee Approval:	**~~01/15~~ n/a**
Board of Directors Approval:	**01/15**

A. **PURPOSE**:

1. To provide guidelines for the hospital staff, patients and/or families when patient care is questioned and/or if there are concerns regarding ethical issues in patient care.

B. **POLICY**:

1. Guidelines addressing concerns regarding optimal patient care:
   a. The attending Medical Staff member is responsible for the medical care and treatment of his/her patients while they are in the hospital. The District, together with the Medical Staff, has established guidelines for Medical Staff members to ensure the highest **quality**~~level~~ of patient care. District staff is responsible for ensuring ~~that~~ these guidelines are maintained.
   b. When a staff member, patient or family member has concerns regarding Medical Staff care or treatment of a patient, or if an attending Medical Staff member cannot be located within a reasonable time, employee should notify the~~,~~ supervisor in charge who will contact the Director or the Administrative Supervisor **(AS)**.
   c. The Director, ~~/~~Supervisor ~~or the~~ **AS**~~Administrative Supervisor~~ will first discuss the case with the attending Medical Staff member if available, or his/her designee. The Director, ~~or~~ ~~/~~Supervisor **or AS** – will then use **their**~~his/her~~ judgment as to whether the information should be reported to the Medical Staff Leadership~~,~~ using the following order of notification:
      i. Chief/Chair of Division/Department involved
      ii. Chief of Staff
      iii. Immediate Past Chief of Staff
      iv. Chief of Staff-Elect
   d. The ~~Administrative Supervisor or~~ Director, ~~/~~Supervisor **or AS** will notify the Chief **Medical Officer**~~Nurse Executive~~, or his/her designee, of any actions taken (directly or in writing).
2. Guidelines for addressing ethical issues in patient care:
   a. The primary health care team has an obligation ~~to TCMC and society~~ to provide medical care within the framework of the ethical codes of the **profession** ~~community~~ as a whole.
   b. The responsibility for addressing ethical problems in medical care resides with the primary health care team~~,~~ **to include as appropriate,** the patient,~~, and where appropriate, with~~ the patient's family, **or an appropriate representative with the patient's best interests in mind.**
   c. Staff or family member concerns regarding ethical issues in patient care must first be discussed among the primary health care team.

d. If following discussion with the primary health care team, the ethical dilemma persists,~~;~~ the staff member should discuss the problem with the Director and/or the **AS**~~Administrative Supervisor~~ who will contact the chair of the Bioethics Committee. **A m**~~M~~ember list of the Bioethics Committee is available through the Medical Staff Office. The Chair or a designated member of the Bioethics Committee is available 7 days a week, 24 hours a day, for consultation.

e. A Committee member may attempt to resolve the conflict independently or refer the issue to the full Committee.

f. The Bioethics Committee functions in a consultative and advisory capacity, not as a decision making body. When the members of the Bioethics Committee are asked to consult on a specific case, the Committee's recommendation **is** made to the attending Medical Staff member. The attending Medical Staff member shall determine **how to apply** ~~the impact of the~~ **the** committee's recommendation**(s)** ~~eton~~ the treatment plan.

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**FEMOSTOP COMPRESSION DEVICE**
Purpose:	~~To promote compression of femoral artery or vein after vessel cannulation to achieve hemostasis. To promote ultrasound-guided compression repair of the femoral artery pseudoaneurysms~~**FemoStop Femoral Compression System is indicated for use in the compression of the femoral artery or vein after vessel cannulation and in ultrasound-guided compression repair of a femoral artery pseudoaneurysm.**
Supportive Data	The benefits of this procedure are consistent placement; having time-controlled pressure, and decreased groin site vascular complications. **Elsevier Skills: Arterial and Venous Sheath Removal Procedure**
Equipment:	~~1.~~ Femostop or compression dome arch with attached manometer. (For one time use only. Do not reuse) ~~2.~~ Belt of FemoStop® ~~3.~~ Suture removal kit ~~4.~~ Patent Intravenous (IV) **access site** ~~5.~~ Doppler ~~6.~~ Chux or drape for padding ~~7.~~ Gloves ~~8.~~ 1 box of ten 4x4s or 6 packages of 4x4s ~~Elastoplast t~~Tape **(preferable Elastoplast or similar product)** ~~9.~~ **Clear occlusive dressing such as a tegaderm**

A. **DO NOT USE FEMOSTOP COMPRESSION DEVICE IF THE PATIENT HAS THE FOLLOWING CONTRAINDICATIONS:**

1. Severe peripheral vascular disease due to the risk of arterial thrombosis
2. Critical limb ischemia
3. Overlying skin necrosis and/or infection
4. Arterial injuries above or near the inguinal ligament
5. The inability to adequately compress due to i.e. coexisting large hematoma, excessive pain or discomfort (despite anesthetics/analgesics)
6. Patient not suitable for compression of the femoral artery due to leg edema, femoral nerve compression or arterial obstruction
7. Femoral artery graft or vein graft due to the risk of damage
8. Ultrasound-guided compression repair of infected femoral pseudoaneurysms

B. **POLICY:**

1. **Review Online Skills~~Elsevier~~ Arterial and Venous Sheath Removal procedure for additional information on removing venous and arterial sheaths.**
2. **If "HHH" is shown on the display, too much pressure has been applied. Open the control knob and decrease the pressure immediately.**
3. **Ensure that the pinch clamp is open when increasing or decreasing the pressure.**
4. **Maintain initial hemostasis pressure for about 1- 3 minutes and do not leave artery completely blocked for more than 3 minutes to prevent limb ischemia.**
5. **Check pedal pulse periodically to confirm whether or not flow remains in the vessels.**
6. **Avoid releasing pressure suddenly to reduce any risk of flushing thrombotic material into the artery.**

Patient Care Services Content Expert ~~Revision~~ Dates	Clinical Policies & Procedures Committee	Nursing Executive Committee ~~uncil~~	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
01/00, 07/03, 04/04, 01/06, 06/08, 02/09, 06/11;10/15, 05/19	11/11, 08/15, 11/15, 04/20	11/11, 12/15, 05/20	n/a	n/a	01/12, 01/16, 05/20	06/20	02/12, 02/16, n/a	02/12, 02/16

a. **Release of thrombotic material may result in embolization which could lead to patient injury.**

7. **To minimize the risk for arterial/venous fistula formation, venous hemostasis should be achieved prior to removal of the arterial sheath.**

~~9.~~8. **Use of FemoStop Femoral Compression System is not intended to replace careful monitoring of the patient's puncture site. The patient should not be left completely unattended during the time of compression.**

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

1. Explain procedure to patient.
2. Ensure patient has patent IV access.
3. Examine puncture sites for preexisting hematoma prior to placement of the device.
   a. If a preexisting hematoma is present, notify the physician for further orders.
4. Perform hand hygiene and don gloves.
   a. If site is palpated, don sterile gloves.
5. Assess pre-sheath removal blood pressure, heart rate, and cardiac rhythm. Check and mark location of pulses.
   a. If unable to palpate previously assessed palpable pulses, confirm pulses with a Doppler and notify physician.
6. Activate the pump ~~by~~:
   a. **Loosen (~~O~~-open)** the control knob ensuring the control knob clears the red battery contact release tab.
      i. Failure to ensure the control knob clears the red battery contact release results in device failure. If this occurs, discard the device and obtain a new one.
   b. Pull the red battery contact release in the direction of the arrow. When --- (three dashes) are shown on the display followed by the number zero, the pump is activated. (If the three dashes do not appear discard the FemoStop and get a new one).
      i. If the following **error** code(s) appears on display (E01, E03, etc.) replace FemoStop.
   c. **The pump software will automatically shut down 72 hours after activation and will show an error code if any attempts to reactivate.**
   d. **If an error code shows or the display goes blank before or during use, replace the device with a new unit.**
   e. **Ensure that the control knob on the pump is closed when increasing the pressure and open when decreasing the pressure.**
   f. **Ensure that the pinch clamp is open when increasing or decreasing the pressure.**
7. **Application of the belt:**
   a. Drape patient and position **and ~~belt under the patient's hips equally on both sides~~. place belt under and around the patient's hips, so that it is pulled up equally on both sides and is directly in line with the puncture site(s).**
      ~~7.~~i. **Check that the belt has not become twisted or folded under the patient.**
   b. **Remove compression arch from sterile package.**
      i. **Remove the protective lid from the sterile surface of the dome. Be careful to maintain sterility of the dome.**
      ii. **Do not contaminate sterile surface.**
   c. **Palpate the entrance site of the sheath(s) at the femoral artery/vein and p~~P~~osition** center of pressure dome 1 to 2 cm **superior** (above) and medial to the arterial insertion site **(where the arterial/venous sheath enters the skin).**
      i. **Thread the belt through the locks at either end of the arch by fully compressing the levers.**
      ~~8.~~ii. **Adjust the belt to a snug but comfortable fit around the patient. The arch should lie level and squarely across the groin area.**
   ~~9.~~d. ~~Remove compression arch from sterile package~~.
   ~~a.~~e. ~~Do not contaminate sterile surface~~.

~~10. Thread belt through side arm locks. Thread belt ends through arch by fully pressing and releasing side arm lock while maintaining pressure dome in place.~~
~~a. Adjust belt from both sides until arch fits snugly and comfortably around patient.~~
~~11. Remove the sutures using the suture removal kit.~~
~~12. Withdraw sheath hub(s) slightly to clear the pressure dome.~~
~~13. Verify stopcock is parallel with the pressure tubing.~~
~~14.~~**8.** Follow the procedures **Online Skills Arterial and Venous Sheath Removal Procedure: Using Manual or Mechanical Compression without a Noninvasive Hemostasis Pad and the instructions below:** ~~below for.~~
a. Removal of venous sheath.
b. Removal of arterial sheath.

~~C.~~**D.** **PROCEDURE: LOW FEMOSTOP DOME PRESSURE**

1. **Inappropriate inflation compression times and/or immobilization may increase risk of thrombosis or embolization, caution should be used when using low FemoStop dome pressure greater than 3 hours.**
2. After hemostasis is maintained, low FemoStop pressure **(maintenance pressure)** may be applied by inflating the dome to 30 mmHg or less **when appropriate for the patient's condition. Examples include but are not limited to:**
   a. **Anticoagulant level**
   b. **Interventional procedure performed**
   c. **Physician order**
   d. **Sheath French size used**
   e. **Loss of hemostasis**
   f. **Oozing secondary to anticoagulant or antiplatelet dose**
   g. **Sustain hemostasis for patients unable to follow instructions**

~~1.~~**3.** ~~.~~ **The patient's baseline pedal pulse must be palpable.**
~~2.~~**4.** Low FemoStop pressure is equivalent to the weight of approximately a ~~10-pound~~**10-pound** sand bag.
   a. Apply sand bag only per physician's order.
~~3.~~**5.** Low FemoStop pressure must be decreased and the dome removed from contact with patient's skin every 3 hours to allow capillary refill **when long compression times are required** and assess skin integrity **if a dressing has not been applied.**~~.~~
~~4. Low FemoStop pressure may be applied for 12 hours with interruption of dome pressure every 3 hours.~~
   ~~a. Inappropriate inflation compression times and/or immobilization may increase risk of thrombosis or embolization.~~
~~5.~~**6.** Assess pulse and temperature of skin with every interruption of Low FemoStop pressure.
~~6.~~**7.** Assess patient's vital signs per physician's orders.
~~7.~~**8.** Assess patient's cardiac rhythm per unit specific policy.
9. ~~Remove FemoStop as outlined in E. 6-9.~~ ~~.~~
~~8.~~

~~D.~~**E.** **PROCEDURE: REMOVAL OF VENOUS SHEATH without an ARTERIAL SHEATH:**

1. **Access the following:**
   a. **Puncture site area for any pre-existing hematomas**
   b. **Blood pressure to determine proper initial inflation pressure**
   c. **Pedal pulse**
   d. **Palpate entrance site of sheath**
2. **Follow the instructions for applying the belt and FemoStop**
   a. **The belt may be threaded through the end of the arch before or after applying the belt.**
3. **Remove the sutures using the suture removal kit, if present.**

4. **Withdraw introducer (sheath) hub(s) about 2cm or just enough to clear the rim of the dome.**
   a. **Verify stopcock is parallel with the pressure tubing prior to slightly withdrawing the sheath hub.**
5. **Ensure the control knob of the pump is closed prior to inflating the dome.**
6. Inflate dome to 20 - 30 mmHg pressure and remove venous sheath. Add additional pressure if needed to control bleeding. **(Allowance for slight bleeding at the site is preferred to preclude introduction of thrombus to the vessel).**
   a. **Ensure that the pinch clamp is open when increasing or decreasing the pressure.**
   b. **Ensure while removing the sheath, the pressure applied is kept low, so that damage to the vessel or a "milking" effect is avoided.**
7. **If no bleeding is present, carefully loosen the belt on the puncture side of the patient without totally removing the belt from the arch. Gently roll the dome off the site and observe the site.**
8. **Remove the FemoStop once hemostasis is achieved.**

~~1.~~ **~~7.~~ Apply a gauze dressing cover with clear occlusive dressing.**

~~E.~~**F. PROCEDURE: REMOVAL OF ARTERIAL SHEATH without a VENOUS SHEATH:**

1. Assess pedal pulse, blood pressure, heart rate, and cardiac rhythm prior to arterial sheath removal.
2. **Follow the instructions for applying the belt and FemoStop.**
   a. **The belt may be threaded through the end of the arch before or after applying the belt.**
3. **Remove the sutures using the suture removal kit, if present.**
4. **Withdraw introducer (sheath) hub about 2cm or just enough to clear the rim of the dome.**
   a. **Verify stopcock is parallel with the pressure tubing prior to slightly withdrawing the sheath hub.**
5. **Ensure the control knob of the pump is closed prior to inflating the dome**

~~2.~~**6.** Inflate compression dome pressure to 60 - 80 mmHg and simultaneously remove arterial sheath.
   a. Continue to increase dome pressure 10 - 20 mmHg above the patient's systolic blood pressure or until bleeding has stopped (initial hemostasis is achieved) and pulse is not palpable or audible by doppler.
   b. If "HHH" is shown on the display, too much pressure has been applied. Open the control knob and decrease the pressure immediately.

~~3.~~**7.** Maintain inflation pressure to occlude patient's pulse for 1 - 3 minutes
   a. Do not occlude pulse for more than 3 minutes to prevent limb ischemia.

~~4.~~**8.** Monitor blood pressure, heart rate, and cardiac rhythm while maintaining inflation pressure.
   a. After 1 - 3 minutes, reduce inflation pressure slowly until a pedal pulse is present by palpation or doppler. If bleeding occurs, increase dome pressure to achieve hemostasis.

9. Maintain inflated pressure for 30 minutes ensuring hemostasis is achieved and then gradually reduce compression pressure by 10 - 20 mmHg every **2-**3 minutes.
10. **Gradually lower the pressure, as long as hemostasis is maintained, and observe the site for 2 – 3 minutes.**

~~5.~~**11. Continue to decrease the pressure until the dome is completely deflated. After a few minutes of observation at zero-pressure (1-2 minutes), either proceed to remove the system as described below or leave it in place at very low pressure as long as necessary to ensure continued hemostasis.**

~~a. Observe puncture site and assess blood pressure, heart rate, and cardiac rhythm.~~
   ~~i. If bleeding occurs, hemostasis is not maintained. Increase compression pressure to 10 - 20 mmHg above systolic blood pressure.~~
   ~~ii. Repeat outlined steps above beginning with E.2~~

~~6. After hemostasis is achieved, continue to decrease pressure until a pressure of zero is achieved and dome is completely deflated..~~

~~7.~~**12.** Continue to observe site and ensure hemostasis is maintained for a few minutes ~~.~~
   a. Assess blood pressure, heart rate, and cardiac rhythm.
   b. Assess patient's level of comfort.

~~8.~~**13.** Loosen the belt on the puncture side of patient and gently roll compression arch to loosen dome, taking care not to dislodge the newly formed clot and verify hemostasis time.
   a. Note the time, this is called hemostasis time.
      i. If blood is present or oozing from site, hemostasis is not maintained.
         1) Retighten belt and increase dome pressure to control bleeding.
         2) Reassess patient's blood pressure, heart rate, and cardiac rhythm.

~~9.~~**14.** Apply pressure dressing using 2 folded 4x4s over puncture site and secure with **clear occlusive dressing or** ~~elastoplast~~**Elastoplast or** ~~tape~~**similar tape**.

F. **REMOVAL OF VENOUS AND ARTERIAL SHEATHS:**

1. Inflate dome to 20 - 30 mmHg pressure and remove venous sheath. Add additional pressure if needed to control bleeding.
2. Assess pedal pulse, blood pressure, heart rate, and cardiac rhythm prior to arterial sheath removal.
3. Continue to increase compression dome pressure to 60 - 80 mmHg and simultaneously remove arterial sheath.
   a. Continue to increase dome pressure 10 - 20 mmHg above the patient's systolic blood pressure or until bleeding has stopped and pulse is not palpable or audible by doppler.
4. Maintain inflation pressure to occlude patient's pulse for 3 minutes, do not occlude pulse for greater than 3 minutes.
5. Continue to follow steps as outlined in Arterial Sheath Removal ~~beginning with E.2~~.

G. **NURSING CARE POST SHEATH REMOVAL:**

1. Keep affected extremity straight with no hip flexion and head of bed flat or no higher than 20 degrees for a minimum of six hours or per physician's orders.
2. Monitor puncture site for bleeding or hematoma below the skin surrounding puncture site. Palpate site to detect hematoma. Monitor pedal pulse, color, temperature, and presence of tingling.
3. Assess the following, if findings are not comparable to pre-sheath removal, notify the physician:
   a. Bilateral pedal pulses (if applicable)
   b. Color and temperature of skin
   c. Presence of tingling
4. Monitor for the following complications and notify physician:
   a. Vasovagal response causing drop in blood pressure and heart rate
   b. Nausea and vomiting
   c. Hematoma or r~~R~~etroperitoneal bleed
      i. Patient may complain of back pain or have unexplained hypotension.

H. **PROCEDURE FOR MANAGING BLEEDING:**

1. If hemostasis is lost, ~~i.e.,~~ notify a 2nd RN to obtain a FemoStop.
2. Remove dressing, find the femoral artery and manually compress.
3. Ask the 2nd RN to activate the FemoStop as outlined in this procedure.
4. While manual pressure is maintained, place the center of the dome over the fingertip that is applying pressure.
5. Inflate the dome to 60mmHg and then start to rotate and remove fingers medially.
6. Continue to inflate dome to approximately 20 mgHg above the patient's SBP.
   a. Do not keep the suprasystolic pressure for more than 3 minutes.
7. Remove the fingers in line with the artery and let the dome take over the pressure.
8. Reduce the pressure **10–20** mmHg every 2 – 3 minutes while ensuring hemostasis is achieved.
9. Once hemostasis is achieved, remove the FemoStop as outlined in this procedure.
10. If unable to manage bleeding, notify physician.

I. **PROCEDURE FOR MANAGING OOZING:**

1. If there is consistent oozing from the puncture tract or a hematoma use a FemoStop to regain hemostasis.
2. Prepare the FemoStop as outlined in this procedure.
3. With the dome positioned on the arteriotmy, inflate the dome to approximately 30 mmHg or until the oozing has stopped.
4. Assess the patient's blood pressure.
5. Maintain low pressures as outlined in this procedure.
6. Remove the FemoStop once hemostasis is achieved.

J. **NURSING TROUBLESHOOTING TOOLS:**

1. Target inflation pressure should be 10 – 20 **mm Hg**above the systolic pressure, or higher if ~~necessary~~**necessary,** to control the bleeding. Exceeding pressures of 200 mmHg or greater may indicate the need to tighten the belt or reposition the dome.
2. ~~Ensure the pinch clap is open when increasing or decreasing the pressure.~~
3. ~~The compression device is single use only.~~
4. ~~Blocking the artery for more than 3 minutes may result in limb ischemia.~~
5. ~~Avoid releasing pressure suddenly to reduce any risk of flushing thrombotic material into the artery.~~
6. For very obese patients~~.~~:
   a. It may be necessary to tighten the belt slightly more to enhance downward compression.
   b. Fatty tissue may be displaced giving a false impression of developing hematoma.
   c. Placement of the system may not be suitable on large patients, or patients with very wide hips as the belt may be too short.

K. **DOCUMENTATION:**

1. Document the following in the **electronic**~~medical~~ **health (EHR)** record:
   a. Circulation: pulse, temperature, color of affected extremity
   b. Condition of puncture site: bleeding, hematoma
   c. Patient response
2. Document the following in the **EHR**~~medical record~~ if low Femostop pressure is applied:
   a. Circulation, condition, and patient response as identified above.
   b. Removal of Femostop every three hours.

L. **REFERENCES:**

1. Elsevier Skills: Arterial and Venous Sheath Removal Procedure
~~1.~~**2.** St. Jude Medical (201~~21, March~~). FemoStop tm gold: Femoral compression system. Package inserts.
~~2. St. Jude Medical (2011). Femostop tm gold: How to use. Retrieved from http://www.sjmknowledge.com-femostopgold~~
~~3. St. Jude Medical (2011). Femostop tm: For urgent and unexpected cases. Retrieved from http://www.sjmknowledge.com-femostopgold~~

Tri-City Medical Center	Patient Care Service
PROCEDURE:	**BLOOD GLUCOSE POINT OF CARE TESTING ~~USING THE NOVA STATSTRIP BLOOD GLUCOSE METER~~**
Purpose:	To accurately determine blood glucose levels at the patient's bedside.
Supportive Data:	The **blood glucose meter** ~~Nova StatStrip Meter~~ is used to monitor **the** blood glucose in patients who have been diagnosed by conventional means. The meter is not to be used for screening or diagnosis of diabetes. Personnel trained and assessed through the Point of Care program may perform this procedure. Testing is under the supervision of the Laboratory Point of Care Coordinator and under the jurisdiction of the Laboratory Medical Director.
Equipment:	Alcohol Swab Docking Station Gauze Gloves Luer lock needleless blood sampling access device Needleless cannula **Blood Glucose** ~~Nova StatStrip~~ Meter Single-use Lancet StatStrip cleaning strips StatStrip control solutions level 1 low (green bottle) & level 3 high (red bottle). StatStrip test strips

A. **DEFINITION(S):**

1. Critically ill adult: any patient receiving intensive medical intervention/therapy with decreased peripheral blood flow, as evidenced by one or more of the following:
   a. Severe hypotension requiring the administration of two or more intravenous vasopressors;
   b. Any patient with a core body temperature equal or less than (≤) 35°C;
   c. Any patient with Emergency Severity Index (ESI) of one.
2. Critically ill neonate: all neonates in the Neonatal Intensive Care Unit (NICU) are defined as critically ill.

B. **PREPARE THE METER:**

1. Touch the screen to activate the meter.
   a. Note: the meter is designed such that the operator uses their finger when dealing with the touch screen. Any sharp or abrasive material may damage the meter.
   b. Blue bar with screen title at the top of the meter will prompt next step.
2. From the Welcome screen, Press OK/Login to begin.
   a. For troubleshooting hints see the ~~StatStrip~~**blood glucose meter** Troubleshooting Guide on the Tri-City Healthcare District (TCHD) Intranet under Departments>Clinical>Clinical Products.
3. Perform Quality Control (QC) if indicated by meter. Meter is configured to require a QC both high and low every 24 hours. Meter will lock out at 24 hours and screen will display QC Lockout L1/L3 QC required if QC not performed. See QC and Calibration section for instructions on completing the QC.
4. At the Enter Operator ID Screen, scan or manually enter your Operator Identification (ID). ID must be 5 digits long; use zeroes to precede a 3- or 4-digit Employee ID Number (EID). Press Ok/Accept.
5. At Patient Test screen press accept or select QC.
6. At the Enter Strip Lot screen, scan the strip lot from the bottle matches the number displayed on the screen.

Patient Care Service Content Expert	Clinical Policies & Procedures	Nurse Executive Council	Department of Pathology	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/13, 08/16, 08/19, 03/20	06/13, 08/16, 11/16, 09/19, 03/20	06/13, 01/17, 09/19, 03/20	04/18, 10/19, 04/20	09/13, n/a	10/13, 04/18, 11/19, 05/20	11/19, 06/20	11/13, 05/18, n/a	12/13, 05/18, 12/19

7. At the Enter Patient ID screen, scan the AZTEC symbol from the Patient's armband or manually enter Patient 10 digit Financial Identification Number (FIN#), Press Accept.
    a. Non-Registered Patients in emergent situations.
        i. Emergent patients should be issued a John/Jane Doe packet. Scan the AZTEC symbol from the packet.
        ii. If packet not available, enter an invalid Patient ID to get to the downtime override key (use the following 10 digit FIN# 1 2 3 4 5 6 7 8 9 0)
        iii. Fill out the Point of Care Testing Correction Form
        iv. Available on TCMC Intranet, click on Forms Icon>Electronic Forms>Patient Care Services Forms
8. At the Confirm Patient ID screen
    a. Valid Patient ID: Verify the FIN# (Account Number) and Patient Name are correct. Press Ok/Accept.
    b. Invalid Patient ID: The Admission/Discharge/Transfer (ADT) feature was unable to pull Patient Name. This will occur if the meter has not been recently downloaded and does not have current ADT information, if the scanned encounter has been discharged, or if the patient is not yet registered and a John/Jane Doe ID was scanned.
        i. Verify the Patient ID. If the correct number was scanned, and the encounter is current press Ok/Accept to Override. The Patient ID will be recognized by the data manager, the error resolved, and the result will chart.
        ii. If the encounter is not current, obtain an armband for the current encounter and continue testing. If staff press OK/Accept and Override a discharged encounter, the result will not chart. Staff must fill out the Point of Care Testing Correction Form and send it to the lab for error resolution.
        iii. If the patient a John/Jane Doe and is not yet registered, press OK/Accept to Override. When the patient is registered, complete the Point of Care Testing Correction Form.
9. At Select Sample Type screen, select the appropriate sample type as Capillary, Venous, Arterial or Neonatal Heel Stick, then press Accept.
10. At the Insert Strip screen, insert a test strip into the strip port at the top of the meter. The print should face up and the gold contacts enter the meter.

C. **PATIENT PREPARATION:**

1. Critically ill adult:
    a. Only arterial or venous whole blood may be used. Do not use serum, plasma, or capillary blood.
        i. To obtain whole blood from an arterial catheter, follow procedure for blood sample collection in Online Clinical Skills Arterial Catheter: Blood Sampling.
        ii. To obtain whole blood from a central venous access device, follow procedure for blood sample collection in Patient Care Services (PCS) Procedure: Central Venous Access Devices, Adults.
        iii. To obtain whole blood by venipuncture, follow procedure for blood sample collection in PCS Venipuncture for Specimen Collection.
            1) Only fresh whole blood or whole blood collected in lithium heparin collection device should be used for arterial and venous specimens. Test within 30 minutes when not sampling directly from a lancing device
            2) Fluoride, EDTA, Sodium and Ammonium blood collection devices should not be used.
        iv. To obtain whole blood from a midline catheter, follow procedure for blood sample collection in PCS Midline Catheter, Adults.
2. Critically ill neonates:
    a. Collect neonatal arterial or neonatal heel stick samples. The system has not been evaluated for use with neonate venous blood,
    b. The system is not intended for use with neonate Cord blood samples.

3. Non-critically ill adult
   a. Capillary, Arterial, or Venous whole blood may be used. Do not use serum or plasma.
   b. Only fresh whole blood or whole blood collected in lithium heparin collection devices should be used for arterial and venous specimens. Test within 30 minutes when not sampling directly from a lancing device.
   c. Sample size is 1.2 uL.
4. Obtain single-use lancet
5. Select puncture site – see Patient Care Service (PCS) Collection of Blood Specimen by Skin Puncture.
   a. Adult/child - finger puncture
   b. Newborn – heel stick
6. Use the lancet to puncture the appropriate site - see PCS Collection of Blood Specimen by Skin Puncture.

D. **SPECIMEN COLLECTION AND PATIENT TEST :**

1. At the Apply Sample screen, obtain blood sample and touch the test strip to ~~the~~ a drop of blood. Hold the test strip to the blood until the meter begins the 6 second countdown.
   a. If the strip is not filled completely in the first attempt, you must repeat the test with a new puncture and a new test strip.
      i. Repeated squeezing of the puncture site may dilute the specimen with tissue fluid
   b. Criteria for rejection: If you receive a strip error for insufficient sample application or any other error code, you must repeat the test with a new finger puncture and a new test strip.
      i. Repeated squeezing of the puncture site may dilute the specimen with tissue fluid
   c. When collecting the sample: keep the meter level, or pointed slightly down while wet test strip is in the meter. Do not tilt the meter up while there is any chance that blood can drip down into the meter. If liquid gets into meter, use the cleaning strips to wick the extra fluid as soon as possible.
   d. Results will display in 6 seconds.
2. At the Patient Test screen
   a. Review results:
      i. Results may be read directly from the meter.
      ii. Results in the normal range display in Blue.
      iii. Results outside the normal range display in Red.
      iv. ↑ One arrow up indicates the result is high, but not critical.
      v. ↑↑ Double up arrows indicate the result is critical high.
         1) Follow PCS Critical Results and Critical Tests/Diagnostic procedure.
      vi. ↓ One arrow down indicates the result is low, but not critical.
      vii. ↓↓ Double down arrows indicate the result is critical low.
         1) Follow PCS Standardized Procedure Hypoglycemia Management in the Adult Patient
         2) Follow PCS Standardized Procedure Newborn Hypoglycemia During Transition to Extrauterine Life
         3) Follow PCS Critical Results and Critical Tests/Diagnostic procedure.
      viii. LO indicates the result is below the readable range of the meter, or <10.
         1) <10 meter reads LO. Repeat test. Continue with treatment and retest according to standardized procedure for hypoglycemia
      ix. HI indicates the result is above the readable range of the meter, or >600.
         1) Results >600 mg/dL. Repeat test. Obtain an order for a STAT lab glucose for a valid result for treatment (Confirmatory Testing).
         2) Results that do not correlate with prior treatment. Repeat test. Obtain an order for a STAT lab glucose to verify result.

b. Accept or Reject:
   i. You must ACCEPT the result at the meter for it to be automatically charted.
   ii. If you select neither and the meter turns off, the result will sit in a queue in the lab awaiting resolution.
   iii. Fill out and submit the Point of Care Testing Correction Form to the LAB.

3. Remove strip by pressing down on ejector button on rear of device of remove strip manually. Ensure safe disposal into biohazard container.
4. Clean and disinfect the meter after each patient. See cleaning under Maintenance section.
5. Log off meter by selecting logout on Patient Test Screen or dock the meter when you are finished testing. Store the meter in the docking cradle and not in the tote. Battery must charge and data must transmit.
   a. The Left light is Green when the meter is connected to the network.
   b. The Center light is Green when data is transmitting
   c. The Right light is Green when the battery is fully charged and Amber when the battery is charging.
   d. Auto log off will occur after 6 ½ minutes of inactivity.

E. DOCUMENTING RESULTS:

1. Patients must be identified with the Financial/ Account Number (FIN). Only results identified with the FIN will be charted in CERNER. The FIN number should be scanned from the AZTEC (2D) barcode on the ARMBAND. Linear Barcodes must not be scanned or the results will not transmit to Cerner.
2. Dock the meter in the cradle. Results and comments will automatically post to the chart.
3. If the result does not immediately chart,
   a. Verify the meter is properly docked and connected, with green arrow indicating data transfer complete.
   b. The INTERFACE may be temporarily down; the results will transmit and post when the interface is again functional.
4. Result was not ACCEPTED in the meter. Complete the Point of Care Testing Correction Form and send to the lab. The lab will resolve the error and process the result to the chart.
   a. Patient ID was not recognized. (John/Jane Doe). Use downtime procedure. Select Override button on the meter, continue testing, accept the result and dock the meter. Manually enter the result on the patient's chart for immediate documentation. Complete the Point of Care Testing Correction Form and send the lab. The lab will resolve the error and process the result to the chart at a later time whenever possible.

F. MAINTENANCE:

1. Charging the Meter:
   a. When the battery Low symbol displays on the screen, place the meter into the docking station. If you have a spare battery that is fully charged, you can change the battery.
   b. The meter should always be left in the docking station when not in use.
2. Cleaning **and Disinfecting** the Meter **Procedure:**
   a. Cleaning is not the same as disinfecting. Disinfecting means to kill or prevent the growth of disease carrying microorganisms.
   b. Prepare the meter for cleaning and disinfecting:
      i. Remove the test strip
      ii. Lay the meter on a flat surface prior to cleaning and disinfecting.

~~a.~~**3. Clean and disinfect after each patient use per manufacturer's guidelines:**
   a. See Nova Biomedical Glucose Meter instructions for use
   b. See Chlorox Germicidal Wipes instructions for use
   ~~b. Never immerse the meter in any cleaning agent or water.~~
   ~~c. Never spray the meter with a disinfectant solution~~
   ~~d. Do not get excess liquid into the strip port or docking port or under the touch screen. This will damage the meter.~~

~~e. Clean daily and when visibly soiled~~
~~f. Disinfect the meter after each patient.~~
~~g. Using a hospital approved disinfectant wipe, remove the wipe and wring out excess liquid, thoroughly clean the outside of the meter, avoiding the bar code scanner and electrical connector. Gently wipe the surface area of the test strip port making sure no fluid enters the port. Allow the meter to dry before docking.~~
~~i.~~c. ~~Hospital approved bleach wipes may be used if required by patient diagnosis (for example clostridium difficile).~~
~~h. If the screen is 'cloudy' from a buildup of cleaning solution, wipe the screen with a water dampened gauze or alcohol pad then dry with clean gauze.~~
~~i.~~d. **If unable to clean the strip port, send the meter to the lab for a replacement.** ~~Strip port well is filled with, QC solution, blood or other liquid, dry the Strip port.~~
~~i.~~e. ~~If unable to remove liquid or the liquid dries and cannot be removed, send the meter to the Lab.~~

~~3.~~4. Changing the Battery:
a. If the meter needs a reset or is left out of the docking station for more than 8 hours or 40 tests, the battery will need to be recharged. If the meter is needed for immediate use, change the battery.
b. Touch the screen or the Sleep Mode Button to wake the meter up. This will allow the operator approximately 2 minutes to change the battery and not lose date/time settings.
c. If it takes longer than 2 minutes to change the battery. Dock the meter to reset the date and time.
d. Push in on the cover latch to release the cover. Take the battery cover off the back of the meter.
e. Remove the battery. Remove the photo below it is unnecessary.
f. Replace with a fully charged battery. (The battery is keyed to allow only insertion from bottom first then push in the top.)
g. Replace the battery cover.
h. Place the drained battery into the docking station to recharge. Be sure the light to the left comes on signifying the correct positioning of the battery.

~~4.~~5. Supplies and Storage :
a. ~~Nova Stat Strip~~ **Blood** Glucose Meter (Operates 15 to 40C; 59 to 104F)
b. ~~Stat Strip~~ Glucose Test Strips (Store in original bottle 15 to 30C)
i. When opened, mark each bottle with the expiration date 180 days or manufacture expiration date, whichever comes first.
ii. Once opened, both Stat Strip bottles in the single package must be labeled because there is no safety seal on the individual bottle.
iii. Stable when stored as indicated for 180 days or until the printed expiration date (whichever comes first).
c. ~~Stat Strip~~ Glucose Control Solutions, level 1 low and level 3 high (Store 15 to 30C)
i. When opened, mark the bottle with the expiration date 90 days or manufacture expiration date, whichever comes first.
ii. Once opened, stable for 90 days or until the printed expiration date (whichever comes first).
d. Do not use strips or controls past their expiration date.
e. Remove the test strip from the vial only when ready to test and recap vial.

G. **QUALITY CONTROL AND CALIBRATION:**
1. Quality Controls (QC) are used to confirm that the meter and test strips are working correctly.
2. Control Frequency:
a. Meter is configured to require a QC with both Level 1 low and Level 3 High every 24 hours. Meter will lock out at 24 hours and screen will display QC Lockout.
b. Perform a QC if a patient test has been repeated and the blood glucose results are still lower or higher than expected

c. Perform a QC any time you have a concern about the function of the meter, i.e it is dropped or problems are identified (storage, operator, instrument)
d. Performing a QC with both Level 1 low and Level 3 high solution is required for Alere / Freedom to recognize new operators in the system. This shall be done upon initial and annual competency.

3. Perform QC with both Level 1 low and Level 3 high QC solutions to unlock meter: If one QC level fails, repeat the test only for the level that failed.
4. Procedure:
   a. From the Welcome Screen press Login.
   b. Manually Enter or Scan your Operator ID and press OK/Accept.
   c. From the Patient Test Screen, press QC.
   d. At the Enter Strip Lot screen, scan the strip lot from the bottles. Verify the strip lot number matches the number displayed on the screen.
   e. At the Enter QC Lot screen, scan the QC lot
   f. At the Insert Strip screen, insert the test strip into the meter.
   g. Mix the control well by rolling the vial, do not shake.
   h. At the Apply Sample screen, touch the tip of the test strip to the drop of control and the strip will fill by capillary action. Keep contact with the drop of control until the meter beeps, indicating sufficient sample was obtained.
      i. The test strip must fill completely on the first attempt. If insufficient sample is obtained, repeat with a new test strip.
      ii. HOLD THE METER LEVEL or downward WHILE TESTING. This prevents any excess liquid from seeping down the strip and into the meter, causing damage.
      iii. If liquid gets into meter, dry strip port.
         1) If unable to remove liquid or the liquid dries and cannot be removed send the meter to the Lab.
   i. The QC Result screen will show with a PASS or FAIL Press Ok/Accept.
   j. If QC fails select comment and, perform corrective action:
      i. Verify the correct level of control was scanned and tested.
      ii. Verify the test strips and control solutions are not expired. If expired, open new strips or controls.
      iii. Mix the control thoroughly. Repeat the test with a new strip. If the second test fails, contact the lab.
   k. Log off meter when you are finished testing. Auto log off will occur after inactivity.
   l. The meter does not require calibration.

H. PRINCIPLE/CLINICAL SIGNIFICANCE:

1. This test is **Clinical Laboratory Improvement Amendment** (-CLIA) WAIVED for capillary, venous, and arterial whole blood and neonatal heel stick whole blood.
2. Glucose is measured amperometrically, using an enzyme based test strip.
3. The meter is plasma calibrated to allow easy comparison of results with laboratory methods.
4. The measurement of glucose is used in the monitoring of carbohydrate metabolism disturbances including diabetes mellitus, and idiopathic hypoglycemia, and of pancreatic islet cell carcinoma.
5. Testing by this method is not for diagnosis of or screening for diabetes.
6. Limitations
   a. Capillary blood glucose testing is not appropriate for persons with decreased peripheral blood flow, as it may not reflect the true physiological state. Venous and arterial whole blood is the only sample that shall be used for any patient receiving intensive medical/interventional therapy with decreased peripheral blood flow, as evidenced by one or more of the following:
      i. Severe hypotension requiring the administration of two or more intravenous vasopressors
      ii. Any patient with a core body temperature equal or less than (≤) 35°C

iii. Any patient with ESI of one

b. When performing frequent testing in a patient, try to use the same blood source as consistently as possible.
   i. Rationale: Venous and capillary blood may differ in glucose concentration by as much as 70 mg/dL, depending on the time of blood collection after food intake. Draw lab serum glucose for the most accurate glucose value.

7. A test within 20% of laboratory results is considered accurate.
8. Interfering Substances
   a. The ~~StatStrip~~**Blood glucose meter** Glucose meter exhibits no interference from the following substances at known therapeutic levels: Acetaminophen, Ascorbic acid, Dopamine, Ephedra, D+ Galactose, Ibuprofen, L-Dopa, Methyl-Dopa, Salicylate, Tetracycline, Tolazamide, and Tobutamide.
   b. The ~~StatStrip~~**Blood glucose meter** Glucose meter exhibits no interference from the following substances at or above the upper clinical normal range concentrations: Bilirubin, Cholesterol, Creatinine, Triglycerides, and Uric Acid.
   c. The ~~StatStrip~~**Blood glucose meter-Blood glucose meter**Glucose meter exhibits no interference from the following substances at the normal therapeutic levels found in renal dialysis: D(+) Maltose monohydrate, D(+) Maltotetraose, and D(+) Maltotetriose.
   d. The **blood glucose meter**~~StatStrip~~**Blood glucose meter-~~Glucose~~** meter exhibits no interference in blood specimens with hematocrits from 20% to 65% or with varying oxygen content.

I. REFERENCE INTERVALS:

1. Meter range 10-600 mg/dL
   a. <10 meter reads LO. Continue with treatment and retest according to standardized procedure for hypoglycemia.
   b. >600 meter reads HI. Order lab glucose to obtain a valid number for treatment.
2. Reference Range (all in mg/dL)

		NORMAL	CRITICAL LOW	CRITICAL HIGH
a.	Adults	70 – 110	≤ 40	≥ 450
b.	Neonates	45 – 120	≤ 30	none established

3. Critical Results must have follow up documentation of physician notification and any interventions.
4. Any result that is questionable or does not correlate with patient symptoms or treatment history should be repeated with a new finger puncture to rule out operator, strip, or meter error. If repeat meter value does not 'make sense', order a lab glucose.

J. REFERENCE(S):

1. Nova Biomedical. ~~StatStrip~~**Blood glucose meter** Glucose Test Strips Package Insert. Ref 42214. 2016-03.
2. Nova Biomedical. ~~StatStrip~~**Blood glucose meter** Glucose Control Solution Package Insert. Ref 41741 & 41743. 2017-03.
3. Nova Biomedical. CIB 04-11SS Rev. B. Cleaning and Disinfection Procedure. 2015-06.
4. Nova Biomedical. ~~StatStrip~~**Blood glucose meter** Glucose Hospital Meter IFU 1.86 Ref.55848F 2019-01

K. FORM(S):

1. Point of Care Testing Correction Form

L. RELATED DOCUMENT(S):

1. Online Clinical Skills Arterial Catheter: Blood Sampling
2. PCS Procedure: Central Venous Access Devices, Adults
3. PCS Procedure: Collection of Blood Specimen by Skin Puncture
4. PCS Procedure: Critical Results and Critical Tests/Diagnostic procedure

5. PCS Procedure: Midline Catheter, Adults
6. PCS Standardized Procedure Hypoglycemia Management in the Adult Patient
7. PCS Standardized Procedure Newborn Hypoglycemia During Transition to Extrauterine Life
8. PCS Procedure: Venipuncture for Specimen Collection
9. Point of Care Correction Form
10. **Blood Glucose Meter**~~StatStrip~~ Troubleshooting Guide
~~10.~~11. **Nova Biomedical Glucose Meter Instructions for Use**

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**HIGH-LEVEL DISINFECTION**
Purpose:	To disinfect semi-critical patient care equipment between uses
Equipment:	Personal protective equipment (gloves, eye protection, impervious gown, face shield or simple surgical mask) ~~Container with e~~Enzymatic~~?~~/-detergent ~~solution~~ Sponge or soft, lint-free cloth Brush **High-level disinfectant (i.e.,** Cidex ortho-phthalaldehyde ~~([~~OPA~~)~~]**)** Tap Water Sterile Water 70% isopropyl alcohol or equivalent

A. **DEFINITION(S):**

1. Critical ~~equipment~~**items: According to Spaulding classification system,** items that enter sterile tissue, **including** ~~or~~ the vascular system ~~and must be sterile when used~~ (i.e., surgical instruments, implants and needles). **Critical items should be sterile when used.**
2. Semi-critical ~~equipment~~**items: According to Spaulding classification system,** items that come in contact with non-intact skin or mucous membranes **(i.e.,** ~~, should receive a minimum of high-level disinfection (i.e.~~ vaginal and rectal probes,**ultrasound probes used during percutananeous guided procedures,** respiratory therapy equipment, bronchoscopes, gastrointestinal endoscopes and accessories). **Semicritical items should be processed by sterilization, or, at a minimum, high-level disinfection.**
3. Non-critical ~~equipment~~**items: According to Spaulding classification system,** items that come into contact only with intact skin **(i.e., tourniquets and blood pressure cuffs). Non-critical items**~~and~~ should receive intermediate ~~level disinfection,~~ **or** low-level disinfection ~~or cleaning (i.e. tourniquets, blood pressure cuffs)~~.
4. High-Level Disinfection (HLD): **A process that deactivates all types of microorganisms with the exception of bacterial spores and prions.**
   ~~a. The destruction of all forms of microbial life, except large numbers of spores~~
   ~~b.~~**a.** Used for reprocessing **reusable** semi-critical **items**~~patient care items~~.
   b. May be accomplished via an automated reprocessor or manual soaking in a high-level disinfecting agent. The method of HLD for each piece of equipment shall be selected based on manufacturer's instructions for use (IFU).
   c. **The effectiveness of HLD depends on effective pre-cleaning, manual cleaning, and rinsing to decrease the organic load and microbial content of the equipment/endoscope, drying after rinsing to avoid dilution of HLD agent, and proper preparation and use of the disinfectant in accordance with the manufacturer's IFU.**
5. Pre-Cleaning: Pre-cleaning **removes organic material (i.e., blood, body fluids, body soil) and decreases the bioburden, making it much more likely that subsequent reprocessing steps will be successful. Pre-cleaning should be performed at the point of use, before bioburden has an opportunity to dry and before complete decontamination.** ~~is the first and most important step in removing the microbial burden from an item. Retained debris may inactivate or interfere with the capability of the active ingredient of the chemical solution to effectively kill and/or inactivate microorganisms.~~
~~5.~~**6. Leak Testing: Testing to detect damage to the interior channels and exterior surfaces of** ~~the~~ **an endoscope that can lead to inadequate disinfection and further damage. Leak**

Department Approval	Clinical Policies & Procedures	Nurse Executive Council	Infection Control Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06, 05/07, 06/09, 09/11, 08/12, 04/15, 06/17, 03/20	08/12, 06/15, 12/16, 07/17, 03/20	08/12, 07/15, 01/17, 07/17, 04/20	07/15, 04/17, 10/17, 03/20, 04/20	10/12, 07/15, 05/17, 11/17, 05/20	06/20	11/12, 08/15, 01/18, n/a	12/12, 08/15, 01/18

testing is done before immersion of the endoscope in reprocessing solutions to minimize damage to parts of the endoscope not designed for fluid exposure.

B. **POLICY:**

1. **With the exception of pre-cleaning, reprocessing of endoscopes should not be conducted in patient care areas because of the risk of patient exposure to contaminated surfaces and devices.**
2. **Gloves should be worn during all phases of endoscope handling, including moving clean scopes from storage to a procedure room, removing scopes from an automated endoscope reprocessor (AER)~~'s~~, and taking the scope into storage.**
3. **Follow manufacturer's recommendations for maximum time to elapse between steps of pre-cleaning, cleaning, and HLD/sterilization. If the maximum allowable time is exceeded between steps, follow manufacturer's recommendations for delayed reprocessing.**

~~1.~~4. **Visual inspection is an essential step to make sure the equipment/endoscope is visibly clean. Endoscopes and reusable accessories should be visually inspected during all stages of handling and reprocessing, before, during and after use, in addition to during and after cleaning and before HLD.**

~~2.~~5. The department **leadership team**~~manager~~ has the responsibility to oversee the HLD process in ~~his/her~~**their** department with consultation from Infection Prevention.

~~3.~~6. The following staff **with documented competency** are authorized to perform HLD, including, but not limited to:

a. Sterile Processing **Department (SPD)** Technicians
b. ~~Endoscopy~~ **Procedural** Registered Nurses (RN's)
c. Respiratory Therapists
d. Equipment Respiratory Technicians
e. Ultrasound Technicians
~~e.~~**f.** **Special Procedure Technicians**
~~f.~~**g.** Cardio**vascular**~~logy~~ Techn**ologists**~~icians~~
h. Endoscopy Technicians
~~g.~~**i.** **Radiology Technologist**
~~h.~~**j.** Surger~~yical~~ RN's

~~4.~~7. Education, Training, and Competency Validation:

a. Initial:
   i. An orientation and training program will be provided to all staff prior to performing HLD. Clinical educators, clinical managers, or any other competent staff member will provide this training. Competency validation will be accomplished through individual return demonstration of skills. **Records of training and competency validation will be maintained.**~~Competency records will be maintained in unit specific staff files.~~
b. Annual:
   i. All staff **who** perform~~ing~~ HLD will complete an annual Computer Based Learning (CBL) module.
   ii. **All S**staff who perform HLD will complete an annual competency.
      1) Additional training will be provided on an as needed basis

C. **PROCEDURE:**

1. **PRE-CLEANING:** Pre-clean equipment **in the procedure room immediately after removal of the equipment or insertion tube from the patient and prior to disconnecting the endoscope from the power source,** according to **manufacturer's** IFU. General guidelines for pre-cleaning include:
   a. Don personal protective equipment **(PPE), including, at a minimum, gloves, eye protection, impervious gown, and face shield or simple surgical mask.**

b. **Immediately after removing** ~~Remove~~ the **equipment/endoscope** ~~item~~ from the patient, ~~immediately~~ wipe the insertion tube with the wet cloth or sponge soaked in a~~n enzymatic or~~ detergent solution (commercially packaged or freshly prepared). Discard the cloth/sponge after use, **according to manufacturer's IFU**.

c. **Place the distal end of the endoscope into the appropriate detergent solution and** ~~S~~suction the ~~enzymatic/~~detergent solution through all channels, **per manufacturer's IFU. Finish by suctioning air, according to manufacturer's IFU.**

~~c.~~i. **Duodenoscopes/Echoendoscopes: Flush and manipulate the forcep elevator per manufacturer's IFU.**

d. **Flush air and water channels per manufacturer's IFU.**

e. **Flush auxiliary water channel per manufacturer's IFU.**

f. **Detach the endoscope from the light source and suction pump.**

g. **Attach protective video caps where applicable.**

~~d.~~h. Transport the **soiled equipment/endoscope**~~item~~ to the reprocessing area in an enclosed, **puncture-resistant** container with a Biohazard label. ~~Reprocessing should occur in a room separate from the procedure room.~~

2. **LEAK TESTING: Leak test equipment/endoscope according to manufacturer's IFU. General guidelines for mechanical (wet) leak testing include:**

a. **Remove suction valves, air water valves, and biopsy valves, according to manufacturer's IFU.**

b. **Discard those parts that are designated as disposable. The endoscope must be completely disassembled so** ~~that~~ **all surfaces may be reached for thorough cleaning, according to manufacturer's IFU.**

c. **Attach the leak tester and pressurize the endoscope before submerging it in clear water, according to manufacturer's IFU.**

i. **Never add detergent to water before or during leak testing. Detergent will obscure bubbles leaking from the endoscope and a leak may be missed. Follow manufacturer's IFU to determine if it is necessary to remove other detachable parts before leak testing.**

d. **With the pressurized endoscope completely submerged, flex the distal portion of the endoscope in all directions, observing for bubbles. Check the insertion tube, distal bending section, and universal cord for bubbles coming from the interior of the endoscope, according to manufacturer's IFU.**

e. **Remove the endoscope from the sink or basin. Turn off the leak tester. Disconnect the leak tester from the video cap. Allow the endoscope to depressurize. Ensure the video cap is secure and has not loosened with the removal of the leak tester. Continue with the reprocessing steps when the test is complete unless a leak is detected, according to manufacturer's IFU.**

f. **Remove the endoscope from service if a leak has been identified or detected, and follow manufacturer's IFU for how to proceed.**

~~2.~~3. **MANUAL CLEANING: Manually** ~~C~~clean equipment/**endoscopes prior to automated/manual HLD or sterilization,** according to **manufacturer's** IFU. General guidelines for **manual** cleaning include:

a. Don ~~personal protective equipment~~**PPE.**

b. Fill a sink or basin with freshly prepared solution of water and a **medical grade,** low-~~sudsing~~ **foaming, pH neutral**~~enzymatic~~ detergent **(with or without enzymes), per manufacturer's IFU**~~compatible with the item~~.

i. Dilute and use according to the detergent **manufacturer's** IFU.

ii. Fresh detergent solution should be used for each item to prevent cross-contamination.

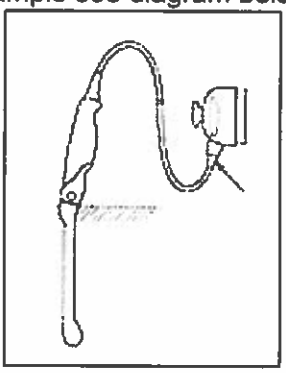
iii. Low-~~sudsing~~ **foaming** detergents are recommended such that the device can be clearly visualized during the cleaning process to preclude personnel injury and to

allow for complete cleaning of **lumen** surfaces. ~~Excessive sudsing can inhibit good fluid contact with the device surfaces.~~

~~c. Leak test equipment according to IFU.~~

~~d.~~**c. Ensure the video cap is secure, if applicable.** Immerse the ~~item~~**equipment/endoscope**.

i. Exception: Non-immersible probes shall only be immersed up to the connector (for example see diagram below)



~~e.~~**d.** Wash all debris from the exterior of the ~~item~~ **equipment/endoscope** by brushing and wiping the instrument while submerged in the detergent solution. ~~Whenever practical, leave the item~~**The equipment/endoscope should be** submerged in the detergent solution when performing all subsequent cleaning steps **to prevent splashing of contaminated fluid and aerosolization of bioburden.** ~~Note that the item should be left under water during the cleaning process to prevent splashing of contaminated fluid.~~

~~f.~~**e.** Use a small, soft brush to clean all **reusable,** removable parts**, including inside and under the suction valve, air/water valve, and biopsy port cover and openings**. Use non-abrasive and lint-free cleaning tools to prevent damage to the ~~item.~~**equipment/endoscope. It is recommended that single-use, disposable cleaning tools be used when possible.**

f. Brush all accessible endoscope channels, as well as the body, insertion tube, and the umbilicus of the endoscope. Use a brush size compatible with each channel. All internal and external surfaces of the endoscope and its removable parts must be thoroughly cleaned, and all auxiliary channels (even if not used) must be brushed and flushed according to manufacturer's IFU.

~~g. Clean all non-removable, non-submersible parts according to IFU.~~

g. Duodenoscopes have an elevator channel which is difficult to clean, requiring additional steps in all phases of reprocessing. Follow manufacturer's IFU for each specific endoscope model for additional steps at each phase of reprocessing.

h. After each passage, rinse the brush in the detergent solution, removing any visible debris before retracting and reinserting it.

~~h.~~**i.** Continue brushing until there is no debris visible on the brush.

i. **All brushes shall be disposable.** Dispose of single-use brushes after each use.

j. Attach the endoscope manufacturer's cleaning adapters for suction, biopsy, air, and water channels. An automated pump may be used according to manufacturer's IFU for flushing, in lieu of manual flushing. Refer to manufacturer's IFU to determine if the automated pump is compatible with the endoscope.

k. Attach the manufacturer's cleaning adapters for special endoscope channels (i.e., elevator channel, auxiliary channel), according to manufacturer's IFU.

l. Flush all channels with the detergent solution to remove debris and soak the endoscope and its internal channels per the manufacturer's IFU, for the period of time specified by the detergent manufacturer's IFU.

~~i.~~m. ~~Soak the item for the period of time specified by the label of the enzymatic detergent. If, due to time constraints, it is not possible to complete the reprocessing immediately, the item should be brushed and allowed to soak in a detergent solution until it can be thoroughly reprocessed.~~ Follow **manufacturer's** IFU for the **recommended reprocessing time frame.** ~~maximum liquid exposure time.~~ **If the time frame is not achievable, implement the manufacturer's procedures for delayed reprocessing.**

~~3.~~4. **RINSE AFTER MANUAL CLEANING: Thoroughly** ~~R~~rinse **the** equipment/**endoscope** after cleaning, according to **manufacturer's** IFU.

a. Thoroughly rinse the ~~item~~ **equipment/endoscope and all removable parts** with clean water to remove residual debris and detergent.

~~a.~~**b.** **Purge water from all channels using forced air.**

~~b.~~**c.** Dry the exterior of the ~~item~~**equipment/endoscope** with a clean soft, lint-free cloth to prevent dilution of the ~~liquid chemical~~ HLD agent used in subsequent steps.

5. **VISUAL INSPECTION: Inspect equipment for cleanliness and integrity, including all exterior surfaces of equipment and internal channels of endoscopes (using a borescope).**

a. **Visually inspect for conditions that could affect the disinfection process (e.g., cracks, corrosion, discoloration, and retained debris).**

b. **Repeat manual cleaning steps if equipment/endoscope is determined not to be visually clean.**

c. **Remove damaged endoscopes and accessories from service for repair or disposal, according to manufacturer's IFU.**

6. **HIGH-LEVEL DISINFECTION:** Perform HLD **(manual or automated)** according to **manufacturer's** IFU.

a. **Follow high level disinfectant manufacturer's IFU:**

i. **Use Cidex OPA directly from the manufacturer's original container, no activation is required, per manufacturer's IFU.**

ii. **Follow manufacturer's IFU for expiration dating:**

1) **Cidex OPA has a 14 day reuse life once it has been poured into a secondary container (soaking basin/tray).**

2) **Record the date Cidex OPA was poured into the secondary container and the expiration date on: the basin/tray, the lid(s) of the basin(s)/tray(s) and on the Cidex OPA Log Sheet for each basin/tray used.**

3) **Any Cidex OPA that remains unused in the manufacturer's original container is good for 75 days from the date the container is opened. Record the date the container was opened directly on the container.**

~~Temperature Recording:~~

~~When the Cidex OPA has been poured into a secondary container, record (on Cidex OPA Log Sheet) the temperature each time the Cidex OPA is used. Temperature must be 68°F or higher for manual disinfection.~~

b. **High level disinfectants must be tested for minimum effective concentration (MEC) according to manufacturer's IFU prior to each use.**

~~i. Minimum Effective Concentration (MEC) Testing:~~

~~1) Cidex OPA must be tested prior to each use for appropriate concentration using Cidex OPA Test Strips.~~

~~a) Test each time a new set of instruments / devices is placed in soaking basin / tray.~~

~~2)~~**i.** **Follow manufacturer's IFU for test strip expiration date.** Cidex OPA Test Strips expire 90 days after the test strip container is opened.

~~a)~~**1)** Label test strip container with ~~date opened and~~ expiration date.

~~b)~~**2)** Tightly re-cap test strip bottle after each use.

~~3)~~ii. Completely submerge the indicating pad of the test strip in the Cidex OPA.
~~4)~~iii. Hold the test strip in the solution for 1 second, and then remove the test strip.
~~a)~~1) Do not swirl the strip.
~~5)~~iv. Remove excess solution from the test strip by standing the strip upright ~~on a paper towel~~.
~~6)~~v. Read the results in 90 seconds. Do not read past 90 seconds. Pad will be completely purple to indicate effective solution.
~~7)~~vi. If any blue remains on the indicator pad apart from the top line, solution is ineffective and must be discarded.
vii. **Results of MEC testing (Pass or Fail) must be documented on the HLD log.**
~~8) Record results (Pass or Fail) on the Log Sheet.~~
~~ii. Quality Control of Test Strips:~~
~~1)~~viii. Cidex OPA test strips must be tested for efficacy each time a new container of test strips is opened. Repeat the quality control testing of the test strips at 30 days and 60 days, if the container is still in use. Results must be recorded on the Cidex OPA Log. Testing is completed as follows:
~~a)~~1) Open new bottle of test strips and record lot # on Cidex OPA Log Sheet.
~~b)~~2) Open a container of Cidex OPA.
~~c)~~3) Dilute one part Cidex OPA solution with one part tap water.
~~i)~~a) Example: one ounce Cidex OPA to one ounce tap water.
~~d)~~4) Submerge 3 Cidex OPA test strips in undiluted Cidex OPA solution and 3 Cidex OPA test strips in the diluted Cidex OPA solution for 1 second. Remove the test strips and read the results in 90 seconds.
~~e)~~5) The test strips that were placed in the full strength Cidex OPA should turn purple. The test strips in the diluted Cidex OPA will either remain the same or have an incomplete color change. Refer to the color chart.
~~f)~~6) Record the test results on the Cidex OPA log sheet.
~~g)~~7) If the test strips fail the test, repeat the test with fresh Cidex OPA solution and test strips from another bottle. If they fail, notify Materials Management. Return the test strips to Materials Management and re-order test strips.

~~4.~~b. HLD may be performed by the following methods:
~~a.~~i. Automated Endoscope Reprocessor (AER)
1) Follow **manufacturer's** IFU for HLD and AER operation.
2) **All channel adapters shall be used according to manufacturer's IFU.**
3) **For duodenoscopes and echoendoscopes, follow manufacturer's IFU for disinfecting the elevator channel and positioning the elevator during HLD.**
4) **Place valves and other removable parts into the soaking basin of the reprocessor. Unless the reprocessor has dedicated space for accessories, reprocess these items separately.**
5) **Set the machine according to manufacturer's IFU and allow it to complete all cycles/phases. If cycles/phases are interrupted, HLD cannot be ensured and the full cycle must be repeated.**
6) **If a final alcohol rinse cycle is not included in the automated reprocessor cycle, this step should be done manually, followed by purging all the channels with air until dry.**
~~i.~~7) **Remove endoscopes promptly from the AER after cycle completion. Do not allow endoscopes to sit in the AER for long periods, such as overnight.**
~~b.~~ii. Hydrogen Peroxide-Based HLD Agent (i.e., Trophon) for endocavity probes **or , ultrasound probes used during percutaneous procedures according to manufacturer's IFU**:

~~i.~~1) Don ~~personal protective equipment~~**PPE**.
~~ii.~~2) Load the clean and dry probe into the Trophon ~~Endocavity~~ Probe Reprocessor (EPR).
~~iii.~~3) Ensure that the probe is secured high in the chamber with tip of probe above the embossed line.
~~iv.~~4) Place the Trophon Chemical indicator into the indicator holder with red side facing up.
~~v.~~5) Close the chamber door.
~~vi.~~6) Confirm that the probe is both clean and dry, if YES, press start.
~~vii.~~7) At the end of the seven minute HLD cycle, Trophon screen will state "cycle complete remove and wipe the probe".
~~viii.~~8) Don clean gloves.
~~ix.~~9) Open the chamber door.
~~x.~~10) Remove the chemical indicator and check the chemical indicator chart on the chemical indicator carton. Discard the chemical indicator after verifying a positive reading.
~~xi.~~11) Remove and wipe the probe using a dry single use cloth.
~~xii.~~12) Close the chamber door.
~~xiii.~~13) Record the HLD cycle on the log **or place cycle verification sticker to the clean probe covering for recording.**

~~c.~~iii. Manual HLD:

~~i. Use Cidex OPA directly from the manufacturer's original container, no activation is required.~~

~~ii. Expiration Dating:~~

~~1) Cidex OPA has a 14 day reuse life once it has been poured into a secondary container (soaking basin/tray).~~

~~a) Record the date Cidex OPA was poured into the secondary container and the expiration date on: the lid(s) of the basin(s)/tray(s) and on the Cidex OPA Log Sheet for each basin/tray used.~~

~~2) Any Cidex OPA that remains unused in the manufacturer's original container is good for 75 days from the date the container is opened. Record the date the container was opened directly on the container.~~

~~3)~~1) Temperature Recording:

a) When the Cidex OPA has been poured into a secondary container, record (on Cidex OPA Log Sheet) the temperature each time the Cidex OPA is used. Temperature must be 68° F or higher for manual disinfection.

~~4)~~2) **Perform MEC testing for high level disinfectant per manufacturers' IFU**

~~iii. Minimum Effective Concentration (MEC) Testing:~~

~~1) Cidex OPA must be tested prior to each use for appropriate concentration using Cidex OPA Test Strips.~~

~~a) Test each time a new set of instruments / devices is placed in soaking basin / tray.~~

~~2) Cidex OPA Test Strips expire 90 days after the test strip container is opened.~~

~~a) Label test strip container with date opened and expiration date.~~

~~b) Tightly re-cap test strip bottle after each use.~~

~~3) Completely submerge the indicating pad of the test strip in the Cidex OPA.~~

~~4) Hold the test strip in the solution for 1 second, and then remove the test strip.~~
~~a) Do not swirl the strip.~~
~~5) Remove excess solution from the test strip by standing the strip upright on a paper towel.~~
~~6) Read the results in 90 seconds. Do not read past 90 seconds. Pad will be completely purple to indicate effective solution.~~
~~7) If any blue remains on the indicator pad apart from the top line, solution is ineffective and must be discarded.~~
~~8) Record results (Pass or Fail) on the Log Sheet.~~

~~iv. Quality Control of Test Strips:~~
~~1) Cidex OPA test strips must be tested for efficacy each time a new container of test strips is opened. Repeat the quality control testing of the test strips at 30 days and 60 days, if the container is still in use. Results must be recorded on the Cidex OPA Log. Testing is completed as follows:~~
~~a) Open new bottle of test strips and record lot # on Cidex OPA Log Sheet.~~
~~b) Open a container of Cidex OPA.~~
~~c) Dilute one part Cidex OPA solution with one part tap water.~~
~~i) Example: one ounce Cidex OPA to one ounce tap water.~~
~~d) Submerge 3 Cidex OPA test strips in undiluted Cidex OPA solution and 3 Cidex OPA test strips in the diluted Cidex OPA solution for 1 second. Remove the test strips and read the results in 90 seconds.~~
~~e) The test strips that were placed in the full strength Cidex OPA should turn purple. The test strips in the diluted Cidex OPA will either remain the same or have an incomplete color change. Refer to the color chart.~~
~~f) Record the test results on the Cidex OPA log sheet.~~
~~g) If the test strips fail the test, repeat the test with fresh Cidex OPA solution and test strips from another bottle. If they fail, notify Materials Management. Return the test strips to Materials Management and re-order test strips.~~

3) **Perform manual HLD according to manufacturer's IFU. Equipment/endoscopes must be purged with air and externally dried prior to immersion to minimize diluting the high level disinfectant.**

~~v.~~**4)** **Completely ~~l~~immerse** the ~~item~~**equipment/endoscope and all removable parts** in a container of **high level disinfectant/sterilant (i.e.~~e.g.~~,** Cidex OPA).

~~1)~~**a)** Exception: Non-~~l~~immersable probes shall only be immersed up to the connector.

~~2)~~**b)** The container must be of a size to accommodate the item without **undue coiling or** overflowing, and ~~must be used in conjunction with a device to contain the~~**ventilation must be sufficient to remove** chemical vapors.

~~3)~~**c)** To prevent damage to the item, the ~~item~~**equipment/endoscope** should not be soaked with other sharp instruments that could potentially **cause** damage ~~the item~~.

~~4) Complete microbial destruction cannot occur unless all surfaces are in complete contact with the chemical.~~

~~5) Use the Cidex OPA in a device used to minimize chemical vapor exposure. Note that:~~
~~a) Exposure to chemical vapors may present a health hazard.~~
~~b) The reprocessing area should have engineering controls to ensure good air quality.~~

d) **Flush the disinfectant into all channels of the endoscope until it can be seen exiting the opposite end of each channel. All channels must be filled with the chemical so no air pockets remain within the channels. Complete microbial destruction cannot occur unless all surfaces are in complete contact with the chemical.**

e) **Cover the soaking basin with a tight-fitting lid to minimize chemical vapor exposure.**

f) Soak the ~~item~~ **equipment/endoscope** in the **high-level disinfectant (i.e.,** Cidex OPA) for the time/temperature required to achieve HLD. Use a timer to verify soaking time. Document device and time.
   i) Cidex OPA requires 12 minutes minimum at room temperature.

~~6)~~g) **Purge all channels completely with air before removing the equipment/endoscope from the high-level disinfectant/sterilant. Purging the channels preserves the concentration and volume of the chemical and prevents exposure from dripping and spilling.**

~~vi.~~7. **RINSE AFTER MANUAL HIGH-LEVEL DISINFECTION:** ~~Rinse After Disinfection:~~
   a. Thoroughly rinse all surfaces **and removable parts** of the ~~item~~ **equipment/endoscope, and flush all channels of the equipment/endoscope and its removable parts,** with ~~copious amounts of~~ clean water **per manufacturer's IFU** (i.e., 2 gallons per rinse).
   ~~1)~~b. Repeat rinsing with fresh rinse water for a total of 3 times.
      ~~a)~~i. Tap water is acceptable for non-endoscopic devices.
      ~~b)~~ii. Use sterile water or filtered potable water for endoscopic devices.
      ~~c)~~iii. Rinsing prevents exposure and potential injury of skin and mucous membranes from chemical residue.
      ~~d)~~iv. Fresh water should be used for each item and each rinse.
      ~~e)~~v. The device should be totally immersed for a minimum of 1 minute with each rinse.
      ~~f)~~vi. Discard rinse water ~~for~~**after** each rinse. Do not reuse water for any other purpose.

~~2.~~8. **DRYING:** ~~Drying:~~
   a. **All channels and the surface of the equipment/endoscope must be thoroughly dried before storage.**
   b. **In order to ensure equipment/endoscopes are thoroughly dried, they must be flushed with 70-90% ethyl or isopropyl alcohol prior to being dried with pressurized, filtered air either by the AER or manually, according to manufacturer's IFU.**
      i. **Alcohol shall be stored in a closed container between uses.**
   c. **Dry the exterior of the item with a soft, clean lint-free cloth.**
   d. ~~Wipe item with clean cloth to remove residual moisture and flush channels with pressurized air~~**Dry all channels per manufacturer's IFU. If forced instrument air is recommended in the manufacturer's IFU, ~~.~~follow manufacturer's recommendations to determine air pressure limits for the particular model of endoscope.**

i. **If forced instrument air is not recommended by the manufacturer's IFU, hang scopes vertically to drip dry for a minimum determined time prior to placing endoscopes in storage.**

a. **Thoroughly rinse and dry all removable parts. Do not attach removable parts (e.g., valves) to the equipment/endoscope during storage.**

~~i. Bacteria such as Pseudomonas aeruginosa have been identified in both tap and filtered water, and may multiply in a moist environment.~~

~~ii. Wipe item with alcohol per IFU for use~~

~~1) 70% isopropyl alcohol is used to assist in drying of surfaces.~~

~~2) Use alcohol that has been properly stored in a closed container between uses. Alcohol rapidly evaporates when exposed to air, and cannot be relied upon to assist in the drying process if below the recommended percentage level.~~

~~3) AER may automatically perform alcohol flush; refer to AER IFU for use.~~

~~iii. Alcohol wipe should be used even when sterile water is used for rinsing.~~

~~iv. Dry the exterior of the item with a soft, clean lint-free cloth.~~

~~3.~~9. **STORAGE:**~~Storage:~~

a. Store ~~the item~~**equipment/endoscopes** in a **clean,** well-ventilated, **and** dust-free area, **according to endoscope and storage cabinet manufacturer's IFU.**

i. **Transport and store items that are processed by HLD and stored before use in accordance with the device manufacturer's IFU and in a manner that protects the device from damage or contamination.**

ii. **Cabinets and equipment/endoscopes shall be visually inspected to ensure cleanliness before storing.**

~~i. A storage area with good ventilation will encourage continued air-drying of the surfaces, and prevent undue moisture build-up, thus discouraging any microbial contamination.~~

iii. Use storage cabinets that are made of a material that can be disinfected.

~~ii.~~iv. **Storage cabinets must be of sufficient height, width, and depth to allow flexible endoscopes to hang vertically without coiling and without touching the bottom of the cabinet.**

v. Wipe down storage cabinets with a hospital-approved disinfectant at least every ~~14~~**seven (7)** days.

~~iii.~~1) **Endoscopes must be removed from the cabinet ~~and reprocessed~~ during storage cabinet cleaning.**

~~iv. Correct storage of the item will prevent damage to the instrument by protecting it from physical impact.~~

~~b. Storage of endoscopes:~~

~~i.~~b. Hang endoscopes in a vertical position, with all caps, valves, and other detachable components removed to prevent moisture accumulation and microbial growth.

~~ii.~~c. ~~Ensure scopes hang freely so they are not damaged by contact with one another~~**Endoscopes should hang freely so they are not damaged or contaminated by physical impact or contact with one another.**~~.~~

~~iii.~~d. Reusable buttons and valves shall be reprocessed and stored together with the endoscope as a unique set for tracking purposes.

~~1)~~e. Endoscopes may be stored for up to **seven** (7) days if they have been **effectively** reprocessed according to **manufacturer's** IFU and ~~they~~ are stored in a way that keeps them completely dry and free from environmental and human contamination.

i. On the 7th day of storage, endoscopes must be reprocessed.

ii. **Endoscopes shall have a tag indicating date reprocessing is due.**

~~2)~~f. **Staff should wear clean gloves when handling processed endoscopes.**

~~4.~~8. Disposal of Cidex OPA:

a. Add a neutralizing agent to Cidex OPA in accordance with the manufacturer's **IFU**~~recommendations~~ prior to disposal.

~~5. Follow manufacturer's recommendations for maximum time to elapse between steps of pre-cleaning, cleaning, and HLD/sterilization. If the maximum allowable time is exceeded between steps, follow manufactures recommendations for delayed reprocessing steps.~~

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

1. ~~Olympus Dual Scope Disinfector (DSD) Log – Sample~~

C. **REFERENCE(S):**

1. **AORN, Inc. (2020).** ***Guidelines for Perioperative Practice.*** **Denver.** ~~AORN Perioperative Guidelines for Practice, 2016 Edition.~~
2. Cidex OPA manufacturer's instructions for use.
~~2.~~3. **Society of Gastroenterology Nurses and Associates, Inc. (2018).** ***Standards of Infection Prevention in Reprocessing Flexible Gastrointestinal Endoscopes.*** **Chicago.**
~~3. Multi-Society Guideline on Reprocessing Flexible Gastrointestinal Endoscopes. Vol73, No 6: 2011.~~
~~4. Standards of Infection Prevention in Reprocessing Flexible Gastrointestinal Endoscopes. Society of Gastroenterology Nurses and Associates, Inc, 2016.~~
~~5. W. A. Rutala, PhD, MPH, D.J. Weber, MD, MPH (2014). Cleaning, disinfection, and sterilization in healthcare facilities. APIC Text of Infection Control & Epidemiology, Chapter 31.~~

Olympus Dual Scope Disinfector (DSD) Log – Sample

Tri-City Medical Center
ADVANCED HEALTH CARE FOR YOU

OLYMPUS DUAL SCOPE DISINFECTOR (DSD) Log

QC OF TEST STRIPS
TO BE COMPLETED WHEN OPENING A NEW VIAL OF TEST STRIPS, 30 DAYS, 60 DAYS
DISCARD TESTS STRIPS AT 90 DAYS

TEST STRIP LOT NUMBER	TEST STRIP DATE OPENED	TEST STRIP EXPIRATION DATE	QC PERFORMED (CIRCLE ONE)	TEST RESULT PASS OR FAIL	TESTED BY (INITIALS)
			INITIAL 30 DAY 60 DAY		

INSTRUCTIONS FOR USE

Pre-Disinfection:
1. Leak test, brush, and clean endoscope
2. Place scope into tray and begin cycle following DSD instructions
3. Record required items in boxes below

Post-Disinfection:
1. Confirm the cycle met parameters per manufacturer's recommendations.
2. Parameters not met require repeating the load in another station.
3. Failure to meet parameters- Notify Engineering Department

PROCESSING LOG

Patient Sticker Procedure & Physician	Time	Temperature	Cidex OPA Test Strip (Pass or Fail)	Leak Test (Pass or Fail)	Alcohol Rinse Complete (Yes/No)	Item Description or Scope #	Operator's Initials

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**4/97**	**SUBJECT:**	**Justice Involved Patients**
REVISION DATE:	**10/99, 6/03, 8/05, 8/07, 4/12 02/13**	**POLICY NUMBER:**	**VI.B.2**

Patient Care Services Content Expert~~Department~~ Approval:	**~~11/16~~02/20**
Clinical Policies & Procedures Committee Approval:	**~~12/16~~04/20**
Nursinge Leadership~~Executive Council~~ Approval:	**~~01/17~~05/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~01/17~~05/20**
Administration Approval:	**06/20**
Professional Affairs Committee Approval:	**~~02/17~~ n/a**
Board of Directors Approval:	**02/17**

A. **PURPOSE:**
1. To establish guidelines for the responsibility of patients who are justice involved individuals receiving medical care, and/or are admitted to Tri-City Healthcare District (TCHD) facility.

B. **DEFINITIONS:**
1. Law Enforcement Personnel: Any Federal, State, or Local Peace Officer or Correctional Officer or their contract agencies that has the responsibility for the custody of justice involved individual.
2. Justice Involved Individual: Any individual who is under lawful physical arrest/ in the custody of a Law Enforcement Officer and brought to TCHD to receive medical care, evaluation, treatment, or admission.

C. **POLICY:**
1. Law Enforcement personnel, in consultation with TCHD personnel, are responsible for considering issues related to the use of restraint for non-clinical purposes; imposition of disciplinary restrictions and the restriction of rights.
2. Law Enforcement shall be responsible for maintaining the security and the detention of any justice involved individual seen or admitted for medical care of the duration of the admission. The TCHD Security Department shall be the contact liaison between the custodial agency and the Medical Center. TCHD Security Department personnel shall not assume any custodial duties as they relate to justice involved individual.
3. The Admitting Physician is responsible for determining the justice involved individuals plan of care while in the Medical Center, including the length of stay for medical treatment, the discharge plan, and consulting with the law enforcement agency in the continuing care and discharge plan.
4. Patient care shall be delivered to the justice involved individual as determined by the Clinical Staff, following the admitting Physician's orders and hospital or departmental standards of care, that also meets and respects security concerns and restrictions
5. TCHD recognizes the American Civil Liberties Union and will ensure that justice involved individuals receive adequate medical care while admitted to TCHD.
6. Registration Department Responsibilities:
   a. The Registration Department shall notify Security via Private Branch Exchange (PBX) when a justice involved individual is admitted to either the Emergency Department or the Medical Center with the following information:

i. Patient Name
ii. Location of justice involved individual
iii. Law Enforcement Agency responsible for patient

7. Security Department Personnel Responsibility:
   a. Security personnel shall:
      i. Contact the Law Enforcement Officer responsible for guarding the justice involved individual.
      ii. Establish communications.
      iii. Orient the Law Enforcement Officer using the "Progressive Care Service Training" form (attachment 1).
      iv. Obtain Custodial Officer's signature indicating they have read the "Forensic Services Training" form.
   b. Security shall liaison with the **Nursing Leadership**~~Assistant Nurse Manager (ANM)~~ or designee and the Administrative Supervisor (AS) to verify that the proper measures are being used by the agency responsible for the justice involved individual as it relates to the safety, security, and welfare of all patients, visitors, and staff members.
   c. Any situation that puts the safety, security, and welfare of any patient, visitor, or staff member at risk shall be immediately reported to the Lead Security Officer on duty. The Lead Security Officer shall inform the Security Supervisor and Risk/Legal Services.
8. Law Enforcement Officer Responsibilities:
   a. Law Enforcement Officers shall maintain custodial restraints on the justice involved individual at all times, unless the medical condition or prescribed treatment indicates otherwise.
   b. Should medical restraints or seclusion of a justice involved individual for behavioral or medical issues become necessary, TCHD policies shall be followed.
9. Security Supervisor Responsibilities:
   a. If the Lead Security Officer informs the Security Supervisor of a safety issue, the Security Supervisor shall contact the law enforcement agency involved in the incident to resolve the issue.
   b. The Security Supervisor shall contact the Administrator of the Law Enforcement agency responsible for the Law Enforcement Officer regarding any violation of this policy.
   c. The Security Supervisor shall maintain a file regarding the involved Law Enforcement Officer and incident.

D. **RELATED DOCUMENT(S):**
1. Custody Officer Orientation Sample

Tri-City Medical Center
Custody Officer Orientation Sample

1. **Medical Evaluation and Treatment:**
The primary concern for TCHD's Clinical Staff is the proper treatment and care of the justice involved individual and the safety, security, and welfare of all patients, visitors, and staff members.

2. **Custodial Restraints:**
Law Enforcement Officers are required to remain with the justice involved patient at all times while in the Medical Center. The justice involved patients must remain in custodial restraints at all times and the Law Enforcement Officer must have a key in his/her possession.

3. **Evacuation:**
Medical Center personnel are familiar with the evacuation routes. In the event an evacuation becomes necessary, the Law Enforcement Officer must remain with the justice involved patients at all times. TCHD personnel shall direct you and the justice involved patients out of the Medical Center.

4. **Facility Orientation:**
The Security Officer conducting this orientation shall show you where the restrooms, phones, and exits are located. Smoking is not permitted inside the Medical Center and only permitted in designated areas on the campus.

5. **Cell Phones**:
The use of personal cell phones shall follow TCHD policy as well as the Law Enforcement Agency Policy regarding use while on duty. Cell phones may not be used to photograph patients or any Individual including self without permission from TCHD admistration.

6. **Security Codes:**
Internal and external disasters or security codes are communicated to Medical Center personnel by overhead paging using the below listed codes. It is not necessary for the Custody Officer Law Enforcement Officer to respond in any way to a code unless directed by a ANM or designee, Security, or the Administrative Supervisor.

Code Blue:	Adult Arrest/Medical Emergency	Code Adam:	Infant Abduction
Code Pink:	Infant Arrest/Medical Emergency	Code Gray:	Hostage Situation
Code Yellow:	Radiation Disaster	Code Orange:	Internal/External Disaster
Code Green:	Oxygen Emergency	Code Red:	Fire
Dr. Strong:	Violent Person	Code Caleb:	Severely ill infant
Code OB	STAT Team Mobilization	Code Silver:	Active shooter situation

7. **Phones:**
To contact the operator in case of an emergency dial "66." Dial "80" and then "911" to contact the local police department in case of an emergency. Dial "80" for an outside line for non-emergency calls. Personal calls are not allowed. The custodial Law Enforcment Officer is required to call Security and notify them if the justice involved patient is transferred within the Medical Center. To contact the operator, Administrative Supervisor, or Security, dial "0."

8. **Relief:**
The custodial Law Enforcement Officer's agency is responsible for providing relief for the on-duty Officer. Medical Center staff, including Medical Center Security Officers, may not take custody of any prisoner. The on-duty custodial Law Enforcement Officer must call the Security Department and have an Officer dispatched to your location to orientate the relief custodial Law Enforcement Officer. Each custodial Law Enforcement Officer shall be required to sign a copy of the "Progressive Care Services Training" form.

9. **Patient Confidentiality:**
In the course of medical treatment for the prisoner, the custodial Law Enforcement Officer may become aware of the justice involved patient's personal history, medical history, diagnosis, and treatment plan. This information is confidential and may not be shared with anyone including the Law Enforcement Officer's agency. Violations of the justice involved individual's confidential information could result in legal action.

I certify that I have read and understand the above requirements and that I have received a copy of this document for my records.

Signature _____ Print Name _____ Date _____

Agency Name _____ Patient Name _____ Room Number _____

White Copy: Security Department File **Yellow Copy: Custody Officer**

Tri-City Medical Center	Patient Care Services ~~Point of Care Manual~~
PROCEDURE:	**NITRAZINE TEST ON VAGINAL FLUID**
Purpose:	To assist in the evaluation of vaginal fluid **pH** for the presence of amniotic fluid.
~~Supportive Data:~~	~~The nitrazine test is a screening test performed on amniotic fluid to evaluate a suspected rupture of membranes. A Registered Nurse (RN) is authorized to perform this procedure. Testing is under the supervision of the Laboratory Point of Care (POC) Coordinator and under the jurisdiction of the Laboratory Medical Director.~~
Equipment:	~~Sterile g~~Gloves **Swab** **Phenaphthazine**/Nitrazine paper **pH 5.0 buffer and pH 7.0 buffer**

A. **DEFINITIONS:**

1. **Buffer - a solution that resists changes in pH when acid or alkali is added to it. Buffers typically involve a weak acid or alkali together with one of its salts.**
2. **CLIA - Clinical Laboratory Improvement Amendments**
3. **Nitrazine- see Phenaphthazine**
4. **pH – a measure of hydrogen ion concentration, a measure of the acidity or alkalinity of a solution.**
5. **Phenaphthazine- commonly known as nitrazine, a pH indicator dye used in healthcare.**
6. **POC – Point of Care**
7. **QC – Quality Control, performed to ensure the validity of test and test results.**
8. **Vaginal fluid – fluid that drains from the opening of the vagina.**

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

1. **The nitrazine test is a screening test performed on amniotic fluid to evaluate a suspected rupture of membranes. A Registered Nurse (RN) is authorized to perform this procedure. Testing is under the supervision of the Laboratory Point of Care (POC) Coordinator and under the jurisdiction of the Laboratory Medical Director.**

C. **PRINCIPLE:**

1. **Phenaphthazine paper is a Nitrazine indicator paper with a wide range of colors intended for invitro, semi quantitative determination of pH in the 4.5 – 7.5 range, used to interpret the alkaline nature of vaginal fluid. This test involves putting a drop of fluid obtained from the vagina onto paper strips. The strips change color depending on the pH of the fluid.**

~~B.~~D. **SPECIMEN:**

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

E. **REAGENTS/SUPPLIES:**

~~Gloves~~

~~Swab~~

1. **Phenaphthazine/ Nitrazine paper**
   a. **Storage: Room Temperature**
   b. **Stability : Unopened – until expiry on the dispenser; Opened – 6 months**
2. **pH 5.0 buffer and pH 7.0 buffer**

Patient Care Services Content Expert	Clinical Policies & Procedures	Nursing Executive Council	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
7/03, 4/04, 4/06; 6/09, 07/15, 05/18, 11/19	07/11, 08/15, 0718, 12/19, 01/20	08/11, 09/15, 07/18, 02/20	03/16, 08/18, 04/20	n/a	10/11, 04/16, 08/18, 05/20	09/18, 06/20	11/11, 05/16, n/a	11/11, 05/16, 09/18

a. **Storage: Room Temperature**
b. **Stability: Until expiry date on the bottle**

F. **INSTRUMENTATION:**

N/A

~~C.~~G. **QUALITY CONTROL (QC):**

1. QC Materials: ~~Normal and abnormal urine control vials~~ **pH 5.0 buffer and pH 7.0 buffer.**
2. Test the ~~normal and abnormal~~ control~~s~~ **buffers** per POC testing **procedure.**
3. Perform QC ~~each day testing is performed and when a new vial is opened.~~ **every month.**
4. Document results on the Point of Care Quality Control Log.
5. If the control results are not within acceptable limits the test is considered invalid and further patient testing is not allowed until corrective action steps are successful and documented.

~~D.~~H. **PROCEDURE:**

1. **Quality Control:**
   a. **Tear off a strip of Phenaphthazine paper from the roll.**
   b. **Dispense a drop of the pH 5.0 buffer solution onto the strip of pH paper.**
   c. **Immediately match the color of the pH paper close with the closest color on the color chart supplied with the Phenaphthazine paper dispenser.**
   d. **Repeat steps 1-3 with pH 7.0 buffer solution.**
   e. **Record the QC result on the Nitrazine QC Log.**
2. **Patient Testing:**
   ~~1.~~a. Perform hand hygiene and apply gloves.
   ~~2.~~b. Verify patient identification according to policy.
   ~~3.~~c. Swab the fluid pooling in the vagina or along the sidewall of the vagina (avoiding the cervix) using a cotton tip applicator.
   ~~4.~~d. Touch the applicator to the test paper ensuring the chemically treated paper is totally moistened.
   ~~5.~~e. Read the nitrazine paper immediately.
   ~~a. Nitrazine paper is a multi-parameter test paper with a wide range of colors used to interpret the alkaline nature of amniotic fluid.~~
   ~~b. Normal amniotic fluid is neutral (pH 7.0) or slightly alkaline (pH 7.25).~~
   ~~c. In the presence of amniotic fluid the moistened nitrazine paper will change from a yellow color to a dark blue color.~~
   ~~6.~~f. Compare the paper visually to the color scale printed on the outside of the ~~box~~ **nitrazine dispenser**.

I. **CALCULATIONS:**

N/A

J. **EXPECTED VALUES/ REFERENCE RANGES/ ACTION VALUES**

~~E. REPORTING RESULTS:~~

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

K. **REPORTING RESULTS:**

1. **Record the result in the electronic health record. Enter the following:**
   a. **Date and time.**
   b. **Result – negative, positive or equivocal**
   c. **Name of person performing test if recording for another person**

~~L.~~ **TECHNICAL NOTES:**

1. **The base stock color of the Phenaphthazine paper may vary from lot to lot, from tan to olive green. This will not affect the accuracy of the results.**
2. **Normal amniotic fluid is neutral (pH 7.0) or slightly alkaline (pH 7.25). In the presence of amniotic fluid the moistened nitrazine paper will change from a yellow color to a dark blue color.**
3. **Color comparison recommended under a combination of fluorescent light and daylight.**
4. **Nitrazine test is considered a waived test under (CLIA) 88 Federal Regulations.**
5. **Personnel performing the testing must be certified prior to performing patient testing. Certification is achieved through a training program coordinated by the nursing education department in conjunction with the lab. Competency is assessed and documented annually. Competency records are maintained on the nursing units.**
6. **Proficiency testing is coordinated through the laboratory staff and performed by testing personnel on the nursing units.**

~~I.~~M. **LIMITATIONS:**

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

~~F. DOCUMENTATION:~~

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

~~G. REGULATORY COMPLIANCE:~~

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

~~H.~~N. **FORM(S):**

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

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

1. Kennedy, B.B., Ruth, J.R., Martin, E.J. (2009). *Intrapartum management modules – A perinatal education program (4th ed.)*. Wolters Kluwer Health/Lippincott Williams & Wilkins: Philadelphia, PA.
2. Clinical Laboratory Improvement Amendments of 1988 Federal Regulations
~~4.~~3. **Micro Essential Laboratory. pHizatest® Phenaphthazine paper. Package Insert. Cat. No. 934. 2008**

Tri-City Medical Center	Distribution: **Patient Care Services**
PROCEDURE:	**PULSE OXIMETRY**
Purpose:	Pulse oximetry is the noninvasive measureme… percent of hemoglobin bound tooxygen. A pul… diode (LED) connected by a cable to an oxime… absorbed and then reflected back by oxygenated and deoxygenated hemoglobin molecules. The reflected light is processed by the oximeter, which calculates pulse oxygen saturation (SpO_2). This procedure applies to pediatric, adolescent and adult patient populations.
Supportive Data:	Masimo SET operator's manual, 2013. Pulse Oximetry Mosby's Nursing Skills (2014) Elsevier.
Equipment:	Oximeter machine, oximeter probe appropriate for patient, record sheet

DELETE – follow Elsevier Skills Pulse Oximetry; Pulse Oximetry (Pediatric), Follow manufacturer's Instructions for Use

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

~~1. Confirm physician order.~~
~~2. Identify patient per the Patient Care Services Policy, Identification, Patient~~
~~3. Position patient comfortably.~~
~~4. Explain to patient the procedure and the reason for the monitoring.~~
~~a. If finger is to be used, you may need to remove fingernail polish with acetone from digit to be assessed.~~
~~5. Choose a site:~~
~~a. The site shall be well perfused and not restrictive of a patient's movements. The ring finger of the non-dominant hand is preferred.~~
~~b. Always choose a site that completely covers the sensor's detector window.~~
~~c. The site shall be cleaned of debris prior to sensor placement.~~
~~i. If patient has tremors, the ear lobe may be used.~~
~~6. Ensure the emitter (red light) and the photo detectors are properly aligned when using a single patient adhesive or disposable sensor.~~
~~a. When using a reusable sensor, ensure it opens and closes smoothly.~~
~~7. Connect the sensor to the patient cable.~~
~~a. Ensure the connection is firm.~~
~~8. Turn on oximeter by activating power.~~
~~9. Ensure the display window is free of alarm and system failure messages.~~
~~10. Verify the following on the display:~~
~~a. High and low alarm limits for SpO_2 and pulse rate.~~
~~b. The reading for SpO_2 and pulse rate.~~
~~11. Wait 10-30 seconds for SpO_2 and pulse rate reading to stabilize.~~
~~a. Motion artifact is the most common cause of inaccurate readings.~~
~~12. Inform the patient the oximeter will alarm if the sensor falls off or if the patient moves the sensor.~~
~~a. If continuous SpO_2 monitoring is planned, verify SpO_2 alarm limits and alarm volume, which are preset by the manufacturer:~~
~~i. SpO_2: low 90%, high 100%~~
~~ii. preset pulse rate: low 50 bpm, high 140 bpm~~
~~iii. Limits for SpO_2 and pulse rate shall be determined by patient's condition~~
~~iv. Pulse oximeter alarms shall be kept on at all times~~
~~b. Adult SpO_2 sensor (Single Patient Use)~~
~~i. The site shall be checked at least every eight (8) hours to ensure proper adhesion, skin integrity, and proper alignment.~~
~~c. Reusable Tip Clip Sensor (for example ear probe)~~
~~i. The site must be changed every four (4) hours or every two (2) hours for patients with poor perfusion.~~
~~ii. The site shall be checked at least every 2 hours.~~

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
4/06; 4/09; 07/14, 03/20	07/11; 07/14, 04/20	07/11; 07/14, 05/20	n/a	08/11; 08/14, 05/20	06/20	9/11; 10/14, n/a	9/11; 11/14

d. Adult, Adolescents and Pediatric Reusable Finger Sensor
i. The site shall be changed every four (4) hours.

13. Remove the sensor from the patient for storage and disposal after monitoring is complete.
a. Disposable single-use sensors may be reapplied to the patient if the emitter and detector windows are clear and the adhesive still adheres to the skin.

14. Clean the sensors by wiping them down with hospital-approved disinfectant after each use.
a. If removing oximeter machine from patient's room, the cable and actual machine must also be wiped clean with hospital-approved disinfectant.
b. Allow the cable and sensor to dry before returning it to operation.

B. REQUIRED OBSERVATION AND DOCUMENTATION:

1. Document SpO_2 readings, oxygen flow & oxygen delivery device in the electronic health record (EHR).

C. REFERENCES:

Masimo Corporation. (2009). Retrieved from www.masimo.com

D. RELATED DOCUMENTS:

1. Patient Care Services Identification of Patient

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 06/10 **SUBJECT:** Surgical Attire

REVISION DATE: 02/12 ~~**POLICY NUMBER: XI.K**~~

Patient Care Services Content Expert~~Department~~ Approval:	~~02/17~~03/20
Clinical Policies and Procedures Approval:	~~03/17~~03/20
Nurse Executive Committee Approval:	~~03/17~~04/20
Operating Room Committee Approval:	~~04/17~~04/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~05/17~~05/20
Administration Approval:	06/20
Professional Affairs Committee Approval:	~~06/17~~ n/a
Board of Directors Approval:	06/17

A. **PURPOSE:**

1. To provide guidelines for attire worn within the semi-restricted and restricted areas of the surgical environment and invasive procedure areas, **for patient and personnel safety.** ~~The human body and inanimate surfaces inherent in the surgical environment are major sources of microbial contamination and transmission. Appropriate surgical attire and personal protective equipment (PPE) must be worn to provide a high level of cleanliness and hygiene within the surgical/procedural area. Appropriate surgical attire and PPE provide an effective barrier to contain bacterial shedding, promote environmental control, and prevent the dissemination of microorganisms to the surgical patient.~~

B. **DEFINITION(S):**

1. **Restricted areas: Areas which are accessible only from semi-restricted areas. Wearing of surgical attire is required and masks are required in the presence of open sterile supplies or scrubbed personnel. Restricted areas include the Operating Rooms (OR's) and sub-sterile rooms.**
2. **Semi-restricted areas: Areas which are accessible from unrestricted, other semi-restricted, or restricted areas. Wearing of surgical attire is required. Semi-restricted areas include corridors leading to the Operating Rooms, sterile storage rooms, peripheral support areas, and sterile processing areas.**
3. **Unrestricted areas: Areas which are accessible from the exterior of the building, other unrestricted areas or semi-restricted areas. Wearing of surgical attire is not required.**

~~1. Restricted Area- includes the Operating Room (OR) or procedure room, the clean core and scrub sink areas.~~

~~2. Semi-Restricted Area- includes the peripheral support areas of the surgical suite/invasive procedure area and storage areas for sterile and clean supplies, work areas for storage and processing of instruments, and corridors leading to the restricted areas.~~

C. **POLICY:**

1. **Clean surgical attire shall be worn when entering the semi-restricted and restricted areas.**
   a. **After each daily use, scrub attire shall be laundered at a health care accredited laundry facility.**
   b. **Laundered surgical attire shall be stored in a manner that prevents contamination.**

c. Scrub attire that has been penetrated by blood, body fluids, or other potentially infectious materials must be removed immediately or as soon as possible, and replaced with clean attire.
d. Remove surgical attire before leaving Tri-City Medical Center (TCMC).
e. Personal clothing worn under scrub attire (i.e., a t-shirt worn under the scrub top) must be completely covered by the surgical attire and shall be laundered daily.
   i. Personal clothing is home-laundered, however, personal clothing contaminated with blood, body fluids, or other potentially infectious materials must remain at TCMC for laundering at a health care accredited laundry facility.
f. Scrub attire shall be made from fabric that is tightly woven and low-linting.
g. Arms may be covered during performance of pre-operative patient skin antisepsis.
   i. Use care not to contaminate the prep with a loose-fitting long sleeve.
h. If worn, cover apparel (i.e., lab coats) should be clean.
i. Visitors entering the semi-restricted or restricted areas (e.g., law enforcement officers, parents, biomedical engineers) should don either clean surgical attire or a single-use jumpsuit (i.e., bunny suit) designed to completely cover personal apparel.

~~1. Scrub Garments:~~
~~a. All individuals entering the semi-restricted and restricted areas of the surgical suite/invasive procedure area shall wear clean, hospital-laundered scrub attire.~~
~~b. Scrub garments shall include pants, tops and cover jackets that are maintained by the medical center through a linen service.~~
~~c. Scrub garments shall be donned in a designated dressing area of the facility upon entry or reentry to the facility.~~
~~i. Scrubs worn into the facility from the outside shall be changed before entering the surgical suite/invasive procedure area to minimize the potential for cross contamination from outside, uncontrolled environments.~~
~~d. Scrub tops shall be tucked into pants, secured at waist, or fit close to the body.~~
~~e. Scrub garments shall be changed daily and whenever visibly soiled, contaminated, or wet.~~
~~i. Worn scrub garments shall be placed in the designated "dirty" container and not hung or placed in a locker for wearing at another time.~~
~~f. Hospital-owned scrubs shall not be removed from the facility.~~
~~g. Home-laundered surgical attire is not permitted.~~
~~h. Disposable, single-use scrub garments are permitted.~~
~~i. Coveralls (bunny suits) may be worn instead of hospital-laundered scrubs by individuals that must enter the semi-restricted and restricted areas of the surgical suite/invasive procedure area for a brief time.~~
~~i. These individuals must not be part of the surgical team.~~
~~j. Laboratory coats shall be removed before entering the semi-restricted or restricted areas of the surgical suite/invasive procedure area.~~
~~k. Cover gowns are not required to be worn when leaving the surgical suite/invasive procedure area.~~
~~l. Non-scrubbed personnel shall wear long-sleeved cover jackets that are buttoned, tied, or snapped closed during use.~~
~~i. Complete closure of the jacket avoids accidental contamination of the sterile field.~~
~~m. Other garments (i.e. short-sleeved undershirts) shall be completely contained or covered by the surgical attire. Clothing that cannot be covered by the surgical attire shall not be worn.~~

2. All personnel entering the surgical/invasive procedure area must wear an identification badge/tag per Administrative Policy: Identification of Employees and Non-TCHD Employees 436~~Identification Badges:~~.

~~a. All personnel entering the surgical/invasive procedure area must wear an identification badge/tag.~~

a. Identification badges shall be cleaned with a low-level disinfectant daily, and when the badge becomes soiled with blood, body fluids, or other potentially infectious materials.

b. Identification badges shall be worn pinned to scrubs; identification tags (stickers) shall be placed directly on scrubs. **Lanyards should not be worn.**

c. Identification badges/tags shall be worn above waist level.

d. Decorative pins shall not be worn on scrubs.

3. Cover the scalp and hair when entering the semi-restricted and restricted areas. ~~Surgical Head Covers:~~

a. Remove head coverings at the end of the shift or when they are contaminated.

~~3.~~4. Cover a beard when entering the restricted areas and while preparing and packaging items in the clean assembly section of Sterile Processing Department (SPD).

~~a. All head and facial hair, including sideburns and necklines, shall be covered when entering the semi-restricted and restricted areas of the surgical suite/invasive procedure area.~~

~~b. Individuals with a bald or shaved head must wear a head cover to prevent shedding of squamous cells.~~

~~c. Disposable, bouffant and hood style covers are preferred; skullcaps that fail to cover the side hair above the ears and hair at the nape of the neck shall not be worn.~~

~~d. If reusable cloth head covers are worn, they must be covered with a disposable cap while in the semi-restricted and restricted areas.~~

~~4.~~5. Wear clean shoe covers when entering the semi-restricted or restricted areas. ~~Shoes / Shoe Covers:~~

a. **Wear protective footwear that provides protection from falling or rolling objects. Open toed shoes shall not be worn.** ~~Shoes worn within the surgical suite should be clean with no visible soiling and should provide protection.~~

~~i. Open toe shoes shall not be worn.~~

b. Fluid-resistant shoe covers **or boots must be worn when gross contamination can reasonably be anticipated.** ~~are considered part of personal protective equipment (PPE) and shall be worn when it can be reasonably anticipated that splashes or spills may occur.~~

c. Shoe covers are single-use **personal protective equipment (PPE)** and shall be **removed immediately after use. After removal, discard the shoe covers and perform hand hygiene. Shoe covers may not be worn outside of the surgical suite/invasive procedure area.** ~~changed whenever they become torn, wet, or soiled. Shoe covers must be removed and discarded before leaving the surgical suite/invasive procedure area.~~

~~5.~~6. Don a clean mask before each procedure. ~~Masks:~~

a. All personnel entering the semi-restricted or restricted areas of the surgical suite/invasive procedure area shall wear a mask when scrubbed personnel **or**~~,~~ open sterile supplies ~~and/or equipment~~ are present.

b. Select the mask that provides the best fit for the individual. The mask should completely cover the mouth, nose, and chin and fit snugly in a manner that prevents gaps at the sides of the mask.

~~b. Masks shall fully cover both the mouth and nose and be secured in a manner that prevents venting at the sides of the mask.~~

i. Masks with ear loops may not provide secure facial fit and are not intended for use as surgical masks.

~~c. A fresh, clean surgical mask should be worn for every procedure.~~

c. Replace the mask and discard it whenever it becomes wet or soiled.

d. Remove the mask last when worn in combination with other PPE, including a gown, gloves, or eye protection.

e. Remove the mask by touching only the ties without touching the front of the mask. Discard it in a waste receptacle and perform hand hygiene.

~~d. After use, masks shall be removed by handling only the ties, and discarded immediately. Hand hygiene should be performed after removal of masks.~~

~~i. Masks shall not be saved by hanging them around the neck or tucking into a pocket for future use.~~

~~ii. The filter portion of the mask harbors bacteria collected from the nasopharyngeal airway; handling this portion of the mask poses risk for cross-contamination.~~

7. Jewelry (i.e., rings, watches, and bracelets) shall not be worn on the hands or wrists in patient care areas~~Jewelry:~~.

~~6.~~a. For additional guidelines on jewelry, accessories and piercings, refer to TCMC Administrative Policy Dress and Appearance Philosophy.

~~a. Rings shall be removed from hands before entering the semi-restricted or restricted areas of the surgical suite/invasive procedure area.~~

~~b. Other jewelry (including, but not limited to, watches, earrings, bracelets, necklaces, and piercings) shall be removed or totally confined within the scrub attire.~~

~~i. Watches and bracelets should be removed prior to performing hand hygiene.~~

~~7.~~8. All perioperative team members should maintain healthy fingernail and hand skin condition~~Nails:~~.

a. Fingernails ~~Nails~~ should be maintained short and natural. Fingernail tips should be no longer than 2mm (0.08 inch).~~must be short, clean and natural.~~

b. Artificial fingernails or extenders may not be worn in surgical/invasive procedure areas.

c. For additional guidelines on nail polish, refer to TCMC Administrative Policy Dress and Appearance Philosophy.~~For complete policy on nail polish and nail hygiene, refer to Administrative Policy Dress and Appearance Philosophy.~~

9. Personal items should be cleaned prior to bringing them into the semi-restricted or restricted areas.

a. Bags (i.e., backpacks, briefcases) that are not able to be cleaned should be contained in a plastic bag or be stored in the unrestricted area.

b. Cell phones, tablets, laptops and other personal communication or hand-held electronic devices should be cleaned before they are brought into the OR/invasive procedure area. Perform hand hygiene after device cleaning.

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

1. Administrative Policy: Dress and Appearance Philosophy 415

~~1.~~2. Administrative Policy: Identification of Employees and Non-TCHD Employees 436

E. **REFERENCES:**

1. ~~AORN Guidelines for Perioperative Practice, 2016 Edition.~~ AORN, Inc. (2020). ***Guidelines for Perioperative Practice.*** Denver.

~~1.~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 01/17 **SUBJECT:** Surgical Skin Stapling

REVISION DATE:

Patient Care Services Content Expert~~Department~~ Approval:	03/20
Clinical Policies & Procedures Committee Approval:	~~01/16~~03/20
Nurse Executive Council Approval:	~~01/16~~04/20
Operating Room Committee Approval:	~~09/16~~04/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~10/16~~05/20
Administration Approval:	06/20
Professional Affairs Committee Approval:	~~01/17~~ n/a
Board of Directors Approval:	01/17

A. **POLICY:**

1. Surgical Technologists and Registered Nurses may utilize an automatic skin stapler ~~gun~~ under the direct supervision of the physician/Allied Health Professional (AHP) for the purpose of skin closure.
   a. Deep tissue stapling is not allowed.

B. **PROCEUDURE:**

1. Under the direction of the physician/AHP, lightly position the automatic skin stapler over the approximated skin edges at the desired position.
   a. It is not necessary to press the stapler into the skin to get a proper placement; lightly touch the skin.
2. Center the staples over the incision line using the locating arrow or guideline on the stapler.
3. Press the stapler anvil to deploy the staples as the physician/AHP approximates the skin edges.
4. Place staples approximately ¼" apart, as directed by the physician/AHP.

C. **REFRENCES:**

1. ~~Rothrock, J. (2014). Alexander's Care of the Patient in Surgery, 15th Edition.~~ **Rothrock, J. C. & McEwen, D. R. (2019). *Alexander's Care of the Patient in Surgery, 16th Edition*. St. Louis, MO: Elsevier.**

Tri-City Medical Center	Patient Care Se	**DELETE – no longer performed as Point of Care – specimens sent to Lab**
PROCEDURE:	**URINE PH**	
Purpose:	To provide an accurate and reliable method for reading urine pH.	
Supportive Data:	An RN may perform this procedure. Testing is under the direction, authority, jurisdiction, and responsibility of the Laboratory Medical Director.	
Equipment:	pH paper or strips, approved by laboratory Two (2) Levels Quality Control (current manufacturer provided by lab)	

~~A. **PRINCIPLE:**~~

~~1. Urine pH can be affected by several internal and external causes. Diet is the main, non- medical determinant of urine pH. A high protein diet will produce acid urine (pH below 7.0). A vegetarian diet will produce alkaline urine (pH above 7.0). Medical factors to consider are respiratory or metabolic acidosis or alkalosis, renal function, crystal or calculi formation, urinary tract status, and medications.~~

~~B. **SPECIMEN:**~~

~~1. All specimens should be handled using the principles of Universal Precautions due to the potential presence of pathogenic material.~~
~~2. Collect fresh clean catch (voided), catheterized (cath) or suprapubic urine.~~
~~3. Collect in a clean dry container. Label with patient identification.~~
~~4. If you do not perform the urine pH testing in the presence of the patient, you must label the urine container.~~
~~5. Because of certain rapid chemical changes and the rapid proliferation of bacteria, test the urine within 2 hours. Reject and re-collect any urine sitting at room temperature greater than two (2) hours as pH will falsely increase with time.~~

~~C. **REAGENTS AND SUPPLIES:**~~

~~1. pH indicator test Strips.~~
~~2. Two levels of urine quality control (QC).~~
~~a. Request test strips and controls from the lab.~~

~~D. **QUALITY CONTROL:**~~

~~1. Two levels of quality control (QC) must be tested daily before performing patient tests and when opening a new vial of strips.~~
~~2. Record results on Point of Care Quality Control log. Verify results are within acceptable ranges.~~

~~E. **PROCEDURE:**~~

~~1. Verify strips are not expired. Strips expire on the date listed on the container. If no expiration date is listed by the manufacturer, assign an expiration date 12 months after open the date. Mark this date on the container.~~
~~2. Use current manufacturer and lot of controls as supplied by the lab. Verify expiration is clearly marked and that the controls are not expired.~~
~~3. Open vial stability may change with a change in the Control Manufacturer, but in general, expiration date is 30 days after opening.~~
~~4. Mix urine sample well before testing.~~
~~5. Dip pH indicator strip into urine. Leave test strip in urine until color no longer changes and is stable. Remove. Draw the edge of the strip along the rim of the container to remove excess urine.~~
~~6. Read pH by comparing the color change of the strip to color chart on package and select the value of the closest match.~~
~~7.~~1. ~~Record Results in the medical record.~~

Department Review	Clinical Policies & Procedures	Nurse Executive Council	Department of Pathology	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
05/13, 11/19	06/13, 03/16, 12/19	06/13, 03/16, 02/20	04/18, 04/20	07/13, 04/18, , 05/20	06/20	8/13, 05/18, n/a	8/13, 05/18

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE ~~POLICY MANUAL~~
DISTRICT OPERATION~~ENVIRONMENT OF CARE~~

ISSUE DATE: 06/94 **SUBJECT: Parking Program**

REVISION DATE: 09/02; 03/03, 07/04; 12/05; 04/08 09/10; 08/14 **POLICY NUMBER:** 8610-261

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

A. **PURPOSE:**

1. To provide adequate parking for patients and visitors by defining Tri-City Healthcare District's (TCHD) parking program.

B. **POLICY:**

1. All employees and physicians are required to complete a parking application form.
   a. The parking application form details their mode of transportation and identifying characteristics.
      i. Employees shall submit a completed and/or revised form to Human Resources.
      ii. Physicians shall submit a completed and revised form to the Medical Staff Office.
   ~~b. All employees and physicians are required to display the TCHD parking placard while parked on TCHD campus.~~
2. All TCHD Board Members, Medical staff, Executives, Directors and authorized administrative staff may park in the Medical Staff parking area.
3. Employees shall park in designated employee parking areas (Refer to Tri-City Healthcare District Parking Map).
   a. Employees or others who use a bike as their mode of transportation shall park and secure bikes in the designated bike parking areas.
   b. Volunteers may park either in reserved volunteer parking areas or in employee parking areas.
4. Construction personnel shall receive parking instructions from the Engineering Department during their orientation.
5. Non-compliance with parking standards results in the issuance of a Security Department Parking Violation.
   a. The department manager shall be notified if an employee receives a second parking violation. Corrective action follows Administrative Policy, Coaching and Counseling for Performance Improvement.
6. Valet services are provided to all District residents with a District benefit card. Valet services are provided Monday – Friday **during designated hours**~~from 8:00 am to 4:30 pm~~ and may be used for special events with notification one week prior to event.
7. The designated speed limit on campus is 15 MPH unless posted otherwise.

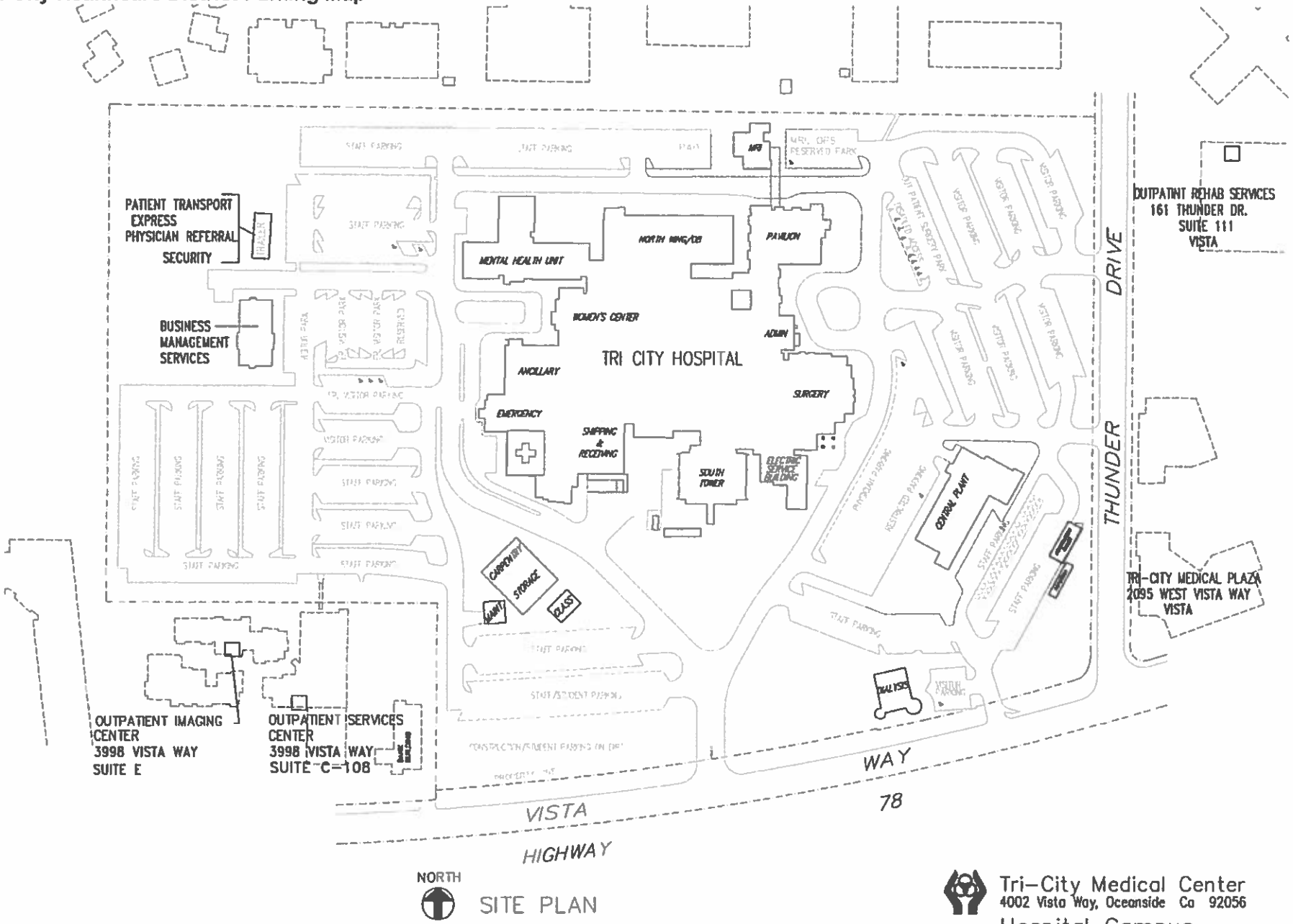
C. **FORM(S):**

1. **Parking Permit Application**

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

1. Tri-City Healthcare District Parking Map

Tri-City Healthcare District Parking Map



Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE ~~POLICY MANUAL~~
DISTRICT OPERATIONS

ISSUE DATE: 04/91

SUBJECT: Weapons on Medical Center Campus

REVISION DATE: 06/99; 09/05; 11/08; 03/11; 08/14 06/17

POLICY NUMBER: 8610-284

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

A. **PURPOSE:**

1. To provide guidelines for all Security Department personnel, for ensuring that patients and visitors are not permitted to bring weapons upon the Tri-City Healthcare District (TCHD) property.

B. **DEFINITION(S):**

1. Weapons include firearms, knives, night sticks, brass knuckles, and other items defined as weapons by California and federal law.

C. **POLICY:**

1. It is the primary objective of the Security Department to provide a safe and secure environment for all Patients, Visitors, and Staff Members and free of any weapons, which could cause bodily harm or injury.
   ~~1.~~**a. See Administrative Policy: Weapons Scanning in the Emergency Department 200. Patients entering the facility via ambulance may be scanned by a wand.**

D. **PROCESS:**

1. Whenever a Security Officer discovers or is notified by staff of the presence of a weapon in the possession of a patient, visitor, or staff member, the Security Officer will immediately respond to the location of occurrence.
2. After evaluating the circumstances of the situation, the responding Security Officer, utilizing the following options, will determine the most practical and safe way to secure the weapon.
   a. If upon admission a patient brings a weapon into TCHD, the weapon will be confiscated and released to a responsible family member.
   b. If a family member is not present, the weapon will be confiscated, made safe, placed in a proper container and locked in the Emergency Department Security Office (EDSO) for safekeeping.
   c. A Property Custody 232 Form will be completed with the receipt given to the patient and the department copy attached to the item.
   d. If the patient informs the **healthcare provider (HCP)**~~Behavioral Health Liaison (BHL)~~ that they have weapons in their possession or in their vehicle, or anywhere on TCHD property, the **HCP**~~BHL~~ is to notify Security, the patient's Emergency Department (ED) physician, The Charge Nurse, and the patient's nurse immediately.

~~b.~~e. Security will ensure that the weapons are secured per security's policy. ~~If the patient is refusing treatment is a danger to self or others, a 5150 must be initiated. If the patient agrees to voluntary treatment, she/he must be allowed to do so, but must be placed on a 5150 if they attempt to leave Against Medical Advice (AMA). Refer to Patient Care Services: 72-Hour Hold, Evaluation and Treatment of Involuntary Patient policy.~~

~~c.~~f. If the patient is already in a patient care area, the Security Officer will confiscate the weapon and follow the procedure as stated above in a timely manner.

~~d.~~g. If it is determined that a Visitor had entered the TCHD in possession of a weapon, the Security Officer will make contact and inform the visitor of this policy. The visitor will then be directed to immediately remove the weapon from TCHD or turn the weapon over to the Security Department for safekeeping. If the weapon is given to the Security Department for safekeeping, "Property Custody" form will be completed.

~~e.~~h. If a Patient or Visitor is unwilling to secure the weapon, the Security Supervisor/Shift Lead will be informed of the situation and attempt to gain cooperation with the individual.

~~f.~~i. If a Patient or Visitor is displaying the weapon in a reckless manner, causing a disturbance, or problem, threatening to cause a problem or disturbance, or is placing unusual/unreasonable demands on the staff, the responding Security Officer will only attempt contact if the safety and security of all involved parties will not be placed in jeopardy.

~~g.~~j. If the situation has escalated to the point where there is a high probability of harm or injury occurring, the responding Security Officer will dial 911 and immediately ensure that the Oceanside Police Department is contacted for assistance. The Security Officer will also ensure that an attempt is made to remove all persons from the immediate location safely.

~~3.~~k. Police Officers or Correctional Officers, who are guarding a "Police Hold"/in-custody patient, are permitted to carry weapons while discharging their duties. All cases requiring law enforcement personnel to carry weapons will be reported to the Security Department.

~~4.~~l. Police Officers or Detectives questioning or interviewing a patient, employee or physician are permitted to carry weapons. All cases requiring law enforcement personnel to carry weapons will be reported to the Security Department.

~~5.~~m. Law Enforcement, being seen as a patient, will relinquish their weapon to a co-worker or security until discharged.

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

1. Property Custody Form 232 – Sample

~~1.~~2. **Administrative Policy: Weapons Scanning in the Emergency Department 200**

~~2. Refer to Patient Care Services: 72-Hour Hold, Evaluation and Treatment of Involuntary Patient Policy~~

3. Property Custody Form 232

Tri-City Medical Center
Security Department
Property Custody Record

Notice to Property Owner: Upon release from the Tri-City Medical Center it will be your responsibility to make arrangements to pick up the hereon-listed items from the Security Department. Any items not picked up within thirty(30) days will be destroyed.

Officer Receiving Property:	Date Received:	Time Received:

Property Received from:

❑ Owner: _____

❑ Other: _____

Location / Reason Property Obtained:

_____

_____

_____

❑ Property Received for Safekeeping

Item #	Qty	Description / Condition:	SN / Tag #

Property Disposition:

❑ Property Returned to Owner
❑ Property Returned to Other Reason: _____
❑ Property Destroyed After Thirty(30) Days
❑ Property Destroyed Before Thirty(30) Days Reason: _____

Property Returned By:		
Officer:	Badge:	Date:

Property Received By:	
Signature:	Date:

White: Security Department - Yellow: Person Receiving Property - Pink: Receipt

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL

ISSUE DATE: 09/00	**SUBJECT:** Epidemiologic Investigation of a Suspected Outbreak
REVISION DATE(S): 03/02, 03/05, 08/14	~~**Standard Number: IC. 3**~~
Infection Control Department Approval:	~~**03/17**~~**04/20**
Infection Control Committee Approval:	~~**04/17**~~**04/20**
Pharmacy and Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	~~**06/17**~~**05/20**
Administration Approval:	**06/20**
Professional Affairs Committee Approval:	~~**07/17**~~ **n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**

1. To provide guidelines for uniform and complete investigation of suspected outbreaks of healthcare associated infections (HAI) or community acquired infections seen in the hospital.

B. **POLICY:**

1. The Infection Control Committee shall have ultimate responsibility for investigating outbreaks and developing policies aimed at prevention and control of healthcare associated infections (HAI). If an outbreak is suspected, the hospital epidemiologist or his designee will direct the investigation. The aim of the process is to identify the source of the organism and the mode of spread so that infection control measures can be instituted to halt an outbreak.
2. An outbreak is defined as an increase over the expected occurrence of an event.

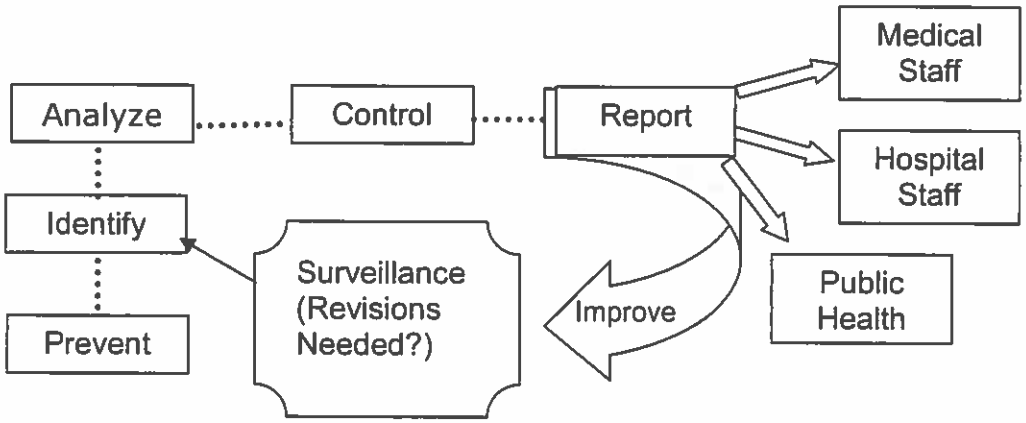
C. **PROCEDURE:**

1. The Medical Director of Infection Control along with the Infection Preventionist(s) will determine whether a situation is a probable outbreak that poses a threat to the health of patients, employees or visitors and warrant further investigation. **Early identification of a suspected outbreak is important.**~~They may elect to call an emergency meeting of the Infection Control Committee. The meeting would be called to accomplish the following~~ **The Infection Control department will take the following investigative steps:**
   - **a. Confirm that an outbreak exists. Determine of the number of "cases" exceeds the background rate, ie: Any increase in infection incidence found during routine surveillance.**
   - ~~a. Clarify the nature and extent of the potential outbreak.~~
   - ~~b. Discuss proposed investigational steps.~~
   - **b. Identify all individuals who meet the case definition (patients and staff) and develop a line listing of cases. (See Data Collection Tool)**
   - **c. Confirm laboratory findings with Lab department.**
   - **d. Ask Lab to collect appropriate clinical specimens and save all outbreak specific isolates from potential cases.**
   - **e. Compare exposure of identified cases to understand the route of transmission and potential risk factors.**
   - **f. Appropriately isolate all individuals who meet the case definition.**
   - **g. Implement immediate control measures as needed.**

h. Report suspected outbreak to local San Diego Public Health (SDPH) Epidemiology department and California Department of Public Health (CDPH) and follow guidance provided.

i. Local & state agencies will assist with case identification, development of investigative approach, prevention and control measures and assist with specimens.

~~c. Determine exact criteria for selection of subjects for possible epidemiologic studies.~~
~~d. Determine and assign responsibility of each department; determine who will collect and record data.~~
~~e. Anticipate questions that may arise and develop consistent answers. Assign resource people to respond to queries and keep personnel informed.~~
~~f. Appraise the State and local health departments of outbreaks and reportable conditions.~~
~~g. Identify components of an Investigation~~
~~h. Confirm that an outbreak exists.~~
~~i. Establish or verify diagnosis of reported cases; identify agent and develop a case definition.~~
~~j. Search for additional cases; collect critical data and specimens (see Data Collection Tool).~~
~~k. Characterize the cases by person, place and time; plot the epidemic curve and geographic areas that are involved.~~
~~l. Analyze the data; show that the current rates are higher than pre-outbreak rates.~~
~~m. Perform a literature review.~~
~~n.~~j. Communicate with department heads, microbiology director, administrators, and employee health as appropriate.
~~o. Formulate tentative hypothesis; keep a diary with detailed notes about the investigation.~~
~~p. Test hypothesis.~~
~~q.~~**k. Implement guidance from local and state agencies.** ~~Consider control measures and alternatives; institute most appropriate measures~~.
l. Perform ongoing surveillance for any continued signs of the outbreak.
m. ~~E~~Evaluate ~~and document~~ efficacy of control measures **implemented.**
~~r.~~**n. When the control measures have terminated transmission, declare outbreak is over.**
~~s.~~**o.** Change policies and procedures if necessary.
~~t.~~**p. Report findings to Infection Control Committee and other Committees as needed.**~~Communicate findings and write report~~.



D. **RELATED DOCUMENT(S):**
1. Data Collection Tool Sample

E. **REFERENCES:**

1. Campbell, E. (2014). Chapter 12 Outbreak Investigation. APIC Text of Infection Control and Epidemiology. Washington DC: APIC, 4th Edition.
2. CDC Principles of Epidemiology: Lesson 6 Investigating an Outbreak
~~3. https://www.cdc.gov/ophss/csels/dsepd/ss1978/lesson6/section1.html~~
~~4.~~3. **CDC: Outbreak Investigations in Healthcare Settings**
https://www.cdc.gov/hai/outbreaks/
~~5.~~4. **CDPH: Outbreaks and Unusual Infection Occurrences 2017**

Data Collection Tool - Sample

MR #	Patient's Name	Admit Date	Date of Onset of S & S	Culture Date	Culture Results	Invasive Device or Procedure	Device / Procedure Date	Unit	Comments

Tri-City Health Care District
Oceanside, California

INFECTION CONTROL

ISSUE DATE: 07/03	**SUBJECT: Hand Hygiene**
REVISION DATE: 04/08	~~**STANDARD NUMBER: IC. 8**~~
Infection Control Department Approval:	~~04/17~~04/20
Infection Control Committee Approval:	~~04/17~~04/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~06/17~~05/20
Administration Approval:	06/20
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

A. **PURPOSE:**

1. The purpose of hand hygiene is to remove microorganisms and reduce the risk of transmitting disease and/or significant pathogens to patients, healthcare workers, environment, and visitors.

B. **GENERAL INFORMATION:**

1. Hand hygiene is the single most important activity for preventing transmission of infectious microorganisms.
2. Multiple studies have shown that the hands of healthcare workers carry large numbers of germs. Transient flora are acquired from patients or contaminated environmental surfaces and are more likely to cause healthcare-associated infections than resident flora – bacteria always found on the skin. Normal shedding of skin cells spreads germs that are carried on the skin.

~~2.~~C. **POLICY STATEMENTS:**

~~3.~~1. Length of nails/Fingernail polish/ Artificial nails:
   a. Fingernails must be less than ¼ inch in length, clean and trimmed. Long natural nails carry twice the number of germs compared to short (less than ¼ inch) natural fingernails.
   b. Fingernail polish is permitted as long as there is no chipping or peeling. Freshly applied nail polish does not increase the number of bacteria but chipped nail polish may support the growth of larger numbers of organisms on fingernails.
   c. Pursuant to Center for Disease Control (CDC) guidelines and the World Health Organization (WHO), all health care workers and providers who provide direct "hands on" patient care cannot wear artificial fingernails, nail extenders/tips or nail jewelry.

~~4.~~2. Wearing gloves does not provide complete protection against microorganisms. Up to 30% of healthcare workers who wear gloves during patient contact will be carrying germs from the patient they just touched after the gloves are removed. Bacteria and viruses gain access to their hands through small holes in gloves and/or during glove removal.

~~5.~~3. Indications for hand washing and hand antisepsis:
   a. Wash hands with hospital-approved soap and water when hands are visibly dirty or contaminated with blood or other potentially infectious material (all body fluids except sweat).
   b. If hands are not visibly soiled, may use an alcohol-based waterless antiseptic agent.
   c. Perform hand hygiene before **and after patient contact.** ~~caring for patients~~
   d. Perform hand hygiene after **contact with a patient's surroundings/ environment.**~~contact with any patient even for simple activities, such as taking a pulse or blood pressure, or lifting a patient.~~
   e. Perform hand hygiene after contact with body fluids or excretions, mucous membranes, **intact and** non-intact skin, or wound dressings.

~~e.~~**f.** **Perform hand hygiene before performing an aseptic task.**

~~f.~~**g.** Perform hand hygiene **before accessing and inserting invasive devices.** ~~if moving from a contaminated body site to a clean body site during patient care.~~

~~g.~~**h.** **Perform hand hygiene before preparing and~~**or administering medication.** ~~Perform hand hygiene after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.~~

~~h.~~**i.** Perform hand hygiene before donning gloves **and after removing gloves.** ~~when performing invasive procedures such as inserting a intravascular catheter, indwelling urinary catheter or naso gastric tube.~~

~~i. Perform hand hygiene after removing gloves.~~

~~C.~~D. HAND HYGIENE TECHNIQUES:

1. Waterless Based Products:
   a. When decontaminating hands with a waterless alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry.
   b. If an adequate volume of an alcohol-based hand rub is used, it should take 15 to 25 seconds for hands to dry. Follow the manufacturer's recommendations for the volume of product to use.
2. Soap and Water:
   a. When washing hands with soap, wet hands first with warm water, apply 3 to 5 ml of detergent to hands and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with warm water and dry thoroughly with a disposable towel. Use the towel to turn off the faucet.
3. Gloves:
   a. Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin will occur.
   b. Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between patients.
   c. Change gloves during patient care if moving from a contaminated body site to a clean body site.
   d. Perform hand hygiene after glove removal.
4. Surgical Hand Antisepsis
   a. See Patient Care Services Policy: Surgical Services: Surgical Hand Asepsis for details.

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

1. Administrative - Human Resources Policy: 8601-415 Dress and Appearance Philosophy Policy
2. Patient Care Services Policy: Surgical Services: Surgical Attire Policy
3. Patient Care Services Policy: Surgical Services: Surgical Hand Asepsis

~~E.~~F. REFERENCES:

1. Center for Disease Control and Prevention. Guideline for Hand Hygiene in Health-Care Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee: ~~and the~~ HICPAC/SHEA/APIC/IDSA ~~Hand Hygiene Task Force.~~ MMWR 2002; **Vol.**51~~(No.RR-16:1-45)~~
2. ~~California OSHA, Title 8, Subchapter 7. General Industry Safety Orders, Group 16. Control of Hazardous Substances Article 109. Hazardous Substances and Processes, 5193. Bloodborne Pathogens. 1991, revised 1998~~.
3. ~~US Dept. of Labor, OSHA Part 1910, Occupational Safety and Health Standards, 29 CFR Toxic and Hazardous Substances 1910.1030 Bloodborne Pathogens. 1991 rev. 1992, 1996 and 2001~~.
3. WHO Guidelines on Hand Hygiene in Health Care 2009
4. **https://www.cdc.gov/handhygiene/providers/index.html**
~~4.~~

Tri-City Health Care District
Oceanside, California

INFECTION CONTROL

ISSUE DATE: 09/01	**SUBJECT:** Management of Patients with HIV-Infection/AIDS
REVISION DATE: 09/04	~~**STANDARD NUMBER: IC. 8**~~
Infection Control Department Approval:	~~04/17~~04/20
Infection Control Committee Approval:	~~04/17~~04/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~06/17~~05/20
Administration Approval:	06/20
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

A. **GENERAL INFORMATION:**

1. Acquired Immunodeficiency Syndrome (AIDS) is caused by a retrovirus, called Human Immune Deficiency Virus (HIV). Routine social or community contact with an HIV-infected person carries no risk of transmission. HIV is only contacted by sexual exposure and exposure to blood or tissues. For example:
   a. Unprotected sexual intercourse.
   b. Direct contact of your blood with an infected person's blood.
   c. Sharing of HIV contaminated needles and syringes.
   d. From mother to newborn, either during pregnancy or after birth.
   e. Breastfeeding by HIV-infected mothers.

B. **PROCEDURE:**

1. The isolation of the individuals for HIV-infection is unnecessary, ineffective and unjustified.
2. Standard precautions apply to all hospitalized patients and additional precautions (Airborne, Droplet, or Contact) may be appropriate for specific infections.
3. Place all HIV positive patients with pulmonary infiltrates in Airborne Precautions until three sputum smears are Acid-Fast Bacilli (AFB) negative or until a diagnosis other than tuberculosis is clearly established.
4. If HIV testing is ordered, follow the policy as outlined in Lab Administrative: Authorization for Laboratory Testing.
5. Healthcare workers with exposure to blood or other body fluids are to follow the Patient Care Services: HIV Testing In an Occupational Exposure Policy.

C. **RELATED DOCUMENTS:**

1. Employee Health: HIV Guideline Grid
2. Infection Control: Aerosol Transmissible Diseases and Tuberculosis Control Plan IC 11 Policy
3. Infection Control: Bloodborne Pathogen Exposure Control Plan Policy
4. Patient Care Services: HIV Testing In an Occupational Exposure Policy

D. **REFERENCES:**

1. California Healthcare Association. (2017) Consent Manual. California Healthcare Association, Sacramento, Ca.
2. Center for Disease Prevention and Control. (2001). June 29, 2001 / 50(RR11);1-42 Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV

~~3. Centers for Disease Control and Prevention. (1996). Guideline for Isolation Precautions in Hospitals. American Journal of Infection Control, 24 (1), 24-4~~

~~4.~~3. https://www.cdc.gov/hai/organisms/hiv/hiv.html

~~5.~~4. ~~Human Immunodeficiency Virus (HIV) in Healthcare Settings~~

~~6.~~5. Recommendations for the prevention of HIV transmission in health-care settings. MMWR, 36, 1S -18S.

~~7.~~6. Updated U.S. Public Health Service guidelines for the management of occupational exposures to HIV and recommendations for postexposure prophylaxis. Published: 9/25/2013 https://stacks.cdc.gov/view/cdc/20711

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES
NEONATAL INTENSIVE CARE UNIT (NICU)

SUBJECT: **Admission and Discharge Criteria for the NICU**

ISSUE DATE: **06/07**
REVISION DATE(S): **04/09, 06/11, 8/14, 12/15, 03/18**

NICU Department Approval:	**~~01/18~~2/20**
Perinatal Collaborative Practice Approval:	**~~02/18~~03/20**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~02/18~~05/20**
Administration Approval:	**06/20**
Professional Affairs Committee Approval:	**~~03/18~~ n/a**
Board of Directors Approval:	**03/18**

A. **PURPOSE:**

1. To define the criteria for admission to and discharge from the Neonatal Intensive Care Unit (NICU).

B. **GENERAL INFORMATION:**

1. **Tri-City Medical Center (TCMC)'s NICU is designated as a Community NICU as defined by California Children's Services (CCS) Standards for NICUs 3.25.2 and is equipped to care for babies requiring intensive care**
2. **As a Level III NICU, TCMC has staff and equipment to provide continuous life support and comprehensive care for extremely high-risk infants and those with complex and life-threatening illnesses.**
   a. **Capable of comprehensive care for infants born at less than 32 weeks' gestational age and weighing less than 1,500 grams**

~~1.~~3. Patients shall be admitted under the care of a California Children's Services (CCS) paneled attending neonatologist.

a. ~~Consult and approval from~~**Acceptance by** on-duty Neonatologist is required prior to admission to NICU~~.~~**, including patients**

~~b. Patients may be admitted as a~~ directly ~~admission~~ **admitted** from the community ~~, after outside provider (Pediatrician) has consulted Neonatologist and received approval.~~**or from**

~~c. Patients presenting to~~ the Emergency Department (ED) ~~without Pediatrician/Neonatologist consult must be triaged and Neonatologist consulted regarding admission.~~

~~2.~~4. All admissions to the NICU are arranged with the ~~NICU Assistant Nurse Manager and/or~~ relief charge Registered Nurse (RN).

~~3.~~5. ~~The back transport from another facility must have a completed negative Methicillin resistant Staphylococcus Aureus (MRSA) screen prior to acceptance of admission~~**Refer to Infection Prevention- NICU policy for guidelines regarding isolation and testing for Methicillin resistant Staphylococcus Aureus (MRSA) in patients admitted from home or back transports from another facility.** ~~.~~

~~4. The attending physician shall be notified of patient arrival in the unit.~~

~~5. All Patients admitted to the NICU shall have a patient history completed and documented in the patient's medical record. An initial assessment by a Physician or Allied Health Professional (AHP) shall be completed within 30 minutes of admission and documented in the Electronic Medical Record (EMR) within 24 hours of admission.~~

~~a. This admission assessment is done and documented on all NICU admissions.~~

~~6. Ongoing assessments are completed based on the patient's acuity and documented in the patient's medical record.~~

C. **ADMISSION CRITERIA:**

1. Inpatient admission criteria may include, but is not limited to the following:
   - ~~a. General:~~
   - ~~i.~~**a.** Patients with gestational age less than 36 weeks.
   - ~~ii.~~**a.** Patients with suspected or confirmed sepsis.
   - **b.** Patients **weighing** less than 2000 grams.
   - **c.** Patients with suspected or confirmed sepsis.
   - ~~iii.~~
   - ~~iv.~~**d.** Any patient requested by a referring physician.
   - ~~v. Patients with suspected seizure-like activity.~~
   - **e.** Patients requiring a medical **or surgical** subspecialist.
   - ~~vi.~~**f.** **Patients requiring medical intervention, monitoring, or support.**
   - **g.** Patients requiring advanced imaging with interpretation on an urgent basis including computer tomography, magnetic resonance imaging, and echocardiography.
   - ~~vii.~~**h.** **Patients requiring a higher level of care will be admitted to the NICU, stabilized and transferred as appropriate.**
     - ~~viii. Patients with suspected or confirmed genetic malformations requiring stabilization, surgical intervention and/or consultation with subspecialist.~~
     - ~~ix. Patients with suspected or confirmed necrotizing enterocolitis.~~
   - ~~b. Respiratory system:~~
     - ~~i. Apnea requiring monitoring and observation~~
     - ~~ii. Respiratory instability (persistent tachypnea, grunting, cyanosis, etc.)~~
   - ~~c. Cardiac system:~~
     - ~~i. Newly diagnosed or suspected arrhythmias.~~
     - ~~ii. Hemodynamic instability.~~
     - ~~iii. Suspected complex congenital heart defects.~~
   - ~~d. Endocrine/Metabolic:~~
     - ~~i. Inborn errors of metabolism with acute deterioration requiring respiratory support, management of intracranial hypertension or inotropic support.~~
     - ~~ii. Other severe electrolyte abnormalities such as hyperkalemia, severe hypo- or hypernatremia, hypo- or hyperglycemia requiring intensive monitoring.~~
     - ~~iii. Severe metabolic acidosis requiring bicarbonate infusion, intensive monitoring or complex intervention to maintain fluid balance.~~
     - ~~iv. Acute Intraventricular Hemorrhage (IVH).~~
     - ~~v. Post-hemorrhahagic hydrocephalus~~
     - ~~vi. Twin-to-twin transfusion~~
     - ~~vii. Anemia of the newborn~~
     - ~~viii. Hyperbilirubinemia~~
     - ~~ix. Thrombocytopenia~~

~~2.~~1. Outpatient Admission Criteria: Neonates may be admitted from the community as either a direct admit, or via the Emergency Department (ED).
   - a. Patients up to adjusted 44 week post conceptual **age** presenting with a diagnosis of a non-communicable nature may be admitted to the NICU at the discretion of the Neonatologist on call and depending on staff and bed availability.
   - **b.** ~~The p~~**P**atients ~~being~~ admitted from the community must be screened for clinical symptoms **of infection** and tested ~~negative~~ for Respiratory Syncytial Virus (RSV) and influenza **if indicated**.
   - ~~b.~~**c.** **If there are concerns for an infectious process in an infant being referred by pediatrician, infant should be sent to the ED for additional testing in lieu of direct admission.**

~~3. Procedure for Admission via ED:~~
~~a. ED physician consults Neonatologist.~~
~~4. Procedure for direct admits from community/home:~~
~~a. Pediatrician or AHP consults to Neonatologist.~~
~~b. During admission consult, give Pediatrician/AHP the NICU fax number: 760-966-2240, and request appropriate documentation as available (prenatal, birth, postnatal, outpatient information, labs)~~
~~c. Neonatologist assesses for infectious/contagious risk factors.~~
~~d. If no risk factors, then to admit directly to NICU.~~
~~e. Neonatologist/Secretary to obtain best parental contact number from Pediatrician/AHP.~~
~~f. Either Secretary or Charge Nurse is to call parent to give instructions:~~
~~i. Emphasize the importance of getting safely to TCMC as soon as possible for infant's admission.~~
~~ii. Come straight to NICU for admission, do not stop in ED. Do not check into ED.~~
~~iii. Obtain Translator services, if needed, to provide accurate instruction.~~
~~g. It is preferred for the baby to come to the NICU first, and then a parent be sent down immediately to Registration.~~
~~h. Unit Secretary or Charge RN to call registration to alert them that a parent is coming downstairs to register an infant who needs treatment ASAP.~~
~~i. If 2 parents are present, one parent should go down to registration and one stay with the infant.~~
~~j. If baby was delivered at another hospital, have parent complete Medical Release Form and submit to the delivery facility's Medical Records Department.~~

D. **DISCHARGE CRITERIA:**

1. To Home:

Achievement of the following:

a. ~~Completion of discharge teaching.~~
- **i.** Stable cardio respiratory status. No apnea or bradycardia episodes requiring intervention within 5 to 7 days of discharge, or per physician discretion.
- **ii.** Ability to maintain temperature without artificial heat source.
- **iii.** Stable nutritional status and ~~weight ≥ 1800 grams~~**sustained weight gain.**
- **iv.** Stable medication regimen.
- **v.** **Administration of immunizations as indicated**
- **vi.** **Performance of Newborn Metabolic Screening test**
- **vii.** ~~Completed assessment of outpatient neurodevelopmental needs~~**Assessment of neurodevelopmental and neurobehavioral status and initiation of referrals if applicable.**~~.~~
- **viii.** Completed Car Seat Challenge ~~as appropriate to~~**per** policy ~~and~~ or Physician order.
- **ix.** Completed Hearing screening and **initiation of** referral~~s as appropriate.~~**if applicable**

~~Completed Newborn Metabolic Screening test.~~
- **x.** ~~Confirmed o~~**O**utpatient physician follow-up **scheduled as indicated.**~~.~~

b. **Parent/Family Readiness:**
- **i.** **Primary caregivers demonstrate competence in providing all components of care**
- **ii.** **Completion of discharge teaching.**

~~1.~~**2.** Transfer to other in-patient facility:

a. Based on level of care required, ~~and~~ bed availability,~~;~~ and/or where the infant's family lives, an infant may be transferred to a tertiary NICU for completion of care.

b. ~~The infant shall be referred to an attending Neonatologist~~**Infant must be accepted by an attending Neonatologist.**

c. These babies may include, but are not limited to the following:

i. Cardiac disease requiring surgical intervention and subspecialist follow up.
ii. Patients requiring surgical intervention.
iii. Neurologic disease needing subspecialist intervention and follow up.

~~2.~~**1.** To Home:

a. Completion of discharge teaching.
~~b.~~**a.** Stable cardio respiratory status. No apnea or bradycardia episodes requiring intervention within 5 to 7 days of discharge, or per physician discretion.
~~c.~~**a.** Ability to maintain temperature without artificial heat source.
~~d.~~**a.** Stable nutritional status and weight ≥ 1800 grams.
~~e.~~**a.** Stable medication regimen.
~~f.~~**a.** Completed assessment of outpatient neurodevelopmental needs.
~~g.~~**a.** Completed Car Seat Challenge as appropriate to policy and or Physician order.
~~h.~~**a.** Completed Hearing screening and referrals as appropriate.
~~i.~~**a.** Completed Newborn Metabolic Screening test.
~~j.~~**a.** Confirmed outpatient physician follow-up.

E. **REFERENCE(S):**

~~1. American Academy of Pediatrics. (2008). Hospital Discharge of the High Risk Neonate: Committee on Fetus and Newborn. Pediatrics; 122 (5) 1119-1127.~~

1. American Academy of Pediatrics and the American Congress of Obstetrician and Gynecologists. (2017). Guidelines for Perinatal Care (8th ed.), 347-408.
2. **Beauman, S. & Bowles, S. (Eds.) (2019). *Policies, procedures, and competencies for neonatal nursing care* (6th edition). National Association of Neonatal Nurses.**
3. **California Children's Services Manual of Procedure. (1999). Retrieved February 27, 2020, from https://www.dhcs.ca.gov/services/ccs/Documents/CommunityNICU.pdf**

~~2.~~

Tri-City Medical Center	Women a Neonatal	DELETE - Duplicate info in other P&P	
PROCEDURE:	BREASTFEEDING FOR THE TERM AND L		J
Purpose:	To promote and support human milk as the preferred method of providing nutrition to infants in the NICU, and to provide assistance to the mother in establishing and maintaining breastfeeding for optimal growth and development		

A. **DEFINITION(S):**
1. LATCH (Latch, audible swallowing, type of nipple, comfort and hold): Scoring system for evaluating quality of a feeding at breast.
2. Supplemental Nursing System (SNS): feeding tube with syringe at breast.

B. **POLICY:**
1. To promote a philosophy of infant care that advocates breastfeeding and the feeding of breastmilk as the preferred method of infant nutrition. To assist those families choosing to breastfeed with initiating and developing a successful and satisfying experience. To facilitate the procedure of collecting breastmilk and/or breastfeeding to benefit the mother/infant dyad.
   a. Skin to skin contact (SSC)
   b. Informed Decision
   c. Attachment/LATCH Breastfeeding Outcome
   d. Pumping and collection of mother's milk for infant nutrition
2. This guideline pertains to healthy term and late preterm infants ≥ 35 weeks that do not have a prolonged NICU stay or extra nutritional goals including fluid restriction and/or higher protein, calorie or mineral needs.

C. **PROCEDURE:**
1. SSC will be encouraged throughout the infant's hospitalization. (Refer to the Women and Newborn Services NICU: Skin to Skin Contact Procedure).
2. First oral feeding shall be at breast whenever possible.
3. Minimize use of pacifiers except for during tube feeding, for pain relief, and for calming infants.
4. Nipple shields may be used for facilitating establishment of breastfeeding, but only after evaluation by qualified staff.
5. Whenever mother is present, assist her in breastfeeding first, before a bottle is offered. Make every effort to communicate with mother to avoid feeding her baby before she arrives.
6. Infant driven feedings will vary in duration. However, an infant actively feeding at breast for longer than 30 minutes shall be evaluated and a lactation consult ordered.
7. Infants may be offered both breasts at each feeding but may only be interested in feeding on one side in the early days.
8. Experienced hospital staff should observe mother breastfeeding to assess for position, latch, and milk transfer. A LATCH score should be documented in the EMR (electronic medical record) at least once a shift.
9. Hospital staff should make sure that mother knows what a swallow of milk sounds like.

D. **EVIDENCE OF SUCCESSFUL FEEDING:**
1. Mother with expressible colostrum/breastmilk
2. Signs of milk transfer: sustained rhythmic suck/swallow pattern with occasional pauses and swallows
3. Signs of adequate infant hydration.
   a. Voiding/Stooling DOL 1 minimum 1 void/1 stool
      i. DOL 2 2 void/2 stool
      ii. DOL 3 3 void/3 stool

NICU Department Review	Perinatal Collaborative Practice	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/14, 02/17, 03/20	06/14, 04/17, 03/20	n/a	07/14, 05/17, 05/20	06/20	08/14, 06/17, n/a	08/14, 06/17

iii. DOL4 – 6-8x/day
b. <3%/day weight loss
c. <8% total weight loss
4. Infant content for 1-3 hours after a feed
5. Normal blood glucose testing (if ordered)
6. Breastfed within 1 hour of birth and evidence of at least 3-4 effective feedings in the first 24 hours

E. SUPPLEMENTATION:

1. Infants whose parents have designated breastmilk as their feeding of choice will not be offered formula as an option unless medically necessary, per physician/AHP orders.
2. Prior to formula supplementation:
   a. The parents will be informed of the risks of formula feeding.
   b. Assess infant ability to feed: observation at breast, LATCH score, weight loss, hydration status.
   c. Avoid feeding by bottle if possible for supplementation for babies whose mothers intend to breast feed, evaluate the use of a SNS as appropriate.
3. Assess mother's breastmilk supply at least every 12 hours and prn.
4. Consider a pre/post weight check in order to assess milk transfer if baby > 48 hours old, mother's breasts are filling and colostrum/milk is easily expressed. Generally performing a pre/post weight before mother appreciates significant breast changes is not useful except in the case when mother is refusing supplementation for an infant with excessive weight loss or hunger signs.
5. Expressed maternal breast milk (MBM) should be used for supplementation if available; formula can be used if MBM not available, per physician/AHP orders.
6. If supplementing, the goal is to transition baby to breast feeding as soon as possible. It is important to give baby supplemental volumes that are appropriate for baby's day of life. Feeding babies inappropriately large volumes during first days of life, sets couplet up for breast feeding challenges when they are ready to transition to exclusive breastfeeding.
7. Mothers in the hospital who are supplementing should be double pumping every 3 hours to stimulate milk supply and empty breasts, unless infant is latching and sucking well. Mothers can also be taught hand expression for small quantities of colostrum.

Table for Supplementation Volumes

Time (hours)	Volume (mL/feed)
1st 24	up to10
24-48	up to 15
48-72	15-30
72-96	30-60

Based on Academy of Breastfeeding Clinical Protocol # 3: Hospital Guidelines for the Use of Supplemental Feedings in the Healthy Term Breastfed Neonate. Revised 2009.

a. An adequately nourished infant feeds 10-12 times per 24 hours.
b. A term infant shall be allowed to feed more frequently than every 3 hours.
c. Infants are expected to lose weight during the first few days of life, but should regain birth weight by two weeks of age. Excessive weight loss (>10% or >3%/day) should prompt a medical and nutritional evaluation of feeding techniques and mother's milk supply. In addition to medical evaluation of the infant, mother should be referred to a lactation evaluation and support.
d. Infants who are discharged prior to regaining birth weight should have a follow-up evaluation by the infant's primary health care provider or home health nurse within 24-48 hours of discharge to monitor weight, hydration, number of wet diapers and stools and assess for jaundice and signs of sepsis.

B. RELATED DOCUMENT(S):

1. Women and Newborn Services-NICU: Skin to Skin Contact Procedure

C. **REFERENCE LIST:**

1. Academy of Breastfeeding Medicine Protocol Committee. (2009). ABM clinical protocol# 3: hospital guidelines for the use of supplementary feedings in the healthy term breastfed neonate, revised 2009.
2. ACOG Committee on Obstetric Practice. (2012). *Guidelines for perinatal care*. American Academy of Pediatrics.
3. Lawrence, R. A., & Lawrence, R. M. (2010). *Breastfeeding: a guide for the medical professional*. Elsevier Health Sciences.
4. Nyqvist, K. H., Häggkvist, A. P., Hansen, M. N., Kylberg, E., Frandsen, A. L., Maastrup, R., & Haiek, L. N. (2013). Expansion of the baby-friendly hospital initiative ten steps to successful breastfeeding into neonatal intensive care: expert group recommendations. *Journal of Human Lactation*, *29*(3), 300-309..
5. Office of the Surgeon General (US. (2011). The Surgeon General's call to action to support breastfeeding. .
6. Stroustrup, A., Trasande, L., & Holzman, I. R. (2012). Randomized controlled trial of restrictive fluid management in transient tachypnea of the newborn. *The Journal of pediatrics*, *160*(1), 38-43.
7. University of San Diego (UCSD). (2015). Feeding Guidelines: Healthy Infants ≥35 weeks. Women and Infant Services Policy and Procedure.
8. World Health Organization. (2009). Acceptable medical reasons for use of breast-milk substitutes.

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES
NEONATAL INTENSIVE CARE UNIT (NICU)

SUBJECT: Neuro-Developmental Supportive Care in the NICU

ISSUE DATE: 09/07
REVISION DATE(S): 04/09, 06/11, 08/12. 08/17

NICU Department Approval:	~~05/17~~03/20
Perinatal Collaborative Practice Approval:	~~07/17~~03/20
~~Division of Neonatology Approval:~~	~~07/17~~
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/17~~05/20
Administration Approval:	06/20
Professional Affairs Committee Approval:	~~08/17~~ n/a
Board of Directors Approval:	08/17

A. **POLICY:**

~~1. Developmental care is an approach to modify the NICU environment so as to minimize the stress experienced by the infant in the NICU. Growth and development of the preterm infant may be enhanced by consistently providing the infant and their family developmentally supportive care. Additionally, developmental outcomes will be improved as a result of stabilization of the preterm infant's unique physiologic and behavioral functioning.~~

1. Neurodevelopmental care has the potential to support the brain development of preterm babies during hospital stay and to enhance parental competencies and wellbeing. The concept encompasses a wide range of environmental and behavioral strategies.
2. Involved, knowledgeable parents are the key to promoting better neurodevelopmental outcomes and facilitating repair and re-wiring of neural connections.
3. All NICU nurses, providers, and therapists have the opportunity to positively impact the sensory, motor, cognitive, language, and emotional/psychosocial outcomes of each and every baby we interact with – for the lifetime of that patient.

B. **PROCEDURE:**

~~2. Minimal Handling and Individualization of Care~~

~~a. Handling should be slow and based on the infant's cues. Sudden changes in movement should be avoided.~~

~~b. Promote sleep by clustering care. Time care around wake cycles as much as possible, allowing for blocks of two to three hours of uninterrupted sleep. Instruct Parents on protective sleep and cluster care.~~

~~c. Hands on care should be coordinated with the needs of the interdisciplinary team (MD, AHP, RCP, OT/PT, Lab, etc.).~~

~~d. Monitor the patient during all routine and medical care procedures for stress responses. Stress may be minimized through containment or swaddling, non nutritive suck on a pacifier, use of oral sucrose solution during painful or invasive procedures and allocation of rest periods. Some critical infants may not tolerate prolonged care times, adjust care accordingly.~~

~~e. Parents should be encouraged to provide gentle touch and containment by cupping head and buttocks/legs rather than stroking.~~

1. Healing Environment/General neuroprotective interventions
   a. Encourage early, frequent, and prolonged Skin-to-Sskin ~~(S2S)~~ care. This is the foundation of neuroprotective care.

b. Provide adequate and comfortable space for parents.
c. Provide a neutral thermal environment
    i. ELGAN patient: provide humidity per NICU Standards of Care
d. Change infant position using gentle, slow handling.
e. Minimize stress and unnecessary/noxious sensory stimuli.
    i. Protect auditory system by minimizing noise
        1) Talk in hushed tones when at bedside.
        2) Have parents ~~K~~keep phones, pagers on vibrate.
    ii. Protect visual system by minimizing direct light
        1) Cover baby's eyes during exams and procedures.
        2) Use isolette covers and blankets to protect from direct light.
    iii. Protect olfactory system by minimizing odors.
        1) Let hand sanitizers dry before putting hands in isolette/crib
    iv. Provide scent and taste of mother's milk.
        1) Loveieis/Scent cloths.
        2) Oral care with expressed mother's milk.

~~3. Noise Stimuli~~
~~a. Staff will respond to all equipment alarms quickly. Anticipate alarms and temporarily silence them before they sound during care interventions known to trigger alarms.~~
~~b. Staff will utilize appropriate sound levels, teach, and encourage sound compliance of visitors and staff.~~
~~c. Minimize noise from equipment. Close isolette doors slowly/softly and avoid placing items on top of the isolette.~~
~~d. Instruct parents on appropriate vocal and sound communication with their infant.~~
~~3. Visual/Light Stimuli:~~
~~a. Avoid direct light on patient care spaces except for during procedures. During procedures, protect eyes from bright lights.~~
~~b. Individualize light exposure through the use of isolette covers. Avoid abrupt increase in light.~~
~~c. Critically ill patients and those <31 weeks will benefit from continuous shielding from ambient lighting.~~
~~d. Patients >31 weeks may benefit from non direct cycled lighting by folding open the isolette covers during the daytime hours.~~
~~e. Periods of dimmed light levels while maintaining safe levels for accurate clinical observation should be provided during nighttime cycles for all patients.~~
~~f. Provide adequate eye protection for patients receiving phototherapy.~~
~~g. Provide the patient with visual stimuli that has a distinctive facial pattern by place pictures on the isolette or crib wall in line with patient's line of vision when awake.~~
~~h. Remove visual stimuli if patient begins to show signs of disorganization.~~
~~5. Olfactory Stimuli:~~
~~a. Staff are to avoid use of scented soaps, lotions and fragrances.~~
~~i. Encourage Parents to avoid use of scented soaps, lotions, fragrances during NICU visits.~~
~~ii. Educate Parents to the risks of NICU infant exposure to second hand smoke.~~
~~b. Open betadine and other skin prep pads away from the isolette to reduce patient exposure to noxious odors.~~
~~c. Remove betadine and other skin prep pads from isolette immediately after use.~~
~~d. Encourage the parents to provide a soft small blanket/cloth that the mother or father have held close to their body to place near or under patient.~~
~~6. Oral Stimuli:~~
~~a. Provide oral care for intubated and/or NPO patients during hands on care, prior to suctioning or at minimum every three to six hours with touch times.~~
~~b. Provide oral stimulation when appropriate to promote non nutritive sucking for patients using an appropriately sized pacifier.~~
~~c. Minimize orally aversive procedures, such as unnecessary oral suctioning or repeated insertion of oral/nasal gastric tube.~~

~~7. Tactile/Vestibular Stimuli:~~
~~a. Introduce one stimulus at a time (visual, tactile, verbal). Observe the patient's physiological response while assessing for changes in baseline color, respiratory rate, heart rate, blood pressure, and oxygen saturations.~~
~~b. Allow the patient to set the pace for care giving. When the patient begins to show signs of disorganization, withdraw stimulus, provide hands on containment and allow recovery time before continuing care.~~

2. Partnering with Families
   a. Parents are the primary caregivers
   b. Orient to the NICU, encourage questions, provide frequent updates and psychosocial support.
   c. Educate parents regarding neurodevelopment, infant sleep/wake states, stress cues, and ways in which they can promote good outcomes.
   d. ~~S2S~~Skin-to-skin care as soon as possible, as often as possible, for as long as possible.
   e. Encourage parent participation in rounds.
   f. Support positive interactions between parents and infant.
   g. Help parents become competent in infant care, building confidence towards discharge.
   h. Support parents as they evolve into their roles as expert and advocate for their child.
3. Handling and Procedures
   a. Assess sleep/wake state before handling.
   b. Promote smooth transitions between states.
      i. Prepare the infant for care-giving, speaking softly to infant before placing hands on.
      ii. Provide 4-handed support during repositioning and care activities whenever possible.
      iii. Utilize slow, smooth movements.
   c. Maintain a flexed and contained position.
   d. Facilitate midline alignment, bringing hands toward face and mouth.
   e. If stress cues are noted, pause to allow recovery.

~~8. Positioning~~
~~a. Developmentally supportive care giving is aimed at minimizing energy expenditure while promoting a balance between flexion and extension in every patient.~~
~~b. Provide age appropriate care based on current gestational age and determine the appropriate position for the neonate based on the following:~~
~~i. The goal is to model behaviors that have been shown to decrease the incidence of SIDS to enhance parental compliance with these recommendations post discharge.~~
~~ii. Stable term neonate and premature neonate greater than 32 weeks' GA position supine.~~
~~iii. The infant's head should be shifted/turned with cares to decrease plagiocephaly.~~
~~iv. Preterm neonates 23 to 32 weeks' gestational age (GA) are to be positioned to sustain head in midline position for the first 72 hours of life. Infant's position may be rotated with cares; however, midline head position will be maintained. No prone positioning.~~
~~v. Critically ill term neonates and preterm neonates greater than 32 weeks' GA ideally are positioned side lying or prone, transitioning to supine as they stabilize.~~
~~vi. For the patient <34 weeks, positioning aids are necessary to support physiological flexion and orientation towards midline.~~
~~vii. Supine positioning facilitates random movement, startling and awakening from sleep.~~

~~c. Shoulders should be rounded with a curved back to avoid hyperextension of the trunk. When in the prone position, a small body positioner can be used to raise the trunk.~~
~~d. The neck should not be extended nor hyperextended~~
~~e. Patient's hands should be near the mouth, with elbows flexed.~~
~~f. The hips and legs should be flexed and midline with knees and ankles together.~~
~~g. Avoid pressure around the patient's medial aspects of the knees and elbows that promote external rotation and extension based posture. Provide appropriate boundaries to maintain desired flexion.~~
~~h. Soft head positioners may be used for patients less than 34 weeks and/or with severe respiratory compromise or injury that would limit head positioning.~~
~~i. Swaddle the patient with shoulders tucked midline and hands free for self consoling, grasping and hand to face and mouth behaviors.~~
~~j. As appropriate, swaddle the patient or provide hands on containment, and sucrose (if ordered,) during stressful procedures.~~
~~k. Oscillator Positioning and Care:~~
~~i. Respiratory Care Practitioner (RCP) should be present to assist with airway maintenance. Do not disconnect from oscillator.~~
~~ii. The patient can be repositioned every 4-6 hours, as needed and as tolerated.~~
~~iii. This can be accomplished by using positioners or blanket rolls to support side lying and rolling the patient from a side to prone position. If unstable, it is also an option to shift position slightly utilizing the soft body positioner to relieve pressure areas.~~
~~iv. Position the patient so that circuit moisture drains from the patient to the ventilator.~~
~~v. Implement position changes to promote skin integrity, developmentally appropriate care, and to minimize torticollis as follows:~~
~~1) Turn body from head to toe, rotating along horizontal axis, allowing the head to be turned to the opposite shoulder.~~
~~2) Roll patient from prone to supine or supine to prone, which permits the head to be turned toward the opposite shoulder.~~
~~3) Assess and document patient's tolerance to position change to include:~~
~~a) Vital signs~~
~~b) ETT cm mark at lip~~
~~c) Breath sounds~~
~~d) Chest wiggle/chest movement~~
~~f. Safe sleep and Tummy Time~~

4. Positioning
- **a. IVH Prevention Bundle for first 72 hours of life (babies < 32 weeks)**
  - **i. Maintain midline position**
  - **ii. After 72 hours continue neurodevelopmental guidelines below.**
- **b. Position infants in a manner to**
  - **i. Support musculoskeletal and motor system development**
  - **ii. Facilitate neurosensory development**
  - **iii. Promote neurobehavioral organization, comfort, and sleep**
  - **iv. Decrease stress and energy expenditure**
  - **v. Mimic the intrauterine environment, providing supportive containment with positioning aids**

5. Safeguarding sleep
- **a. Protect sleep cycles, and especially REM sleep.**
  - **i. Both REM and non-REM sleep are crucial during fetal and neonatal life for the development of neurosensory function.**
- **b. Allow rest periods of at least 60 minutes to complete a normal sleep cycle.**
- **c. Use spontaneous awake periods for routine caregiving whenever possible.**
- **4)d. Cluster cares whenever possible, unless infant unable to tolerate all measures being bundled into single session.**

~~l. Safe sleep guidelines will be followed on all patients when transferred to an open crib.~~

~~i. At 35 weeks, flatten the head of bed unless otherwise ordered by physician/AHP due to evidence of reflux.~~

~~ii. Remove all positioning devices unless suggested by OT/PT, AND ordered by the Physician/AHP.~~

~~iii. Term patients, who are in open cribs upon admission, should be swaddled or in a sleep sack and supine.~~

~~iv. Demonstrate and encourage parents to practice tummy time during visits when patient is awake and active.~~

~~v. Patient's beds should be free of all soft objects, i.e., stuffed animals.~~

6. **Minimize Stress and Pain**
   a. **Helping to provide containment during uncomfortable procedures is an ideal opportunity for parent participation.**
   b. **Allow infant to fully recover from painful stimulus before resuming caregiving.**
   c. **Comfort measures are indicated for all minor or moderately stressful procedures.**
   d. **Containment**
   e. **Non-nutritive sucking**
   f. **Sucrose.**
   g. **Add pharmacologic agents to comfort measures whenever moderate or severe pain is anticipated.**
   h. **Judicious use of sedatives and analgesics.**
7. **Protecting the Skin**
   a. **Humidity for ELBW infants for first 1-2 weeks of life (See NICU Standards of Care).**
   b. **Use appropriate positioning aids.**
   c. **Assess skin from respiratory equipment, leads, pulse oximetry probe, etc.**
   d. **Bathing no more frequently than every 72-96 hours.**
   e. **Involve parents in bathing whenever possible.**
   f. **Judicious use of tapes, dressings, adhesives, and other medical equipment.**
8. **Optimizing Nutrition**
   a. **Mother's milk decreases risk of NEC, sepsis, and ROP.**
      i. **Explain to parent the need- for early and frequent pumping if baby is unable to breastfeed.**
   b. **When possible, stable infants should be held during gavage feeds.**
   c. **Utilize non-nutritive sucking when gavage feeding.**
   d. **Oral feedings should be infant-driven/cue-based.**
      i. **The first oral feeding should be at the breast if mother plans on breastfeeding.**
      ii. **Provide a safe, functional, nurturing, and developmentally appropriate feeding experience.**
      ~~i.~~iii. **Focus should be on quality of feeding, not quantity.**
      ~~ii.~~

C. **REFERENCE(S):**

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Tri-City Medical Center	Women and Newborn Services Neonatal Intensive Care Unit (NICU)
PROCEDURE:	**HIGH RISK INFANT FOLLOW-UP PROGRAM (HRIF)**
Purpose:	To provide periodic follow-up developmental assessments of high-risk infants discharged from TCMC's NICU, from birth to 3 years of age.To make referrals to appropriate community services.To provide education to parent/caregiver regarding infant's/child's developmental status, with a home program provided as needed.
Supportive Data:	In order to identifying neonates, infants and children who may develop a CCS-eligible medical condition and provide better outcomes for infants at high risk due to extreme pre-maturity, low birth weight and/or medical eligibility criteria that require support and/or treatment beyond the normal birthing experience. Follow-up programs have been instituted to assist families in addressing their social and medical needs.
Equipment:	1. Treatment Room 2. Scale and length board 3. Bayley Scales of Infant and Toddler Development
Issue Date:	08/06

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES –
NEONATAL INTENSIVE CARE UNIT (NICU)

SUBJECT: High Risk Infant Follow-Up (HRIF) Program Referral Process

ISSUE DATE: 08/06
REVISION DATE(S): 05/08, 06/09, 6/11, 8/12, 01/15, 03/16

Women and Newborn Services NICU Department Approval:	02/20
Perinatal Collaborative Practice Approval:	04/1502/2003/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	01/1605/20
Administration Approval:	06/20
Professional Affairs Committee Approval:	03/16 n/a
Board of Directors Approval:	03/16

A. **POLICY:**

1. It is the policy of Tri-City Medical Center's NICU to provide high risk follow-up care that is compliant with the California Children's Services (CCS) guidelines.

B.A. **PROCEDURE:**

1. As part of the NICU discharge planning process, **all HRIF-eligible infants (as defined by California Code of Regulations, Title 22, Section 41800 through 41872, CCS Medical Eligibility Regulations) will be referred to the HRIF program**the NICU must identify and refer to the CCS Program clients identified as potentially eligible for the HRIF Program.
   a. It is the responsibility of the discharging to home CCS NICU/Hospital or the last CCS NICU/Hospital providing care to make the referral to the HRIF Program.
2. Eligibility for High Risk Infant Follow-up program**HRIF**:
   a. Infants discharged from a CCS (California Children Services)-approved NICU with a CCS-eligible condition, or without a CCS-eligible condition but who continue to be at risk of developing a CCS-medically eligible condition, shall be **referred to the HRIF**

Department Review	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
05/08, 06/09, 6/11, 8/12, 01/15	04/15	n/a	01/16	03/16	06/13, 03/16

program.followed for the first three years of life. Infants who are discharged from a CCS-approved hospital after transfer from an approved NICU are similarly eligible.

3.b. Criteria for High Risk Infant Follow-up programHRIF: Appendix A includes the following:

a. Meets CCS medical eligibility criteria for NICU care in a CCS approved NICU (regardless of length of stay)(as per numbered letter 05-0502, Medical Eligibility in a CCS Approved NICU).

Or

b. Had a CCS eligible medical condition in a CCS approved NICU (regardless of length of stay), (as per California Code of Regulations, Title 22, Section 41800 through 41872, CCS Medical Eligibility Regulations).

And

c. The birth weight was less than 1500 grams or more and the gestational age at birth was less than 32 weeks.

Or

d. The birth weight was 1500 grams or more and the gestational age at birth was less than 32 weeks or more and one of the following criteria was met during the NICU stay:

i. Cardiorespiratory depression at birth (defined as pH less than 7.0 on an umbilical blood sample or a blood gas obtained within one hour of life) or an Apgar score of less than or equal to three at five minutes.

ii. A persistently and severely unstable infant manifested by prolonged hypoxia, acidemia, hypoglycemia and/or hypotension requiring pressor support.

iii. Persistent apnea, which required medication (e.g., caffeine) for the treatment of apnea at discharge.

iv. Required oxygen for more than 28 days of hospital stay and had radiographic finding consistent with chronic lung disease (CLD).

v. Patients placed on extracorporeal membrane oxygenation (ECMO).

vi. Patients who received inhaled nitric oxide greater than four hours for persistent pulmonary hypertension of the newborn (PPHN).

vii. History of documented seizure activity.

viii. Evidence of intracranial pathology, including but not limited to, intracranial hemorrhage (grade II or worse), periventricular leukomalacia (PVL), cerebral thrombosis, cerebral infarction, developmental central nervous systems (CNS) abnormality or "other CNS problems associated with adverse neurologic outcome."

ix. Other problems that could result in a neurologic abnormality (e.g., history of CNS infection, documented sepsis, bilirubin in excess of usual exchange transfusion level, cardiovascular instability, hypoxic ischemic encephalopathy, et cetera).

4. Eligible infants shall receive the following evaluations:

a. An interim comprehensive history and physical examination (including neurological assessment) at 4-6 months, 9-12 months, and 18-36 months corrected age. Evaluation is done by a physician.

b. A development assessment including a standardized developmental test such as the Bayley Scales of Infant Development (BSID) 3rd edition is performed. This may be done by a physician, nurse practitioner, physical therapist, occupational therapist, speech therapist, or a developmental specialist – all with training in the evaluation of motor, sensory, language and social development of high-risk infants.

c. A family psychosocial assessment is performed by a clinical social worker with expertise in this area or by the assessment team.

5. Eligible infants may receive the following referrals:

a. Audiological Screening: It is expected that all infants will be screened prior to discharge. Infants not screened in the hospital or infants whose hospital screening was abnormal should be screened once through the HRIF program.

b. Ophthalmologic assessment to be performed by a CCS-paneled ophthalmologist. For evaluation of retinopathy of prematurity, infants should be examined at 4-6 weeks of life if clinical condition permits; subsequent examinations should be performed until retinae are mature, as deemed appropriate by the ophthalmologist. (In general, the retinae are

considered mature by 42 weeks, post-conceptual age.) Outpatient visits may be scheduled.

e. A Home Assessment for the purpose of evaluating the family for specific needs within the home environment may be provided by a Health Home Agency (HHA) nurse.

d. Based on clinical findings referrals are made by Social Services and therapists to outside agencies. Infants in need of a more definitive evaluation or those requiring a long-term diagnostic evaluation should be referred to the general CCS program for such diagnostic follow-up until a suspected diagnosis is either established or ruled out.

e. Referral outcomes are reviewed via returned information from agencies and subsequent HRIF visits.

C. **ROLES AND RESPONSIBILITIES OF THE MEMBERS OF THE HIGH RISK INFANT FOLLOW-UP TEAM:**

1. NICU Medical Director
   a. May be one of the following: Pediatrician or Neonatologist
   b. Ensures that the HRIF Program fully participates in the CCS Program evaluation, including submission of required information and data.
2. HIRF Coordinator
   a. May be one of the following: CCS-approved: pediatrician or neonatologist, pediatric nurse practitioner, nurse specialist, psychologist, social worker, physical therapist, or occupational therapist. The pediatric nurse practitioner only requires CCS approval when functioning in the CCS HRIF Program as a HRIF Coordinator.
   b. The specific responsibilities of the coordinator are:
      i. Serve as the primary person coordinating HRIF services among the County CCS Programs, other HRIF Programs located in CCS-approved Regional, Community, and Intermediate NICUs, State Regional Offices, clients/families, and others in matters related to the client's HRIF services.
      ii. Participate in NICU discharge planning process or multidisciplinary rounds.
      iii. Ensure identification of HRIF eligible clients according to HRIF eligibility criteria.
      iv. Ensure the NICU discharge planning process includes referral and SAR submission to the County CCS Program or Regional Office.
      v. Ensure copies of the authorizations are distributed to HRIF team members and consultants.
      vi. Gather medical reports and assessments for review by team members, and prepare a summary report.
      vii. Ensure that a copy of the summary report is sent to the County CCS Program or Regional Office.
      viii. Confer with parents regarding services provided and results of clinical evaluations and assessments of their infant or child.
      ix. Assist families in establishing a Medical Home for the infant or child.
      x. Assist clients/families in making linkages to necessary medical and social services.
      xi. Ensure there is a system in place to follow-up with families including those who have missed appointments. Collect documentation of the reason for missed appointments and develop a plan of action for improving HRIF Program adherence for evaluations and assessments.
      xii. Provide coordination between the HRIF Program and the infant's or child's (pediatric) primary care physician, specialists, and County CCS Program or Regional Office when appropriate.
      xiii. Coordinate HRIF services with the County CCS Program and Regional Offices and other local programs.
      xiv. Coordinate follow-up service needs among the CCS-approved Regional, Community and Intermediate NICUs within the community catchment area and with those NICUs that provide HRIF referrals to their agency.
   c. The Coordinator will facilitate the following Client Referral Services and Follow-Up and Education Services Program:
      i. Ensure and document referrals are made to the Early Start (ES) Program for children who meet ES eligibility criteria.

~~ii. Ensure referrals are made to the Regional Center when these services are appropriate.~~
~~iii. Ensure referrals to HRIF diagnostic consultations and assessments are made with CCS-approved providers. High Risk Infant Follow-Up Quality Of Care Initiative: Manual Of Definitions – Release 01.15.13~~
~~iv. Ensure referrals to CCS Medical Therapy Program (MTP) are made as needed. Reminder: CCS Program eligibility and referral criteria for MTP are different from CCS/CPQCC HRIF data collection definitions for MTP eligibility.~~
~~v. Provide referral and resource information for other social and developmental programs within the community, as required.~~
~~vi. Provide education and outreach about the HRIF Program and services, clinical care, required documentation on transfer, and referral options, including outreach to NICUs with which there is a NICU Regional Cooperation Agreement to CCS-approved Community and Intermediate NICU's and other community referral agencies, as appropriate.~~
~~vii. Develop and provide education to parents and family members about the high risk infant's medical condition(s), care and treatment, special needs and expected outcomes of care.~~
~~viii. Provide education to parents and family members about the system of care and services (including social services) available to help them nurture, support, and care for the high risk infant.~~

~~3. Social Worker~~

~~a.~~3. ~~The r~~**NICU Social Worker will**~~esponsibilities of the Social Worker includ:es:~~

~~i.~~**a.** Participate in NICU discharge planning process or multidisciplinary rounds.

b. Prior to discharge:

~~ii.~~**i.** Ensure identification of HRIF eligible clients according to HRIF eligibility criteria.

~~iii.~~**ii.** Ensure the NICU discharge planning process includes referral and SAR submission to the County CCS Program or Regional Office. ~~(See Section IV.B.)~~

iii. Ensure ~~copies of the authorizations are distributed to HRIF team members and consultants.~~**copy of NICU discharge summary is provided to HRIF Program**

c. Eligible infants may receive the following referrals as appropriate:

i. Audiological Screening: It is expected that all infants will be screened prior to discharge. Infants not screened in the hospital or infants whose hospital screening was abnormal should be screened once through the HRIF program.

ii. Ophthalmologic assessment to be performed by a CCS-paneled ophthalmologist. For evaluation of retinopathy of prematurity, infants should be examined at 4-6 weeks of life if clinical condition permits; subsequent examinations should be performed until retinae are mature, as deemed appropriate by the ophthalmologist. (In general, the retinae are considered mature by 42 weeks, post-conceptual age.) Outpatient visits may be scheduled.

iii. Referral to Public Health Nurse for a Home Assessment

iv. Referrals to outside agencies as needed. Infants in need of a more definitive evaluation or those requiring a long-term diagnostic evaluation should be referred to the general CCS program for such diagnostic follow-up until a suspected diagnosis is either established or ruled out.

~~v. Assist families in establishing a Medical Home for the infant or child.~~
~~vi. Assist clients/families in making linkages to necessary medical and social services.~~
~~vii. Ensure and document referrals are made to the Early Start (ES) Program for children who meet ES eligibility criteria.~~

d. Ensure referrals are made to the Regional Center ~~when these services are appropriate~~**as appropriate**

~~viii.~~**i. Regional Center will determine eligibility for Early Start (ES) Program.**

~~ix.~~**e.** Provide referral and resource information for other social and developmental programs within the community, as required.

~~x.~~**f.** Provide education to parents and family members about the system of care and services (including social services) available to help them nurture, support, and care for the high risk infant.

~~4. History and Physical Exam Team~~

~~a. May include the following: pediatrician or neonatologist, pediatric nurse practitioner, nurse specialist, and/or psychologist.~~

~~b. The responsibilities of the History and Physical Exam Team include:~~

~~i. Perform a Comprehensive History and Physical Examination, including neurologic assessment, at approximately 4 to 8 months, 12 to16 months, and 18 to 36 months (adjusted for chronological age).~~

~~ii. Participate in NICU discharge planning process or multidisciplinary rounds.~~

~~iii. Ensure identification of HRIF eligible clients according to HRIF eligibility criteria.~~

~~iv. Gather medical reports and assessments for review by team members, and prepare a summary report.~~

~~v. Confer with parents regarding services provided and results of clinical evaluations and assessments of their infant or child.~~

~~vi. Assist families in establishing a Medical Home for the infant or child.~~

~~vii. Assist clients/families in making linkages to necessary medical and social services.~~

~~viii. Provide coordination between the HRIF Program and the infant's or child's (pediatric) primary care physician, specialists, and County CCS Program or Regional Office when appropriate.~~

~~ix. Coordinate HRIF services with the County CCS Program and Regional Offices and other local programs.~~

~~x. Coordinate follow up service needs among the CCS approved Regional, Community and Intermediate NICUs within the community catchment area and with those NICUs that provide HRIF referrals to their agency.~~

~~xi. Ensure and document referrals are made to the Early Start (ES) Program for children who meet ES eligibility criteria.~~

~~xii. Ensure referrals are made to the Regional Center when those services are appropriate.~~

~~xiii. Ensure referrals to HRIF diagnostic consultations and assessments are made with CCS approved providers.~~

~~xiv. Ensure referrals to CCS Medical Therapy Program (MTP) are made as needed.~~

~~xv. Provide referral and resource information for other social and developmental programs within the community, as required.~~

~~xvi. Provide education and outreach about the HRIF Program and services, clinical care, required documentation on transfer, and referral options, including outreach to NICUs with which there is a NICU Regional Cooperation Agreement to CCS approved Community and Intermediate NICU's and other community referral agencies, as appropriate.~~

~~xvii. Develop and provide education to parents and family members about the high risk infant's medical condition(s), care and treatment, special needs and expected outcomes of care.~~

~~xviii. Provide education to parents and family members about the system of care and services (including social services) available to help them nurture, support, and care for the high risk infant.~~

~~5. Developmental Assessment Team~~

~~a. May include the following: a CCS approved pediatrician or neonatologist, pediatric nurse practitioner, CCS approved nurse specialist (registered nurse with a Bachelor's of Science Degree in Nursing), CCS approved physical therapist, CCS approved occupational therapist, and/or CCS approved psychologist, all of whom have training in the evaluation of motor and sensory development of high risk infants.~~

~~b. The responsibilities of the Developmental Assessment Team include:~~

~~i. Perform a Developmental Assessment at each of the three Standard Visits (4 to 8 months, 12 to 16 months, and 18 to 36 months). At the 3rd and final Standard Visit~~

~~(18-to-36 months), a developmental test such as the Bayley Scales of Infant Development (BSID) 3rd edition must be performed.~~

~~ii. Gather medical reports and assessments for review by team members, and prepare a summary report.~~

~~iii. Ensure that a copy of the summary report is sent to the County CCS Program or Regional Office.~~

~~iv. Confer with parents regarding services provided and results of clinical evaluations and assessments of their infant or child.~~

~~v. Assist clients/families in making linkages to necessary medical and social services.~~

~~vi. Provide coordination between the HRIF Program and the infant's or child's (pediatric) primary care physician, specialists, and County CCS Program or Regional Office when appropriate.~~

~~vii. Coordinate HRIF services with the County CCS Program and Regional Offices and other local programs.~~

~~viii. Coordinate follow-up service needs among the CCS-approved Regional, Community and Intermediate NICUs within the community catchment area and with those NICUs that provide HRIF referrals to their agency.~~

~~6. Administrative Support Team~~

~~a. May include the following: receptionist, secretary, referral coordinator, registration clerk, aide, and/or access management personnel.~~

~~i. Ensure the NICU discharge planning process includes referral and SAR submission to the County CCS Program or Regional Office.~~

~~ii. Ensure copies of the authorizations are distributed to HRIF team members and consultants.~~

~~iii. Gather medical reports and assessments for review by team members, and prepare a summary report.~~

~~iv. Ensure that a copy of the summary report is sent to the County CCS Program or Regional Office.~~

~~v. Assist in registration, scheduling appointments, contact and notification for appointments, preparation of forms and caregiver letters, medical record keeping, billing.~~

~~D. EXTERNAL LINKS:~~

~~1. https://www.ccshrif.org/download/Version%2001.15/2015%20HRIF-QCI%20Manual%20of%20Defintions%20v01.15.pdf~~

~~E.~~B. **REFERENCES:**

1. High Risk Infant Follow-up Quality of Care Initiative: Manual of Definitions, Release January 2015. California Children's Services (CCS) & California Perinatal Quality Care Collaborative (CPQCC), State of California.

~~1.~~

C. **ATTACHMENTS:**

1. **Appendix A: Criteria for HRIF Referral**

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES
NEONATAL INTENSIVE CARE UNIT (NICU)

SUBJECT: Palliative Care of the Neonate at the End of Life

ISSUE DATE: 07/07
REVISION DATE: 05/08, 4/09, 6/11, 8/12, 11/16

NICU Department Approval ~~Date(s)~~:	~~05/16~~03/20
Perinatal Collaborative Practice Approval ~~Date(s)~~:	~~08/16~~03/20
~~**Division of Neonatology Approval Date(s)**~~**:**	08/16
Pharmacy and Therapeutics Approval ~~Date(s)~~:	n/a
Medical Executive Committee Approval ~~Date(s)~~:	~~09/16~~05/20
Administration Approval:	06/20
Professional Affairs Committee Approval ~~Date(s)~~:	~~10/16~~ n/a
Board of Directors Approval ~~Date(s)~~:	11/16

A. **PURPOSE:**
1. To ~~provide a supportive atmosphere for grieving families who have experienced a newborn death~~ **support a peaceful, dignified, and loving death for the infant, family, and staff.**.
2. To provide interventions ~~in caring for the dying patient that is~~ directed toward maximizing comfort.**for the dying infant.** ~~and provide support for the patient/family/significant others~~.
3. To provide emotional, spiritual, and cultural support with respect for patient/family/significant others' values and preferences.

B. **POLICY:**
1. Palliative care focuses on relieving the newborn's pain and symptoms while extending emotional and spiritual support for the newborn and family. Palliative care provides non-curative interventions that address the physical, emotional, social, cultural, and spiritual needs of neonates and their families at the end of life.
   a. Palliative care seeks to ensure that bereaved families are able to remain functional and intact.
   b. Palliative care includes the control of pain and other symptoms and addresses the psychological, social, or spiritual problems of the neonate and family.
   c. The needs and feelings of the ~~parent(s)~~ **family** will be respected.
   d. The institution of palliative care should be prompt.
   e. ~~Decisions should be collaborative and clearly communicated~~. **Palliative care is an interdisciplinary endeavor. Decisions should be collaborative and clearly communicated**

~~f.~~**2.** The following guidelines apply to the care of neonates ~~in either of three~~ **in these** situations:
   ~~i.~~**a.** Following the decision not to resuscitate (i.e., non-viability, conditions incompatible with life).
   ~~ii.~~**b.** From the point at which resuscitative efforts/treatments are withdrawn.

~~g.~~**3.** The palliative care neonate is a 1:1 ~~or no greater than a 1:2~~ assignments due to the **needs of the infant and family during the dying process.** ~~needs of the family during the dying process.~~

C. **EQUIPMENT:**
1. **Measures to anticipate and apply symptom management**
   a. **Pain relief**
   ~~C.~~b. **Oral care/suction**

~~1. Personal protective equipment~~
~~2. Infant scale~~

~~3. Disposable tape measure~~

2. Supplies to create family memories:

a. Memory box
b. Layette set
c. Camera
d. Footprints/handprints
e. Condolence card

~~4. Memory box~~

~~5. Baby clothes: hats, booties, blanket~~
~~6. Camera/film~~
~~7. Bathing supplies~~

~~D.~~ **~~PROCEDURE:~~ PROCESS:**

~~1. Process:~~

~~a.~~3. When a transition to palliative end-of-life care is made, a quiet and comforting environment is created:
~~i.~~4. Alarms are turned off. Pagers/phones are turned to silent to avoid disturbing those in attendance.
~~ii.~~5. Routine vital sign measurement and lab analyses are ceased.
~~iii.~~6. Pain assessments should be continued and may need to be done more frequently to identify infant distress.
~~iv.~~7. No painful assessments (heel sticks, blood gases) are done.
~~v.~~8. Provide privacy for patient and family. If unable to provide a quiet area in NICU, a room on OB may be requested.
~~vi.~~9. Assist parent/family to hold newborn; when not held, place in isolette or crib.
~~vii.~~10. Visiting hours and sibling restrictions are waived.
~~b.~~11. Care of family is a central focus.
- a. Physical, emotional, and spiritual comfort is provided.
- **b. Contact social worker.**
- ~~i.~~**c. Contact chaplain services, at parents request.**
- ~~ii.~~**d.** Mothers may need normal postpartum nursing assessments and interventions and will need assistance with lactation cessation or milk donation.
- ~~c.~~**e.** Making memories is an important part of palliative and end-of-life care.
  - i. Family photographs have been found helpful in many cultures. Many communities have photographers who specialize in this work. Photographs of the child can be kept on file for families who may not wish to have them at the time of death.
  - ii. Handprints, footprints, and locks of hair have been appreciated.
  - iii. Special spiritual or religious ceremonies can provide comfort.
  - iv. Introducing the child to the extended family can be important.
  - v. Kangaroo care has provided family comfort.
  - **vi.** There are occasions of multiple births in which some infants die and some infants live. These families will need special attention, such as photos of all the infants together; there are special community support groups for this type of loss.

12. Palliative care may include removal of life-sustaining technology:

- **a. Ensure physician has confirmed decision to withdraw life-prolonging therapies. Offer family support as needed, allow for support personnel requested by family to be present with them. Parents can decide who should be present and how the process will go. There are no visitation restrictions.**
- **b. Removal of ventilatory support**
  - **i. Infants should be weaned off any neuromuscular-blocking agents.**
  - **ii. Vasopressors and antibiotics may be ceased.**
  - **iii. Stop all infusions except for pain and/or sedation; IV converted to saline lock.**
  - **iv. Administer analgesia as needed based on clinical signs**
  - **v. Nurses should explain the process to parents, including as many details as the parent wishes to hear.**

vi. **Gentle suction of the endotracheal tube may be done and the endotracheal tube is removed.**
vii. **Tape and additional lines can be removed.**
viii. **Frequent pain and symptom assessment continues.**
~~vi.~~ix. **If respiratory discomfort exists, medication such as morphine should be given. Oxygen usually is not given.**

~~2. Palliative care may include removal of life-sustaining technology:~~
~~a.~~c. ~~Ensure physician has confirmed decision to withdraw life-prolonging therapies. Offer family support as needed, allow for support personnel requested by family to be present with them.~~
~~b. Stop all infusions except for pain and/or sedation; IV converted to saline lock.~~
~~c.~~d. ~~Administer analgesia as needed based on clinical signs~~.
~~d.~~e. ~~Place hat on newborn's head and wrap newborn in blanket.~~**Patient and family will be allowed adequate time with infant.**
~~e.~~f. ~~Allow parent/family to hold infant.~~ **When infant is not being held by family or support persons, place in bassinet/crib.**~~;~~
~~i. When not held, place in isolette or crib.~~
~~f. An RN will weigh, measure, and bathe infant if needed.~~
~~g. Patient and family will be allowed adequate time with infant prior to morgue or pathology.~~
~~3. Removal of ventilatory support~~
~~a. Infants should be weaned off any neuromuscular blocking agents.~~
~~b. Vasopressors and antibiotics may be ceased.~~
~~c. Parents can decide who should be present and how the process will go.~~
~~d. Nurses should explain the process to parents, including as many details as the parent wishes to hear.~~
~~e. Infants should be held in a parent's or staff member's arms. Some parents may not wish to hold a dying infant.~~
~~f. Gentle suction of the endotracheal tube may be done and the endotracheal tube is removed.~~
~~g. Tape and additional lines can be removed.~~
~~h. Frequent pain and symptom assessment continues.~~
~~i. If respiratory discomfort exists, medication such as morphine should be given. Oxygen usually is not given.~~

~~4.~~13. Support services also should be offered to all members of the healthcare team. Facilitated debriefing after difficult deaths is essential.

~~5.~~14. Complete the following after the family viewing (preparation for the morgue):
i. Attach identification bracelet to arm of newborn. This allows correct identification for mortuary or correct disposition of fetal remains.
ii. Place newborn on disposable drape, wrap in receiving blanket, and a second disposable drape, and secure with tape.
iii. Arrange for body to be taken to the Morgue.
iv. If the patient requests to see infant again, notify the Unit or Administrative Supervisor who will call transport to retrieve the infant from the morgue or pathology.
v. The infant will be **placed on a radiant warmer,** re-dressed, **wrapped in warm blankets,** and taken to the mother's room or to a pre-arranged private area.

D. **ADDITIONAL SUPPORT SERVICES:**
1. **Photography service: https://www.nowilaymedowntosleep.org/**
2. **Tri-City Perinatal Loss booklet**
~~vi.~~3. **March of Dimes https://www.marchofdimes.org/index.aspx**

E. **DOCUMENTATION:**
1. Caregiver's psychosocial response to perinatal loss and interaction with infant in patient's medical record.
2. Complete unit log book with time of birth/delivery, time of expiration.

3. Comfort measures provided.

F. **REFERENCES:**

~~1. Engler, A., Cusson, R., Brockett, R., Cannon-Heinrich, C., Goldberg, M., West, M., et al. (2004). Neonatal staff and advanced practice nurse's perceptions of bereavement/end of life care of families of critically ill and/or dying infants. American Journal of Critical Care; 13 (6): 489 – 498.~~

~~2. Nelson, R., Botkin, J., Kodish, E.M. Lovetown, J., Truman, J., Wilfond, B., et al. (2000). Palliative care for children. Pediatrics; 106 (2): 351 – 357.~~

1. National Association of Neonatal Nurses (~~2011~~**2019**). Policy: Palliative Care. Policies, Procedures, and Competencies for Neonatal Nursing Care, **6th ed.**.

~~3.~~**2. Gardner, S. L., Carter, B. S., Hines, M. E., & Hernandez, J. A. (2016). *Merenstein & Gardners handbook of neonatal intensive care* (8th ed.). St. Louis, MO: Elsevier.**

~~4. Stringer, M., Shaw, V., & Savani, R. (2004). Comfort care of neonates at the end of life. Neonatal Network; 23 (5): 41 – 45.~~

Tri-City Medical Center	Wo	DELETE - Refer to Online Skill: Skin-to-Skin, Newborn

~~PROCEDURE:~~	~~SKIN-TO-SKIN CONTACT~~
~~Purpose:~~	~~Promote caregiver patient bonding, facilitate lactation, and increase confidence in providing patient care. Benefits to patient may include decreased oxygen requirements during holding, early breastfeeding; longer sleep periods, lowered caloric requirements and shortened hospitalization. Benefits to caregivers may include improved lactation, greater involvement and participation in patient's care and earlier readiness for discharge.~~
~~Supportive Data:~~	~~Skin-to-skin Contact literature supports that patients who are held skin to skin are able to maintain temperature, have regular heart rates and respirations, more deep sleep and alert states, less crying, less infections, greater weight gain and earlier discharge.~~
~~Equipment:~~	~~1. Comfortable chair~~ ~~2. Front opening shirt or patient gown for the caregiver~~ ~~3. Foot stool (optional)~~ ~~4. Privacy Screen (optional)~~ ~~5. Blankets~~ ~~6. Tape~~ ~~7. Hat~~ ~~8.~~**1.** ~~Viewing mirror for the caregiver (optional)~~
Issue Date: 9/07	Revision Date(s): 5/08, 6/09, 6/11, 8/12

~~A. **DEFINITIONS:**~~

~~1. Skin-to-Skin Contact (SSC): Also known as Kangaroo Care.~~

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

~~1. SSC provides both emotional and physiologic benefits to neonates and parents.~~
~~2. There is no patient weight limitation for SSC.~~
~~3. UAC's, UVC's, and PICC lines shall be assessed individually.~~
~~4. SSC should be performed for a minimum of 60 minutes, especially for a ventilated patient. Two hours is ideal, to give the patient time to acclimate and promote regulation of the sleep cycle.~~
~~a. SSC may be done before, during or after a feeding.~~

~~C. **PROCEDURE:**~~

~~1. Preparation~~
~~a. Assess the family's understanding of the reasons for and the risks and benefits of the procedure.~~
~~b. Confirm patient identity using two identifier system.~~
~~c. Provide privacy screen, comfortable chair and appropriate lighting.~~
~~d. Have the caregiver/ wear a shirt or blouse that opens in front, or provide a hospital gown that opens in the front.~~
~~e. Ask if the parent needs to use the restroom before beginning the procedure.~~
~~f. Perform hand hygiene; have the caregiver perform hand hygiene.~~
~~2. Assessment~~
~~a. Before initiating SSC document the patient's baseline assessment and vital signs.~~
~~3. Action Steps~~
~~a. Place the chair in optimal position with wheels locked.~~
~~b. Have caregiver unbutton shirt or blouse, mother should remove bra.~~
~~c. Dress patient in diaper and hat only.~~
~~d. Transfer the patient to the parent using either of the following techniques:~~
~~i. Caregiver assisted transfer~~
~~1) Have the parent stand as close to the isolette as possible.~~

NICU Department Review	Perinatal Collaborative Practice	~~Division of Neonatology~~	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
05/16, 02/20	05/16, 03/20	~~05/16~~	n/a	08/16, 05/20	06/20	06/13, 09/16, n/a	06/13, 09/16

2) Support the patient's head and any tubing as the parent supports the patient's back and buttocks by sliding hands under him or her.
3) With nurse and parent (or second nurse) moving at the same time, turn the patient to the vertical position, instruct the parent to lean over the isolette and gently lift the patient to the parent's chest.
4) Have the parent slowly sit down in the chair. Secure any tubing to the parent's shoulder.

ii. Staff-assisted transfer
1) Have the parent sit down in the chair.
2) Place a forearm under the patient and cup his or her head with the other hand. Have another nurse support any tubing during the patient's transfer
3) Lean over the isolette and gently lift the patient to the chest.
4) Guide the patient toward the parent along with any tubing, and place the patient prone on the parent's chest.
5) Secure any tubing to the parent's shoulder.

e. Reposition the patient, as needed, so his or her head is turned to the side with the ear resting above the parent's heart.
f. For an intubated patient, check and secure the ventilator tubing, auscultate breath sounds, suction as indicated, and visually verify ET tube placement.
g. Place a light blanket over patient and tuck under caregiver's arm.
h. Check the patient's temperature within a few minutes of the transfer. Then, if is stable, check it at regular intervals.
i. To transfer the patient back from the parent to the bed, use either of the following techniques:

i. Caregiver-assisted back transfer
1) Ask the parent to rise slowly to a standing position while containing the patient prone to the chest. Support the patient's head and buttocks and any tubing while the parent rises.
2) Continuing to support the patient's head and any tubing, have the parent support the patient's back and buttocks and, together, slowly lower the patient to the mattress. Place him or her in a supine or side-lying position.
3) Keep in mind that transfer may be easier to complete with two nurses, especially with a patient who is intubated.

ii. Staff-assisted back transfer
1) Lean over the parent and gently lift the patient, containing him or her prone to the chest while cupping the head.
2) Keep in mind that transfer may be easier to complete with two nurses, especially with a patient who is intubated.
3) Guide the patient and any tubing back to the bed, and place him or her in a supine or side-lying position.

4. Monitoring
a. All patients in the NICU will be continuously monitored on a cardio-respiratory monitor and a pulse oximeter.
b. Hemodynamic stability of patient (temperature, heart rate, respiratory rate).
c. Monitor the patient's behavioral cues (comfort level, agitation) frequently throughout SSC.
d. Allow the patient some time after transfer from the isolette or bed to the caregiver's chest to ascertain tolerance.
e. Monitor the caregiver's comfort level during the SSC.

5. Signs of intolerance:
a. Return patient to isolette if patient demonstrates changes in temperature, respiratory rate, oxygen saturation or increased apnea and bradycardia episodes that do not resolve with repositioning on the parent's chest.
b.

D. **DOCUMENTATION:**

1. Patient tolerance of SSC.
2. Caregiver's response to SSC, including specific observations.
3. Caregiver education.
4. Duration of SSC.

E. REFERENCES:

1. Altimier, L., Brown, B., & Tedeschi, L. (2006). *Neonatal nursing policies, procedures, competencies, and clinical pathways, 4th ed.* Glenview, IL: National Association of Neonatal Nurses.
2. Dodd, U.L. (2005). Implication of Kangaroo Care for the Growth and Development in Preterm Infants. *Journal of Obstetric, Gynecological, and Neonatal Nursing*, 34(1), 218-232.
3. Fohe, K., Kropf, S., & Avenarius, S. (2000). Skin-to-skin contact improves gas exchange in premature neonates. *Journal of Perinatology*, 20, 311-315.
4. Galligan, M. (2006). Proposed Guidelines for Skin-to-Skin treatment of Neonatal Hypothermia. *The American Journal of Maternal Child Nursing*. September/October, 31(5), 298-304; quiz 305-306.
5. Ludington-Hoe, S.M. et al. (2004). Randomized controlled trial of kangaroo care: Cardiorespiratory and thermal effects on healthy preterms. *Neonatal Network*, 23, 39-48.
6. Merenstein, G. B. & Gardner, S. L. (2011). *Handbook of neonatal intensive care*, 7th ed. Mosby Elsevier.
7. Mosby's Nursing Skills. (2016). Skin-to-skin Contact. Elsevier, Inc.
8. Roller, C.G. (2005). Getting to Know You: Mother's Experiences of Kangaroo Care. *Journal of Obstetrics, Gynecologic, and Neonatal Nursing*, 34(1) 210-217.
9. Smith, K. M. (2007). Sleep and Kangaroo Care: Clinical Practice in the Newborn Intensive Care Unit: Where the Baby Sleeps [horizontal ellipsis]. *The Journal of Perinatal & Neonatal Nursing*, 21(2), 151-157.
10. Verger, J.T. & Lebet, R.M. (Eds.) (2007). *AACN procedure manual for pediatric acute and critical care*. St. Louis: Saunders.

Tri-City Medical Center
Oceanside, California

OUTPATIENT ~~FORENSIC CLINIC~~Speciality

Delete. Follow Outpatient Specimen Transport to TCMC Main Hospital Laboratory policy

ISSUE DATE: 05/11

SUBJECT: Specimen Transport

REVISION DATE(S):

Department Approval:	03/20
Department of Pathology:	04/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	05/20
Administration Approval;	~~05/11~~06/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

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

~~1. To protect the integrity of all laboratory specimens and to ensure accuracy of results, specimens collected at the Outpatient Forensic Clinic must be transported in a timely manner, as mandated by the hospital's laboratory policies.~~

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

~~1. All specimens will be delivered to the laboratory as prescribed by laboratory policy.~~
~~2. In the event that a specimen cannot be transported in the prescribed time period, the laboratory will be contacted for assistance to accomplish transport.~~

~~C. **PROCEDURE:**~~

~~1. When collecting specimens, clinic staff will wear, at a minimum, exam gloves. If soiling or splattering is likely, the proper personal protective equipment will be utilized during the specimen collection procedure.~~
~~2. All specimens are collected following specific laboratory procedure.~~
~~3. The specimen container shall be properly labeled with:~~
~~a. Patient name~~
~~b. Patient age~~
~~c. Medical record number~~
~~d. Physician name~~
~~e. Type of specimen (e.g. culture wound) and the specific anatomical site (e.g., left lower leg)~~
~~4. Specimens will be placed in plastic sealed biohazard bags with an outside pouch to secure the appropriate request form.~~
~~5. Specimens will be brought to the laboratory within the timeframe designated by the hospital laboratory.~~
~~6. If the Clinic cannot deliver the specimen in a timely manner, the laboratory will be contacted for assistance.~~
~~7. The laboratory will notify the Clinic when specimens are not acceptable.~~
~~a. The clinician will notify the physician for further orders~~

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: **NEW** **SUBJECT:** **After Hours Tissue Receiving**

REVISION DATE(S):

Department Approval:	**03/20**
Operating Room Committee Approval:	**03/20**
Department of Anesthesiology Approval:	**n/a**
Department of Pathology Approval:	**04/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**05/20**
Administration Approval:	**06/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **POLICY:**
1. Every attempt is made to receive tissue during normal business hours, however, in the event of an urgent/emergent need for tissue after hours, the following procedure shall be followed.
2. Only room temperature tissue will be accepted at the OR desk. All other (i.e., frozen) must be delivered to the Laboratory Tissue Bank.

B. **PROCEDURE:**
1. After hours ordering and delivery of room temperature tissue, grafts, valves and mesh:
   a. The surgeon shall alert OR staff of the need for a specific implant.
   b. Guidelines for OR staff ordering implants:
      i. The vendor will be verified as an approved tissue provider on the TIM application.
      ii. OR staff will document requested implant on OR Scheduling sheet, including requested implant name(s), size(s), and quantity.
      iii. OR staff will contact the company representative and provide the following information:
         1) Implant requested
         2) Surgery date and time
         3) Verification if requested implant contains human tissue
         4) If human tissue:
            a) Alert representative of need to use licensed courier to deliver tissue
            b) Alert representative to inform courier to provide copy of license to transport human tissue
   c. OR Staff responsibilities for receiving tissue:
      i. Verify tissue being delivered with the OR Scheduling Sheet.
      ii. Verify courier license is present and current if human tissue. Make a photocopy of the courier license and retain with tissue documents.
      iii. Verify packaging is not damaged.
      iv. Verify temperature is within range, if required.
      v. Stamp manufacturer packing slip with stamp provided.
      vi. Document condition of product being received.
      vii. Place packing slip with completed documentation in materials box at the OR desk.

I inspected the products listed above on receipt and determined for each that the product appearance was acceptable, the container was intact and the label was complete, affixed, and legible

Print Name

Signature Date

Is temp indicator within range? [ ]Yes [ ]No [ ]n/a
Ambient Room Temp (no indicator) [ ]Yes [ ]No

Courier Lic # _____

2. After hours delivery of room temperature tissue, grafts, valves, and mesh (i.e., tissue order has been placed by Materials Management):
   a. Scheduled after-hours delivery:
      i. Materials Management:
         1) A representative from Materials Management will verbally alert the OR Supervisor/designee of the scheduled date and time of delivery.
         2) Materials representative will provide the OR Supervisor/designee a copy of the printed Purchase Order (PO), including the following information:
            a) Manufacturer
            b) Manufacturer representative name and contact information
            c) Name and catalog number of product being delivered
            d) Amount of product being delivered
            e) Type of tissue: i.e., human tissue, bovine, porcine, synthetic
            f) Expected date and time of delivery
         3) If human tissue is being delivered, materials representative will alert courier service of need to provide a copy of human tissue courier service license upon delivery to the OR.
         4) Human tissue can only be transported via a licensed courier.
      ii. OR staff responsibilities for receiving tissue:
         1) Verification of tissue being delivered with PO issued by materials.
         2) Verification courier license is present and current if human tissue. Make a photocopy of the courier license and retain with tissue documents.
         3) Verification packaging is not damaged.
         4) Verification temperature is within range, if required.
         5) Stamp manufacturer packing slip with stamp provided.
         6) Documentation of condition of product being received.
         7) Place packing slip with completed documentation in materials box at the OR desk.

I inspected the products listed above on receipt and determined for each that the product appearance was acceptable, the container was intact and the label was complete, affixed, and legible

Print Name

Signature Date

Is temp indicator within range? [ ]Yes [ ]No [ ]n/a
Ambient Room Temp (no indicator) [ ]Yes [ ]No

Courier Lic # _____

      iii. OR staff documentation responsibilities:
         1) OR RN will document the implant in patient's electronic health record (EHR). Documentation shall include:
            a) Manufacturer
            b) Description of item implanted
            c) Catalog number

d) Lot and/or serial number
e) Expiration date
f) Type of solution/medication used to rinse/reconstitute
g) Lot number(s) of solution/medication used to rinse/reconstitute
h) Site implanted

2) Copy of implant box showing the item name, catalog number, lot/serial number and expiration date.
3) Place a patient label and implant stickers on Tissue Verification Form and submit the form to the collection box in the OR Bone/Tissue Pyxis.
4) Staple the tissue form and packing slip together and place at the OR desk for collection by the Materials Manager and documentation auditor.

iv. If not all received items are implanted, place the unused items in the OR Bone/Tissue Pyxis.
1) Alert Materials representative of unused items in Pyxis.

v. Materials Manager responsibilities after implantation:
1) Add implanted items into the Tissue and Implant Module (TIM) System.
2) Return unused items to the manufacturer per policy.

vi. TIM Administrative Manager/Surgical RN responsibilities after implantation:
1) Complete TIM documentation.

3. **QUALITY ASSURANCE:**

a. Staff shall submit a Tissue Verification Sheet for each case using tissue implants.
i. Tissue Verification Sheet shall include a patient label and stickers for all tissue implants used.
ii. Tissue Verification Sheets shall be submitted to the collection bin in the OR Tissue Pyxis.

b. A daily report is system generated from Pyxis with of all tissue issued from Tissue Pyxis. The report is reviewed routinely by the Surgery Tissue Administrator/designee, to verify tissue was removed under a patient name, cross-referenced with TIM system to ensure tissue documentation has been completed, and verifying accuracy of lot numbers and expiration dates.

c. Discrepancies are addressed with OR Material Specialist/designee and staff member as needed.

C. **REFERENCES:**

1. AABB. (2008). Hospital Tissue Management: A Practitioner's Handbook, First Edition.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: NEW

SUBJECT: Autologous Tissue Preservation & Storage

REVISION DATE(S):

Department Approval:	03/20
Operating Room Committee Approval:	03/20
Department of Anesthesiology Approval:	n/a
Department of Pathology Approval:	04/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	05/20
Administration Approval:	06/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **DEFINITIONS:**
1. Autologous tissue: Tissue removed from a patient and stored for future use for transplantation to the same patient.
2. Autotransplantation: Transplantation of tissue from one site to another in the same individual.

B. **POLICY:**
1. Tri-City Medical Center (TCMC) is not a tissue establishment. Autologous tissue collected at TCMC is sent to an off-site tissue storage vendor for storage. Autologous tissue is not stored at TCMC.
2. The patient's autologous tissue (such as cranial bone flap) may be preserved and replanted.
3. Autologous tissues must be preserved and prepared according to tissue storage vendor's specifications.
4. Tri-City Medical Center's autologous tissue storage vendor is California Transplant Services (CTS), Inc, 5845 Owens Avenue, Carlsbad, CA 92008.

C. **PROCEDURE:**
1. Procedure for tissue preservation:
   a. Open the numbered CTS Autologous Tissue Preservation Kit. Review and follow the Instructions for Storage of Autologous Tissue included with the kit. The kit consists of a shipping container with cardboard outer and contains a sterile surgical pack and media.
   b. Per physician order, collect swab cultures of collected tissue and enter Microbiology orders.
2. Use methods to reduce the risk of dropping or contaminating the cranial bone flap, including, but not limited to:
   a. Stabilize the bone flap during elevation, replantation, and drilling processes.
   b. Hold a sterile container below the bone flap elevation and insertion sites.
   c. Designate an area on the sterile field for holding the bone flap steady while drilling.
   d. Transfer the bone flap in a container when moving it from the surgical incision site to the instrument table.
3. Follow surgeon's orders for decontaminating contaminated cranial bone flaps for replantation.
   a. Methods for decontaminating contaminated bone flaps may include:
      i. Mechanical rinse with normal saline solution.

ii. Soaking in normal saline solution for five (5) minutes followed by a one (1) minute mechanical scrub with the bristles of a scrub brush and normal saline solution.
iii. Pulsatile lavage at low-pressure settings (e.g., 6-14 PSI) with normal saline solution.
iv. Processing at a tissue bank.

b. Do not use hydrogen peroxide, chlorhexidine gluconate, or ethanol to decontaminate bone flaps.
c. When decontaminating a cranial bone flap:
i. Use a separate field for decontamination of the flap.
ii. Use interventions to prevent contamination of the sterile field during decontamination (i.e., cover the main sterile field and cover the active hand piece of the pulsatile lavage).
iii. Change gown and gloves after decontamination is complete.
iv. Change the wound classification for the procedure to Class III, Contaminated.
d. Cranial bone flaps may not be sterilized.

4. Reduce the risk of contamination and cross contamination throughout the steps of tissue handling:
a. Transfer autologous tissue intended for preservation off the sterile field as soon as possible.
b. Verify the patient and tissue information verbally with the surgeon using a read-back technique before transferring the tissue from the sterile field.
c. Use standard precautions and sterile technique while transferring autologous tissue from the sterile field.
d. Take measures to prevent contamination of autologous tissue that is on the sterile field including, but not limited to, minimizing handling of the tissue.
5. Keep autologous tissue moist or in solution while it is on the sterile field. Do not place tissue on dry, absorbent surfaces or materials.
6. Clearly label, sequester, and monitor autologous tissue that is kept on the sterile field.

D. **DOCUMENTATION:**
1. Complete the "Autograft Tissue Preservation Service" form (CTS Form 40-2000-1) according to instructions on the form, by completing all known information, or enter the word "no" for unknown items. Information on the form is subject to change per CTS.
a. Name of Patient (required): Enter the patient's name or Trauma name and trauma number.
b. Patient's Medical Record Number (required): Enter the medical record or hospital number.
c. PO#: Obtain and enter the purchase order number, if available.
d. Patient's Sex (required): Check Male (M) or Female (F) for the patient's true biological sex, as applicable.
e. Patient's Age (required): State the patient's age, if known.
f. Date of Birth (DOB): Enter the DOB as MM/DD/YY, if known.
g. Patient's home address or mailing address. This is for purposes of notification and assuring the patient can be notified of the existence and location of the autograft being stored.
h. Name of Hospital (required): Enter the complete name of the hospital. There are many UMC's and Community Hospitals, so we need to know the exact name of the correct facility.
i. Hospital address (required): Provide the street address, city, state, and zip code.
j. Date and Time of Autograft Recovery (required): Enter the date and time the tissue was removed from the patient. This question does not pertain to the start of the surgery.
k. Date and Time placed in Shipper (required): Enter the date and time the tissue was placed in the shipper with wet ice.
l. Informed consent signed? Check Yes (Y) or No (N), or Not Applicable (N/A) as applicable. Include a copy of the operative consent form if obtained.

m. Check Type of Tissue (required). ☐ Skull Flap ☐ Bone ☐ Skin, or ☐ Other (please specify): State the kind of bone or soft tissue recovered, e.g. vertebral body or parathyroid.

n. Antibiotic (required): Answer the question ☐ Y, or ☐ N. If an antibiotic has been administered to the solution used to cover the graft state the kind of antibiotic and dosage in mass/volume.

2. If possible, obtain a PO number for the Tissue Preservation Service and record it on the Autograft Tissue Preservation Form.
3. Obtain the surgeon's signature on the Autograft Tissue Preservation Form.
4. Immediately call California Transplant Services, Inc. for pick-up of the tissue. Toll-free telephone number: (800) 928-4778.
5. Place a copy of the Autograft Tissue Preservation Service Form in the patient's chart.
   a. Place a TIM barcode label in the lower left corner of the form.
   b. Place a patient label in the lower right corner of the form.
6. Make an additional copy of the completed Autograft Tissue Preservation Service Form and submit to the Surgery Materials Manager/Tissue Administrator.
7. Document the autologous tissue explant in the patient's electronic health record (EHR).

E. **FORMS & RELATED DOCUMENTS:**

1. California Transplant Services (CTS), Inc. Autograft Tissue Preservation Service form (CTS Form 40-2000-1).

F. **REFERENCES:**

1. AORN, Inc. (2020). *Guidelines for Perioperative Practice*. Denver.
2. AABB. (2008). Hospital Tissue Management: A Practitioner's Handbook, First Edition.
3. California Transplant Autograft Tissue Preservation Service Instruction Sheet.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 01/05 **SUBJECT:** Freeze-Dried Room Temperature Tissue

REVISION DATE(S): 12/05; 04/09; 05/06; 08/09; ~~11/12~~01/13

Department Approval:	02/20
Operating Room Committee Approval:	03/20
Department of Anesthesiology Approval:	n/a
Department of Pathology Approval:	05/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	05/20
Administration Approval:	06/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/13

A. **PURPOSE:**

1. To describe the process for the Department of Surgery to order, receive, store, and issue freeze-dried tissue as a satellite location of the Tri-City Medical Center Clinical Laboratory Tissue Bank.

B. **POLICY:**

1. **Routine shipments of room temperature tissue, grafts, valves and mesh shall be received and tracked through the Carefusion Tissue and Implant Module (TIM) System according to Surgery Policy "Freeze-Dried Room Temperature Tissue".**
2. **Tri-City Medical Center is not a source facility. No freeze-dried tissue will be issued outside the hospital, including to surgery centers.**

~~B.~~C. **ORDERING FREEZE-DRIED TISSUE:**

1. Surgical Services will complete a Non-Stock Supply Purchase Requisition for all tissue orders. If the tissue is ordered for a specific patient, the requisition must have the patient's name, the physician's name and the date and time of surgery. The completed requisitions are then sent to the Materials Department. All special orders should be placed 48 hours before the scheduled surgery to assure delivery.
2. Tissues must only be ordered from Tissue Banks or Tissue Distribution Centers licensed by the State of California Department of Health Services and registered by the FDA. TCMC Tissue Bank maintains a list of approved vendors.

~~C.~~D. **RECEIVING FREEZE-DRIED TISSUE:**

1. Upon ~~entry~~**arrival** to the hospital, freeze-dried room temperature tissue will ~~then be delivered to OR Materials Manager/designee~~**be received at the receiving dock.**
2. The person receiving the tissue **at the receiving dock** is responsible for the following:
   - a. Verify the shipping container is labeled with the names and addresses of the distributor, TCMC, and any special warnings and/or storage requirements.
   - b. **Scan the shipping tracking label into the TIM system and place the package onto the TIM workstation in the receiving area.**
     - ~~a.~~i. **An email is system generated to a Tissue Receiving Distribution list alerting to the tissue arrival time.**
   - ~~b. Verify that the distributor is licensed with the State of California and registered by FDA.~~
3. **The OR Material Specialist/designee is responsible for the following:**

~~c.~~**a.** Verify the packing list has the name and address of the tissue supplier, shows TCMC as the recipient and has a PO number.

~~d.~~**b.** Compare the packing list to the tissue package to verify identification numbers, expiration dates and storage temperature requirements.

~~e.~~**c.** Inspect the outside of the tissue package for signs of contamination of the tissue, such as a tear in the package, breakage or discoloration of the tissue.

i. The package must not be damaged or altered.
ii. Damaged tissue must not be used.
iii. Return damaged tissue to the supplier.

d. The ~~OR Materials Manager/designee~~**OR Material Specialist/designee** verifies package integrity was met. ~~then stamps the package list with the stamp that states, "I inspected the products listed above or receipt and determined that the product appearance was acceptable, the container was intact and label was complete, affixed and legible.".~~

i. Verification of package integrity is documented in the TIM system.
ii. The packing slip is sent to the receiving department in Materials Management.

~~f. The Materials Manager/designee signs and dates the stamped imprint.~~

~~g. For downtime of Pyxis, complete a Tissue Tracking Card.~~

e. The tissue is documented into the TIM system, verifying the following information, as applicable:

i. Catalog number
ii. Serial/Lot number
iii. Expiration date

f. A TIM system IMP label (with a unique identifying number) is generated and attached to each individual tissue package.

g. Tissue is stocked into the OR Bone Bank Pyxis (i.e., Tissue Pyxis) at room temperature.

h. During TIM and/or Pyxis downtime, all packing slips and packaging materials are retained, to be entered into the TIM/Pyxis system at a later date.

E. STORAGE OF FREEZE-DRIED TISSUE:

~~3.~~**1.** The temperature **of the Tissue Pyxis** must be monitored.

a. Manual temperature readings are ~~to be~~ recorded daily onto the Daily Temperature Log, located on the ~~clipboard, by the Bone~~**Tissue** Pyxis.

b. If the temperature is out of acceptable range (19-25˚C), document date, problem, action taken, and resolution on the Daily Temperature Log.

~~b.~~**c.** Notify the Clinical Laboratory Tissue Bank, **Materials Management, and Surgical Services Director/Assistant Director/designee** immediately if the thermometer readings are outside of the 19-25˚C temperature range.

~~c. Date, initial and indicate the readings are acceptable or that the Clinical Laboratory Tissue Bank was notified.~~

d. Arrange immediately to move freeze-dried **tissue, as directed,** to an area of acceptable temperature if out of range.

~~4.~~**2.** The Daily Temperature Log is ~~to be~~ reviewed ~~by the night charge person then dated, signed, and sent to the Clinical Laboratory Tissue Bank at the end of each month~~**monthly by a member of the Surgical Services leadership team.**~~.~~

3. No tissue will be stored past the tissue expiration date as stated on the tissue package.

a. A monthly Tissue Expiration Batch Report is system generated monthly and reviewed by the OR Material Specialist/designee.

~~5.~~**b. Tissue approaching expiration date is removed from Pyxis inventory and documented in TIM system as discarded. Tissue is discarded in biohazardous waste.**

~~a. If a tissue has expired, send the tissue and the completed Tissue Tracking Card to the Clinical Laboratory Tissue Bank.~~

~~6.~~4. **Tri-City Medical Center is not a source facility. No freeze-dried tissue will be issued outside the hospital.**

~~D.~~F. **OBTAINING AND IMPLANTING FREEZE-DRIED TISSUE:**

1. The OR ~~Circulating~~ **Registered** Nurse **(RN)/designee** will ~~enter~~**log into** the **Tissue** Pyxis, **and** ~~and choose the correct~~ **select the appropriate** patient.~~name.~~
   ~~1.~~**a.** ~~i~~If the patient is not on the list, ~~add the correct patient.~~**contact the OR Material Specialist/designee to add the patient.**
2. The OR ~~Circulating Nurse~~**RN/designee** will remove the **selected** tissue from the Pyxis and inspect the ~~tissue~~ package for **integrity and** visible signs of contamination. ~~The documentation accompanying the tissue must be reviewed for the results of non-reactive serologic testing for the appropriate infectious diseases.~~
3. The ~~Circulating Nurse~~**OR RN/designee** will select the appropriate tissue and press the "take" button.
   a. Scan the TIM label on each package removed after pressing "take".
   b. If the scanner is unavailable or not functioning, manually enter the IMP number into the Pyxis.
4. **All tissue will be transported, handled, prepared, stored and used according to the source facilities or manufacturer's instructions for use (IFU).**
   ~~3.~~**a. Documentation shall include preparation methods, per manufacturer's IFU, including lot numbers, serial numbers, and expiration dates of solutions/medications used to prepare the tissue, as applicable.**
5. **The documentation accompanying the tissue must be reviewed for the results of non-reactive serologic testing for the appropriate infectious diseases.**
4.~~6.~~ **If applicable,** ~~T~~the Circulating Nurse will verify that a package insert containing a statement indicating the donor has been screened and found non-reactive by laboratory tests for evidence of infection with HIV (HIV 1 and HIV 2), agents of viral hepatitis (HBV and HCV), human T lymphotrophic virus-1 (HTLV-1) and syphilis is with the tissue. If no insert is found, call the facility and ask if the appropriate testing has been performed and has non-reactive results. ~~THE~~**he** package insert must also contain instructions for proper handling, storage, transport and use/reconstituting of the tissue. If no insert is found, call the supplier and ask them to fax the required testing results and instructions STAT.
   a. Tissues received without required negative testing results or with reactive test results, will not be used for implantation at TCMC.
   b. When the fax is received attach it to the product.
   c. If the supplier cannot fax the required documentation, the tissue must be returned to the supplier.
~~5. The Circulating Nurse will remove the tissue from the Pyxis and enter the lot number and/or serial number into the Pyxis. All tissue will be transported, handled, stored and used according to the source facilities or manufacturers written directions.~~
7. After implantation of tissue into the patient, the Circulating ~~Nurse~~ **RN** completes the ~~OR Documentation under the Implant Record Section~~**documentation in the Carefusion TIM application**.
   ~~6.~~**a. In the event of TIM application downtime, document the tissue implant in the implant section of the patient's electronic health record.**
   ~~a.~~**b.** The Circulating ~~Nurse~~ **RN** will complete the tissue tracking form from the ~~Company Tissue Bank~~**manufacturer, if applicable,** and return the paper-work to the OR ~~Inventory Supervisor~~**Material Specialist/designee** at the end of the case.
   ~~b. A weekly report is generated of all tissue implanting and the lot and serial number tracking.~~
8. **The OR RN shall complete a Surgery Tissue Implant Verification Form (located in Tissue Pyxis) with a patient label and labels from each implanted tissue. Return completed Tissue Implant Verification Forms to the Tissue Pyxis.**
9. If the freeze-dried ~~bone~~ **tissue** is opened but not used, the ~~Circulating~~ **OR RN** ~~Nurse~~ will complete **TIM documentation, noting the tissue was discarded, and complete** a Tissue

Tracking Card. ~~-and d~~**D**ispose of the tissue in the biohazard**ous waste container.**~~-sharps container in the "dirty utility" room at the end of the case.~~

~~7.~~**a. Notify the Surgery Biller/designee the tissue was opened but not used.**

~~E.~~**G. RETURNED FREEZE-DRIED TISSUE:**

1. Freeze-dried room temperature stored tissue may be returned to the Pyxis for reissue if the tissue is in its original unopened, sterile container and the storage temperature requirements of the tissue have been maintained.
2. Inspect the tissue package to ensure that it is still sealed ~~and sterile~~ and all documentation issued with the tissue has also been returned.
3. The Circulating Nurse will log into the **Tissue** Pyxis and select the correct patient, **push the appropriate "return" button and scan the IMP label on the tissue package.** ~~r~~Return the tissue to the appropriate bin~~, and push the "return" button~~ and close the door of the Pyxis. Repeat this process for each tissue returned and exit from the Pyxis.
4. ~~If the tissue package has been opened, appears to have been contaminated, or if the storage temperature has not been maintained, the Circulating Nurse will complete a Tissue Tracking Card and return the card with the tissue to the OR Inventory Supervisor and/or designee.~~
5. ~~Wasted tissue is disposed in the Biohazard Sharps containers in the Dirty Utility Room.~~

H. QUALITY ASSURANCE:

1. **Staff shall submit a Tissue Verification Sheet for each case using tissue implants.**
   a. **Tissue Verification Sheet shall include a patient label and stickers for all tissue implants used.**
   b. **Tissue Verification Sheets shall be submitted to the collection bin in the OR Tissue Pyxis.**
2. ~~OR Inventory Supervisor and/~~**A daily report is system generated from Pyxis** ~~or Designee will run a daily report to~~**with** ~~track~~ **of** all tissue **issued from Tissue Pyxis. The report is reviewed routinely by the Surgery Tissue Administrator/designee, to verify tissue was removed under a patient name, cross-referenced with TIM system to ensure tissue documentation has been completed, and verifying accuracy of lot numbers and expiration dates.**~~implanted and verify tracking card was received.~~
3. **Discrepancies are addressed with OR Material Specialist/designee and staff member as needed.**

~~6.~~

~~F.~~**I. REPORTING OF ADVERSE REACTION TO FREEZE-DRIED TISSUE:**

1. All adverse outcomes of tissue implantation must be reported to the Clinical Laboratory Tissue Bank **and Risk Management**. These adverse outcomes may include, but are not limited to:
   a. Infections
   b. Tissue failures
   c. ~~Other complaints by the operating room staff or the surgeon~~**Other quality issues.**
2. The following information must be acquired from the person reporting the adverse outcome and sent to the Clinical Laboratory Tissue Bank within 24 hours of notification on a ~~Q~~quality ~~R~~review ~~R~~report ~~(QRR)~~**via the RL system**. The Clinical Laboratory **Tissue Bank/designee** will **promptly** report **the following to** the source facility**, as applicable**:
   a. Patient name
   b. Patient Medical Record Number (MRN)
   c. Implanting physician's name
   d. Type of tissue implanted
   e. Date of the implant
   f. Date the adverse outcome is being reported
   g. Patient symptoms
   h. Name of the person reporting the adverse reaction
   i. Name of the person obtaining the information
   j. Date the report was obtained

~~3. Clinical Lab Tissue Bank promptly reports post transplant infections or adverse events to the Source Facility.~~

~~G.~~J. **RECALL OF FREEZE-DRIED TISSUE:**

1. The tissue supplier will notify TCMC when a tissue has been recalled.
2. If the tissue has not been issued, send the tissue to the ~~Clinical Laboratory Tissue Bank~~**OR Material Specialist/designee** for quarantine immediately.
3. If the tissue has been issued, obtain the following information and send to ~~the Clinical Laboratory Tissue Bank~~**Risk Management** within 24 hours of notification and complete a ~~Q~~quality ~~R~~review ~~R~~report **via the RL system**.
   a. Patient name
   b. Patient Medical Record Number (MRN)
   c. Implanting physician's name
   d. Type of tissue implanted
   e. Date of the implant
   f. Date the recall was received
   g. Reason for the recall
   h. Patient symptoms, if any
   i. Name of the company issuing the recall
   j. Name of the person obtaining the information

~~4. Recipients of tissue from donors who are subsequently found to have infectious agents known to be transmissible by tissue are identified and informed of infection risk by the Clinical Laboratory Tissue Bank. Refer to the Clinical Laboratory Tissue Bank Procedure Manual Policy "Recall of Tissue".~~

~~H. RECORD KEEPING:~~

~~1. The hospital's records, including storage temperature logs, are retained for a minimum of ten (10) years.~~

~~2. The hospital's records/patient records document the source facility. The original numeric or alpha numeric donor and lot identification, all recipients or other final disposition of each tissue and applicable expiration dates and are retained for a minimum of ten (10) years beyond the date of distribution, transplantation, disposition or expiration of tissue (whichever is latest).~~

~~I.~~K. **RECORDS:**

1. TCMC records permit tracing of any tissue from the supplier to the recipient or to final disposition or discard.
2. All records are maintained ~~on line~~**electronically or hard copy** ~~or in storage~~ **(in storage)** for at least 10 years from the date of implantation or date of tissue expiration/disposition as applicable.

~~J.~~L. **REFERENCES:**

1. **AABB. (2008). Hospital Tissue Management: A Practitioner's Handbook, First Edition.**
~~1. California Health and Safety Code section 1635.~~
~~2. Standards for Tissue Banking, "American Association of Tissue Banks, 2002"~~
~~3. Comprehensive Accreditation Manual for Hospitals: The Official Handbook, Joint Commission on the Accreditation of Health Care Organizations.~~

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 10/11

SUBJECT: Scope of Service for Surgical Services

REVISION DATE(S): 12/11; 10/12; 5/15; ~~02/20~~

Department Approval:	~~10/16~~03/20
Department of Anesthesiology Approval:	n/a
Operating Room Committee Approval:	~~10/16~~04/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~01/17~~05/20
Administration Approval:	06/20
Professional Affairs Committee Approval:	~~02/17~~ n/a
Board of Directors Approval:	02/17

A. **PURPOSE:**

1. To describe the Scope of Service for the department of Surgical Services at Tri-City Medical Center, including Pre-~~e~~Operative Education **(POE)**, Pre-~~e~~Operative Hold (POH)~~,~~**, Post Anesthesia Care Unit (PACU),** Surgery, ~~and~~ Endoscopy**, and the Sterile Processing Department (SPD)**.

B. **POLICY:**

1. Goals
   a. To improve the general health and well-being of patients who require surgical care.
   b. To improve patients' health knowledge related to pre-operative preparation, the scheduled surgical procedure, and post-operative plan for patients requiring surgical care.
   c. To reduce and manage complications and unexpected outcomes.
   d. To continuously evaluate and improve the services provided.
2. Description of Service & Assessing Department Services
   a. The department of surgical services provides diagnostic, therapeutic and operative interventions for patients requiring a variety of surgical procedures 24 hours a day, 7 days a week.
   b. Assessment activities include pre-operative, intra-operative and post-operative patient care for persons requiring elective, urgent or emergent surgery.
   c. The Pre-~~e~~Operative Education department provides instructions to patients electively scheduled for procedures regarding preparation for surgery, surgical procedures and post-operative care.
      i. **POE**~~,~~ facilitates ordered laboratory and diagnostic procedures as part of the pre-operative patient preparation, and gathers patient health history information. ~~Pre-operative Education~~
      ~~c.~~**ii.** **POE** appointments are conducted in-person or via telephone, Monday-Friday 8:00am-5:00pm.
   d. The Pre-~~e~~Operative Hold department is responsible for assessing patients prior to surgery and carrying out pre-operative orders. POH is staffed with RN's Monday-Friday 5:30am-~~5~~**6:30 pm**. After hours, the surgical RN is responsible for assessing patients pre-operatively and completing pre-operative orders.

e. The PACU provides nursing care to patients requiring post anesthesia recovery from a variety of surgical, endoscopic, cardiac and interventional radiology procedures 24 hours a day, 7 days a week

~~d.~~**f. SPD provides 24/7 support to Surgery by providing sterile instruments, supplies and equipment necessary to complete surgical procedures.**

3. Methods Used To Assess Patient Needs
   a. Patient health history and educational needs related to the surgical procedure and post-operative care are assessed by a Pre-~~o~~**O**perative Education Registered Nurse (RN) during the Pre-~~o~~**O**perative Education appointment (as applicable).
   b. Pre-Operative patient assessment and care is performed by a Pre-Operative Hold (POH) Registered Nurse (RN).
   ~~a.~~**c. Post anesthesia patient assessment and care is performed by a PACU RN.**
   ~~b.~~**d.** Patients are assessed and prepared for surgery by a perioperative RN on the day of surgery.
   ~~c.~~**e.** Patient**s area assessed** ~~assessment is performed~~ by a surgical Registered Nurse (RN) and anesthesia care provider (if applicable) prior to ~~going~~ **transfer** to ~~surgery/Endoscopy suite~~**the Operating Room (OR) or Endoscopy procedure room.**
   ~~d.~~**f.** Ongoing patient assessment and care is performed by the circulating RN and anesthesia care provider in the ~~surgical suite~~ **OR** throughout the procedure. RN's may monitor patients and administer moderate sedation for appropriate procedures (including Endoscopy procedures), **per Patient Care Services Policy: Sedation/Analgesia Used During ~~Theraputic~~Therapeutic or Diagnostic Procedures.**
4. Scope of Services
   a. Service specialties include orthopedic, thoracic, vascular, neurosurgical, urologic, gynecological, anesthesia, plastics, otolaryngolic, ophthalmologic, oral surgery, endoscopic, cardiac, robotic and general surgery.
   b. There are 12 rooms in the OR suite, including 10 operating rooms (1-10) that can accommodate any type of case, a cystoscopy suite (OR #11) and an Endoscopy suite (OR #12).
   c. Patients are discharged from the Operating Room by the surgeon and/or anesthesiologist upon completion of the surgical procedure, and admitted to the appropriate postoperative level of care.
   d. The POE department services electively scheduled outpatients and AM admissions for all surgical specialties.
   e. The ~~Pre-oOperative Hold~~**POH** department ~~, located in the surgical pavilion,~~ contains patient ~~8~~**16** bays~~, with additional access to two private cubicles located in the Post-Anesthesia Care Unit (PACU)~~. —A Pre-**O**~~o~~perative Hold **and Phase II** area with six **(6)** bays is available for elective admission of Progressive Care Unit patients **and Phase II recovery**. POH services inpatients, outpatients and AM admissions for all surgical specialties and Endoscopy.
   f. PACU is a sixteen bay unit, including two cubicles enabled to act as isolation rooms.
      i. Recovery services are provided to both inpatients and outpatients requiring post anesthesia recovery from a variety of surgical, endoscopic, cardiac and interventional radiology procedures
   ~~d.~~**g. Patients are discharged from the PACU and/or Phase II when discharge criteria are met. Patients may be discharged home or to the next appropriate level of care, per physician order.**
   ~~e. The Pre-oOperative Education department services electively scheduled outpatients and AM admissions for all surgical specialties.~~
5. Staffing ~~and Availability of Staff~~

a. Sufficient staffing is maintained at all times in terms of number of personnel, skill mix, and competency to meet the needs of the patients in the OR. ~~Standby~~**On call** and call-back will be utilized to additionally staff those shifts that have minimal staffing in-house.
b. Each patient is assigned at least two surgical team members, one of which is the RN circulator.
c. The ~~Assistant Nurse Manager (ANM) or charge nurse~~ **Surgery Supervisor/designee** will make staff assignments according to individual staff competencies and patient needs.
d. **Complex P**procedures requiring additional resources~~, due to severity of illness of the patient or complexity of the procedure,~~ shall be staffed with additional personnel as appropriate.
e. For complete staffing and on-call guidelines see Surgical Services ~~Policies Staffing~~**Policies Staffing**~~, Admission~~**, Admission**/Discharge Criteria ~~and On~~**and On**-call.
~~f. Pre-o~~**O**~~perative Education~~**POE** appointments are conducted by RN's. Appointments are scheduled in advance by the surgery schedulers.
f. ~~Pre-o~~**O**~~perative Hold departments are staffed with RN's during normal business hours. After hours, the surgical RN conducts the pre-operative patient assessment and preparation.~~
g. Staffing for Pre-Operative Hold and the Post Anesthesia Care Unit is maintained in compliance with current American Society of Perianesthesia Nurses (ASPAN) Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements. On-call staff is available to cover the night shift and weekend
~~g.~~**h. After hours, the surgical RN conducts the pre-operative patient assessment and preparation.**

6. Patient Population
   a. ~~Adolescent, a~~**A**dult~~,~~ and geriatric patients requiring surgical management.~~ Patients between the ages of 14-18 must meet defined criteria set forth in Surgical Services Policy Scheduling Surgical Procedures.~~
7. Extent to Which The Department's Level of Care/Service Meet Patient Needs
   a. The services provided by surgical services meet the needs of both inpatients and outpatients through availability of staff who are competent to provide service for the current patient population.
8. Performance Improvement (PI)
   a. In order to improve patient care, several indicators are monitored and reported to the OR Committee, Infection Control Committee, Quality Committee or other committees as requested.
   b. PI data is posted in the department.
9. Standards of Practice
   a. Surgical Services follows practice recommendations as outlined in the Association of Peri~~o~~**O**perative Registered Nurses (AORN) Guidelines for Perioperative Practice
   ~~a.~~**b. POE, POH and PACU follows standards and practice recommendations as outlined in the American Society of PeriAnesthesia Nurses (ASPAN) Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements.**
   ~~b.~~**c.** The nursing service abides by regulations of California Title XXII, Joint Commission guidelines, CMS and the Board of Registered Nursing.
   ~~c.~~**d.** See Surgical Services Policy Perioperative Standards of Practice~~.~~
10. Medication Administration Standards Related to Care of The Patient
    a. Medications~~, general and narcotics,~~ are dispensed via the Pyxis **Medstation** system. Emergency cardiac medications **requiring refrigeration** are stored in Cardiac OR ~~Suites in~~ locked ~~cabinets and~~ refrigerator. ~~Medications requiring refrigeration are stored~~

~~at the appropriate temperature~~**The refrigerator temperature is monitored by Pharmacy.**

b. Anesthesia Pyxis ~~machines~~ **Medstations** are maintained in ~~each~~ OR**'s 1-11** ~~suite~~.

c. Preoperative antibiotics and medications dispensed to and/or administered on the surgical field during the surgical procedure are documented in the surgical nursing record.

d. Anesthesiologists are responsible for documenting all medications they administer on the Anesthesia record.

e. Medications administered in POH **and PACU** are documented in the electronic Medication Administration Record (eMAR) **in the electronic health record (EHR).**

~~e.~~**f.** **Medications in PACU shall be kept in wall-mounted lock boxes within each individual patient bay. Medications will be properly labeled and discarded/wasted before the patient is transferred/discharged from PACU. Medications shall not be left unattended outside a lock box.**

~~f.~~**g.** See Surgical Services Policy Medications in Surgery.

~~C. RELATED DOCUMENTS:~~

~~1. Surgical Services Policy: Admission/Discharge Criteria~~
~~2. Surgical Services Policy: On-call~~
~~3. Surgical Services Policy: Scheduling Surgical Procedures~~
~~4. Surgical Services Policy: Staffing~~

Tri-City Health Care District
Oceanside, California

~~CENTER FOR~~ WOUND CARE CENTER~~&~~
HYPERBARIC CLINIC~~MEDICINE~~
~~POLICY MANUAL~~

ISSUE DATE: 06/07 **SUBJECT: HBOT Consultation**

REVISION DATE(S):

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**05/20**
Administration Approval:	**06/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE**

1. The purpose of this document is to define the procedure for evaluating patients for hyperbaric oxygen treatment.

B. **POLICY**

1. Patients referred for hyperbaric oxygen therapy (HBOT) will be evaluated for appropriateness for treatment by a qualified HBOT physician prior to treatment.
2. Patients evaluated for treatment will be screened for contraindications.
3. Patients approved for treatment will sign informed consent prior to the first treatment.

C. **PROCEDURE**

1. Only physicians trained in hyperbaric medicine will supervise/evaluate patients for HBOT. The evaluation will include:
   a. Evaluation for indication
   b. History and physical
   c. Screening for contraindications
   d. Lab testing
   e. Radiology test(s)
   f. $TcPO_2$
2. The HBOT staff will:
   a. Set up patient appointments
   b. Ensure that all proper documents are available and completed by the HBOT physician
   c. Be responsible for obtaining test results for HBOT physician's review
   d. Orient patients approved for treatment
   e. Ensure that the patient or patient's legal representative has given signed consent prior to treatment and that the signed consent is to be had in the medical record.

Community Healthcare & Alliance Committee (No meeting held in June, 2020)

Finance, Operations & Planning Committee (No meeting held in June, 2020)

Audit, Compliance & Ethics Committee
(No meeting held in June, 2020)

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

May 28, 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 May 28, 2020.

The following Directors constituting a quorum of the Board of Directors were present via teleconference:

Director Rocky J. Chavez
Director George W. Coulter
Director Leigh Anne Grass
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock
Director Tracy M. Younger

Also present were:

Steven Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Barbara Vogelsang, Chief Nurse Executive
Dr. Gene Ma, Chief Medical Officer
Susan Bond, General Counsel
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 4:05 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 Schallock seconded the motion. The motion passed unanimously (7-0) via roll call vote.

3. Pledge of Allegiance

   Director Younger led the Pledge of Allegiance.

4. Public Comments – Announcement

   Chairperson Grass read the Public Comments section listed on the May 28, 2020 Regular Board of Directors Meeting Agenda.

The following individuals requested the right to speak on Item 6a) - 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.

- Pamai Fita
- Kim Leonard
- Stacy Ericson
- Charles Harris
- Leticia Carrion
- Karen Scriven
- Rob Jerskey
- Jeanette Wright
- Kory Langwell
- Lennie Pisco-Garcia
- Mali Woods Drake
- Dr. Cary Mells
- Dr. Gene Ma
- Anna Aguilar
- Scott Livingstone

The following individuals requested the right to speak under Item 10, Comments from Members of the Public:

- Camille Bryan
- Marisa Langstom
- Laketa Ducat

5. April, 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 - $19,326
- Operating Expense - $25,080
- EBITDA – $3,159
- EROE – $1,921

Mr. Rivas noted the EBITDA profit was due to the $7 million one-time Cares Act grant. Without the grant there would have been a $5 million loss.

Mr. Rivas reported on current month Key Indicators as follows:

- Average Daily Census – 124
- Adjusted Patient Days – 6,296
- Surgery Cases - 294
- ED Visits – 2,877

Director Nygaard requested an explanation from Mr. Rivas related to the impact on the financials due to the cancellation of elective surgeries. Mr. Rivas stated surgeries dropped to 300 compared to a budget of 536 which made a significant impact. He noted there has been an "uptick" in our elective services, however patients are not visiting their physicians so it is difficult to predict how long the uptick will last.

Mr. Dietlin further explained that surgeries that are being performed presently are "time essential" where a patient's condition could be digressing. Surgeries were down 50% in March and 45% in April. In addition, ED visits were down 40% and people were not going to see their primary care physicians and there is the potential downstream effect of that. From a net revenue perspective, net revenue is down 36% from budget in April. Mr. Dietlin stated it has been widely reported that April 2020 is the worst month on record for United States healthcare systems. He commented on the need to mitigate costs as much as possible in order to preserve liquidity. Without the impact of the Cares Act of $7 million (which is a one-time grant) Tri-city would have seen a negative $5 million.

Chairperson Grass questioned if we should anticipate a $5 million loss in May. Mr. Rivas stated we do expect a significant loss in May and a combined loss of almost $9.5 to $10 million.

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. She expressed her appreciation to SEIU for their continued efforts to support Tri-City Medical Center, our employees, our community and our mission.

Chairperson Grass stated the Board was graciously approached by Service Employees International Union (SEIU) approximately six (6) weeks ago regarding their interest in helping the District pass a Bond Measure Proposition.

Chairperson Grass explained the proposition would request between $450 and $550 million in general obligation bonds for campus development, construction and upgrades to make our facilities seismically compliant, add new services to meet the needs of our community and to complete the new acute care tower. She emphasized that general obligations bonds require the approval of two-thirds of the voters in an election.

Chairperson Grass presented the arguments in favor of and against supporting a Bond Measure.

It was moved by Director Reno to support a General Obligation Bond Measure for improvements or a new hospital for Tri-City Medical Center and place the Bond Measure on the ballot for the November 3, 2020 General Election.

Chairperson Grass recognized Pamai Fita, Kim Leonard, Stacy Ericson, Charles Harris, Leticia Carrion, Karen Scriven, Jeanette Wright, Kory Langwell, Lennie Pisco-Garcia, Mali Woods Drake, Dr. Cary Mells, Dr. Gene Ma, Scott Livingston and Ray Rivas who all spoke in favor of supporting a Bond Measure.

Mr. Steve Dietlin, CEO stated he appreciates the speakers and their passion as well as the support and partnership of everyone. Mr. Dietlin stated a successful bond measure would provide capital not only for seismic compliance but additional and enhanced services for our community.

All Directors provided comments on their support or opposition to the proposed Bond Measure.

Ms. Mali Woods-Drake stated the goal is to work hand-in hand with the union and she is here today to ask the Board for their unanimous support.

There was not a second to Director Reno's initial motion.

It was moved by Director Younger that the TCHD Board of Directors agree to support a Bond proposition and move forward with language and a plan provided the SEIU polling shows there is enough community support seen through these polls. Director Reno seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Grass, Reno and Younger**
NOES:	**Directors:**	**Chavez, Nygaard and Schallock**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Coulter**

The motion failed.

b) Consideration for the Board of Directors of Tri-City Healthcare District to suspend their stipend payments for all meetings during this healthcare crisis.

It was moved by Director Schallock to suspend Board member stipend payments for all meetings during this healthcare crisis effective May 28, 2020. Director Nygaard seconded the motion.

Director Chavez amended the motion to suspend Board member stipend payments until the State of California reaches Stage 4 as determined by the County and the Governor. Director Nygaard accepted the amendment to the motion.

Director Reno stated she was not in favor of the mandatory suspension and believes Directors should have the ability to make the decision to suspend their stipends on an individual basis.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Grass, Nygaard and Schallock**
NOES:	**Directors:**	**Coulter, Reno and Younger**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

The motion passed.

Director Coulter rejoined the meeting stating he had technical difficulties and requested the opportunity to vote on the Bond Measure Ballot. Mr. Jeff Scott, Board Counsel recommended that the Chairperson in fairness to Director Coulter allow a revote on the ballot measure.

Chairperson Grass restated the motion:

It was moved by Director Younger that the TCHD Board of Directors agree to support a Bond proposition and move forward with language and a plan provided the SEIU polling shows there is enough community support seen through these polls. Director Reno seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Coulter, Grass, Reno and Younger, Nygaard**
NOES:	**Directors:**	**Chavez, Nygaard and Schallock**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

The motion now has passed.

7. Old Business – None

8. Chief of Staff

a) Consideration of May 2020 Credentialing Actions and Reappointments Involving the Medical Staff and as recommended by the Medical Executive Committee on May 26, 2020.

Dr. Yamanaka presented the May Credentialing Actions Involving the Medical Staff and as well as the Critical Care Privilege Card.

There were no questions or comments by Board members.

It was moved by Director Reno to approve the May 2020 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee. Director Schallock seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

c) Consideration of Privilege Forms:

1) Critical Care Privilege Card

It was moved by Director Schallock to approve the Critical Care Privilege Card as presented and recommended by the Medical Executive Committee. Director Reno seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**

ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

9. Consideration of Consent Calendar

It was moved by Director Reno to approve the Consent Agenda. Director Schallock seconded the motion.

It was moved by Director Reno to pull the minutes of the May 28, 2020 Regular Board Meeting. Director Schallock seconded the motion.

The vote on the main motion minus the pulled item was as follows via a roll call vote:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

10. Discussion of items pulled from Consent Calendar

Director Reno who pulled the May 28, 2020 Regular Board Meeting minutes stated she was having technical difficulties however it was her intent to vote "yes" on all items in which her vote is recorded as an "abstention". Board Counsel Jeff Scott, instructed the Board secretary to modify Director Reno's votes to "yes" with concurrence from the Board.

It was moved by Director Reno to approve the minutes of the May 28, 2020 Regular Board Meeting as amended. Director Coulter seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

10. Comments by Members of the Public

Chairperson Grass recognized Camille Bryan, RN, ICU, Marisa Langston, RN, ICU and Laketa Ducat, RN, NICU who all spoke in support of safe staffing and break coverage.

11. Comments by Chief Executive Officer

Mr. Steve Dietlin, CEO thanked today's speakers for their input. He emphasized that our number one priority is the safety of our front line workers, patients and visitors.

Mr. Dietlin encouraged the community to access the care that is available and emphasized that hospitals continue to be a safe place to go for treatment.

With regard to COVID-19 Tri-City primarily tests those individuals that present with symptoms and we have an approximate 4% positive rate on that testing. In the past few weeks we have seen 19-21 positive patients in the hospital. He noted there has also been a spike in COVID-19 positive cases near the border.

Mr. Dietlin commented on the fact that revenue has decreased across the nation. Tri-City has implemented a few voluntary furlough programs. However furloughed employees continue to retain benefits including their seniority. Flexing is also occurring in non-patient areas. Mr. Dietlin noted the importance of staffing to volumes.

Mr. Dietlin reported Tri-City recently received a "B" Leap Frog rating and will continue on the journey to an "A".

Lastly, Mr. Dietlin reported this past Friday the United States Airforce did a "fly-over" in recognition of front line workers.

12. Board Communications

Director Schallock thanked everyone at the hospital for their time, efforts and sacrifices in helping us address this healthcare crisis.

Director Reno reported longtime friend and publisher Tom Missety passed away earlier this month.

Director Younger expressed her appreciation to SEIU for their support and comments at today's meeting.

Director Chavez expressed his appreciation to all who made comments at today's meeting.

Director Coulter expressed his appreciation for staff's efforts in keeping the hospital clean and sanitized.

Director Nygaard also thanked the staff for all their hard work.

13. Report from Chairperson

Chairperson Grass reported in the county of San Diego there are 7,100 COVID-19 positive cases and 216 deaths. Today an additional 117 new cases were reported and we lost five more citizens.

Chairperson Grass also reported the San Diego Department of Public Health reported it will be permissible to sit on county beaches beginning June 2nd, however masks must be worn in public.

14. Move to adjourn

It was moved by Director Reno and seconded by Direction Coulter to adjourn the meeting. The motion passed unanimously (7-0) by a roll call vote.

15. There being no further business Chairperson Grass adjourned the meeting at 5:40 p.m.

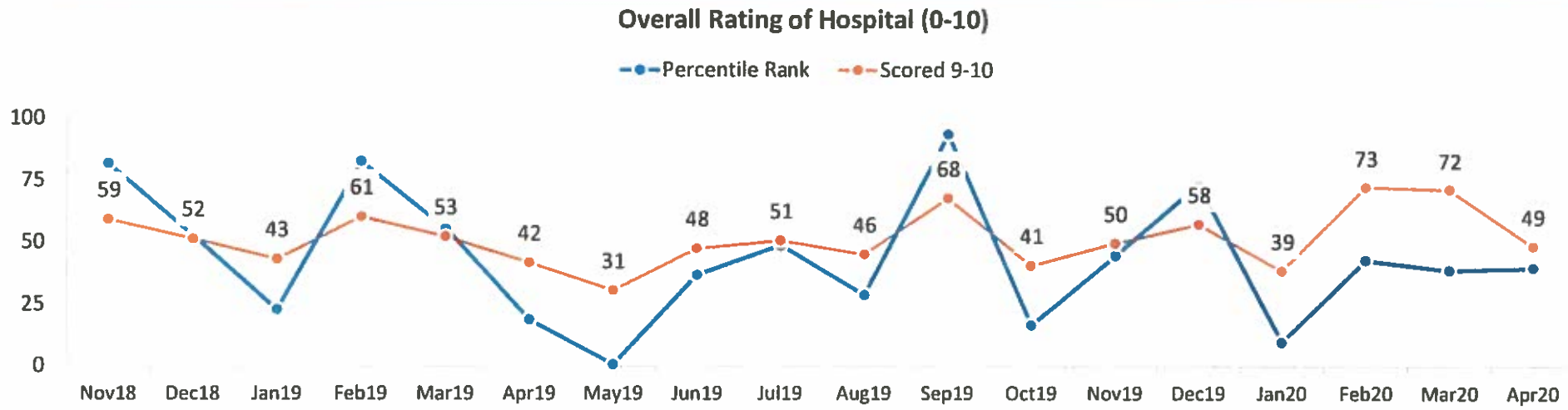
Leigh Anne Grass, Chairperson

ATTEST:

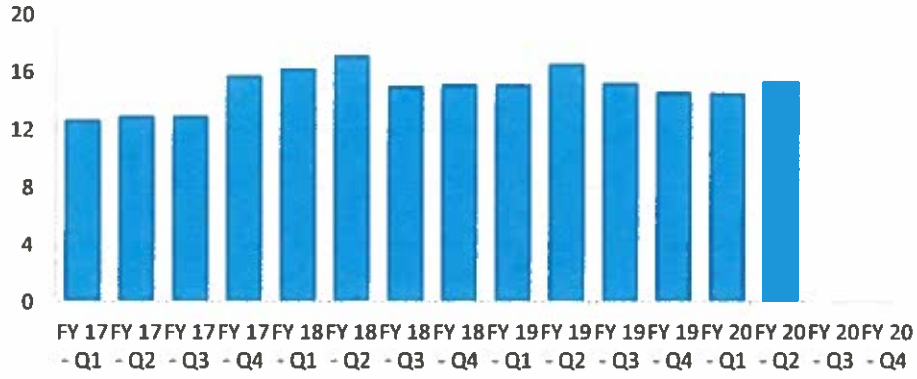
Julie Nygaard, Secretary

Stakeholder Experiences

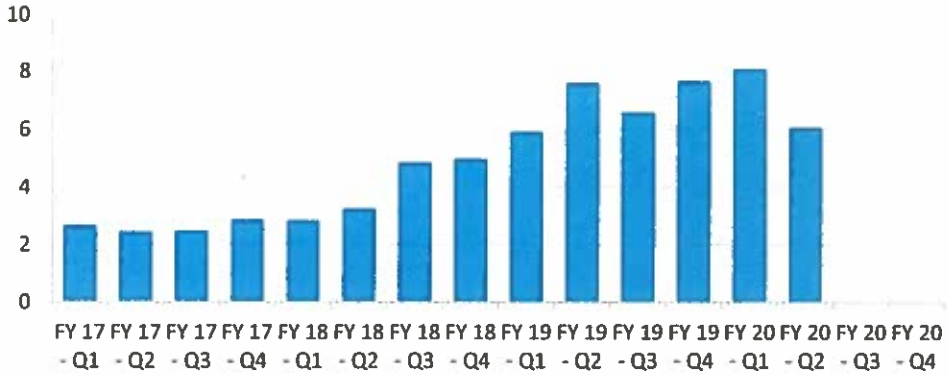
Overall Rating of Hospital (0-10)



Voluntary Employee Turnover Rate



Involuntary Employee Turnover Rate



Volume

Performance compared to prior year: Better | Same | Worse

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	16	19	18	31	30	15	20	19	24	15	18		225
FY19	18	29	19	27	18	24	22	16	23	30	25	24	251

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	8		94
FY19	10	12	3	7	7	9	10	4	16	15	11	12	104

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	7		110
FY19	19	16	12	16	12	16	17	13	18	16	10	15	165

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	18		266
FY19	20	23	18	22	17	21	19	16	18	12	20	24	206

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	33	33	23	31	35	31	26	29	20	12	18		291
FY19	31	31	27	35	38	31	23	40	36	24	29	36	345

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	-	-	-	-	-	-	-	-	-	2.9

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	9.3		6.7
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	6.4

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	9.4	10.3	13.4	9.7	9.5	9.4	7.8	10.7	10.0	6.3	8.8		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	10.2

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	143.4	143.6	150.6	143.2	144.0	160.2	153.9	149.3	137.6	124.0	132.0		143.8
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	153.0

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	133		1,618
FY19	186	202	170	187	185	166	170	150	177	131	146	156	1,870

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	10		108
FY19	8	10	6	8	3	15	6	9	11	10	20	13	106

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	4		94
FY19	3	4	3	13	13	6	11	17	6	10	7	9	93

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	4		59
FY19	8	8	6	8	4	14	8	10	16	6	7	5	95

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	1.81		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	56.4		57.7	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	52.7	

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	105.5		93.2	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	88.9	

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	($2,982)		($11,239)	$2,203
FY19	($478)	($121)	$119	$254	$342	$236	($527)	$99	$206	$885	$904	($6,138)	$1,919	

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%	-14.31%		-3.84%	0.68%
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%	0.58%	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCHD EBITDA $ in Thousands (Earnings before Interest, Taxes, Depreciation and Amortization)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY20	$686	$681	$412	$683	$62	$128	$367	$551	($3,164)	$3,159	($1,774)		$1,792	$ 15,114
FY19	$796	$1,168	$1,417	$1,561	$1,618	$1,544	$826	$1,468	$1,548	$2,219	$2,221	($4,712)	$16,386	

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%	-8.51%		0.61%	4.64%
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%	4.99%	

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	5.61		6.66	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	6.90	

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	$62.3		
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 May 31, 2020

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	Ending	Services & Location	Cost Center
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.59	(a)	47,418.30	07/01/17	06/30/27	**OSNC - Carlsbad** 6121 Paseo Del Norte, Suite 200 Carlsbad, CA 92011	7095
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	06/30/20	**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
JDS FINCO LLC/Oceanside MOB 499 N EL Camino Real Encinitas, CA 92024 V#83694	Approx 2,460	$2.15	(a)	7,011.00	04/01/20	04/30/21	**La Costa Urology** 3907 Waring Road, Suite 4 Oceanside, CA 92056	7082
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
TCMC, A Joint Venture 3231 Waring Court, Suit D Oceanside, CA 92056 V#83685	Approx 1,444	$2.59	(a)	3,754.00	02/01/20	05/30/20	**Pulmonary Specialists of NC** 3231 Waring Court Suit D Oceanside, CA 92056	7088
Total				$ 174,471.47				

(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 May 2020

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6185	ONS/ONCC CHEMOTHERAPY RENEWAL	52120 EDU	103.00	82126	GEORGIENA CABUANG
8756	CMS HOSPITAL QAPI WEBINAR	52520 EDU	119.00	83102	JACLYN HUNTER
8756	CMS HOSPITAL QAPI WEBINAR	52520 EDU	119.00	83102	J DANIELS
8756	CMS HOSPITAL QAPI WEBINAR	52520 EDU	119.00	83102	P REYNOLDS
8756	CMS HOSPITAL QAPI WEBINAR	52520 EDU	119.00	83102	M LEVINE

**This report shows reimbursements to employees and Board members in the Education & Travel expense category in excess of $100.00.

**Detailed backup is available from the Finance department upon request.